Our Ten Point Plan (cont'd)

5. Leadership and Structure

We will empower leaders at all levels of the organisation, and help them to support and lead their teams, by giving them fewer priorities, clearer expectations and genuine accountability, underpinned by more effective structures. Immediate changes include bringing together our Urgent & Emergency Care and Specialty Medicine clinical divisions to support our focus on patient flow.

6. Governance

We will spend less time in meetings and ensure that any meetings which do take place are kept short and have a clear purpose for everyone involved. Our revised performance and accountability framework will support the delivery of sustainable quality, safety and efficiency improvements.

Our Ten Point Plan (cont'd)

7. 4ward Improvement System

We will make our improvement system simpler, more accessible and more relevant to our staff and focus on its practical application to deliver our priorities, improve quality and safety and drive efficiency and cost improvement.

8. Think (and Act) as a Lead Provider

Looking beyond the walls of our hospitals we will actively work with partners across our health and care system to improve wellbeing of people in the communities we serve, deliver better health outcomes and reduce pressure on our services.

9. Partnership with large specialist (tertiary) providers

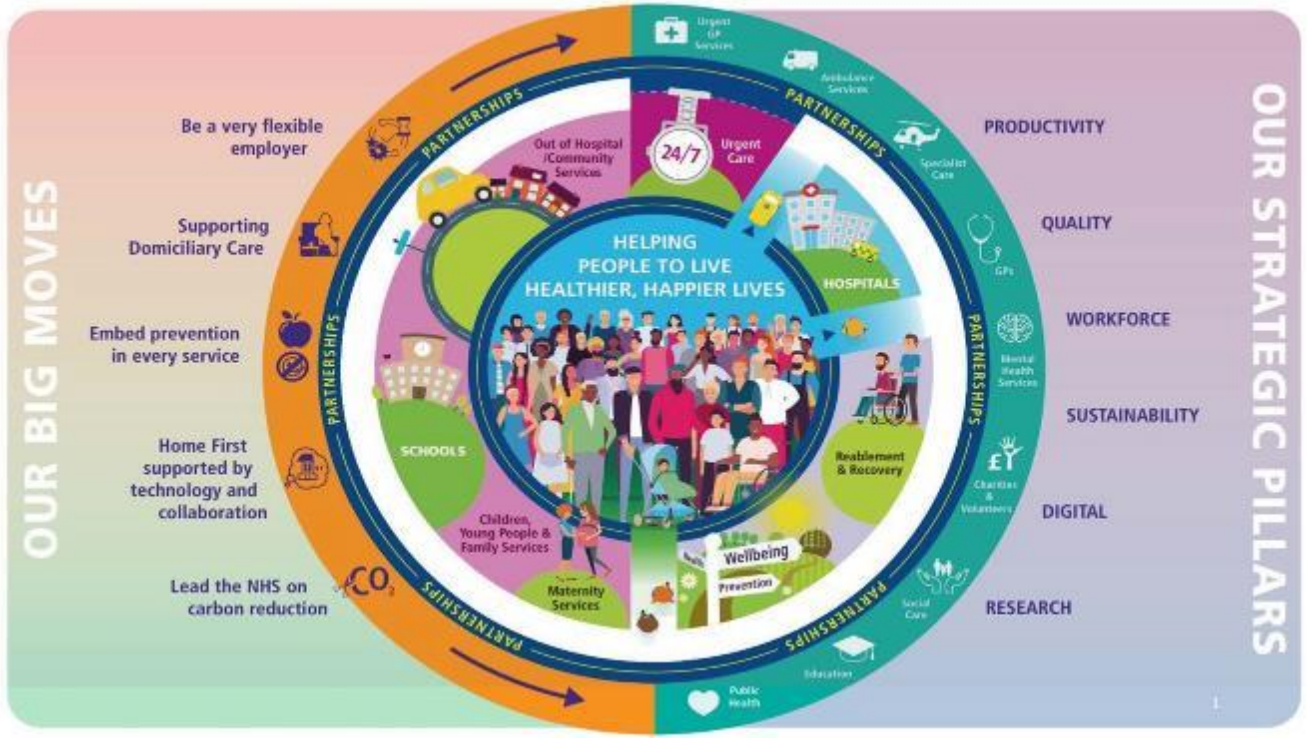
Working regionally and with Group colleagues we will build productive, supportive partnerships which improve care for our patients and secure a sustainable future for our more challenged or fragile services.

Our Ten Point Plan (cont'd)

10. Big Moves

We will embrace the opportunities open to us as members of the Foundation Group family.

We will test and refine our priorities (with our patients, our partners and our people) to make sure that we are meeting the immediate needs of our patients while also delivering improvements that move us closer to achieving our Group's shared long term strategic objectives and 'Big Moves' (including our environmental commitments as a major employer and user of resources).



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NHS Wye Valley NHS Trust
NHS Worcestershire Acute Hospitals NHS Trust
NHS George Eliot Hospital NHS Trust
NHS South Warwickshire University NHS Foundation Trust

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**12/03/2024**
Title of Report:	Risk Management Framework – Policy and Procedures
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Trust Management Board, Executive Risk Management
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Sarah Shingler, CNO
Documents covered by this report:	20240306 – NEW risk-management-framework-and-procedures DRAFT updated

1. Purpose of the report

To update and seek Trust Board approval of the new Risk Management Framework.

2. Recommendation(s)

The Chief Nursing Officer requests that the Trust Board:

1. Note the content of the Risk Management Framework and the responsibilities required of Trust Board; and,
2. Approve the Risk Management Framework – Policy and Procedures

3. Chief Officer/Executive Director Opinion[1]

The attached document sets out the Trust's new risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees.

The form and functions of the Board Assurance Framework (BAF), which is informed by the risks to achieving the strategic objectives, and the risk register structure for operational risks, are also set out.

The strategy is written in the context of good governance, business planning, performance management and assurance.

As part of the review of the Risk Management Framework the CNO has recommended that an Executive Risk Management Committee is introduced into the Trust reporting structure. The overall purpose of the Executive Risk Management Committee is to ensure the effective implementation of the Risk Management Strategy and that there are core processes in place to manage risks across the organisation. The Executive Risk Management Committee replaces the Risk Management Group and had its first meeting 1 March 2024.

In addition, a Corporate Division Risk Management Group has been introduced, chaired by the Board Secretary. This group will review Health & Safety, IT, Finance, Human Resources, Workforce and Estates risks reporting, as with the other divisions, their high risk into the Executive Risk Management Committee.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☐ *Focus on Flow*	☐ *Think/Act as a Lead Provider*
☒ *Governance*	☐ *Improve Staff Experience*
☐ *Home First Mindset*	☐ *Tertiary Partnerships*
☐ *4ward Improvement System*	☐ *Leadership and Structures*
☐ *Elective Care: No Delays*	☐ *Strategic 'Big Moves'*

NHS
Worcestershire
Acute Hospitals
NHS Trust

Risk Management Framework Policy and Procedures

Department/Service:	Clinical Governance and Risk Management
Originator:	Sarah Shingler – Chief Nursing Officer Allan Bailey – Associate Director Patient Safety and Risk
Accountable Director:	Sarah Shingler - Chief Nursing Officer
Approved by: **Ratified by:** **Endorsed by:**	Executive Risk Management Committee Trust Management Board Trust Board
Date of Approval: **Date of Ratification:** **Date Endorsed:**	TBC TBC TBC
Next Revision Date: **This is the most current document and is to be used until a revised version is in place**	This Policy requires to be revised every 3 years or sooner if circumstances dictate
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Departments
Target staff categories	All Staff

Strategy Overview:

This Policy sets out the Trust's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees.

It describes the Trust's appetite for risk for a range of circumstances and objectives.

The form and functions of the Board Assurance Framework (BAF), which is informed by strategic risks and the risk register structure for operational risks, are also set out.

The strategy is written in the context of good governance, business planning, performance management and assurance.

Key amendments to this Document

Date	Amendment	By:
Jul 2005	Revision with more detail about Risk Registers, targeted training, revised risk management objectives, Directorate Performance reviews etc.	C. Rawlings
Nov 2006	Revision includes actions to meet the requirements of the pilot National Health Service Litigation Authority (NHSLA) Risk Management Standards, including the need for risk management strategies for all areas and a revised risk escalation process.	C. Rawlings
Jan 2008	Editing to define the strategy and policy elements. Revision of the means of monitoring compliance with implementation of this strategy and to revise its objectives. Requirement for Directorate Risk Coordinators removed although GMs, CDs or equivalents have a responsibility for managing risk by having processes in place and allocating specific roles in supporting them. Addition of identification of partnership risks	C Rawlings
Jul 2008	Revisions made for FT application. Review and changes include: risk scoring matrix; risk escalation process; corporate risk register process; training requirements; monitoring arrangements; creation of the Risk Validation Group	C. Rawlings
Sep 2008	– Board Assurance Framework section re-established at section 5. Risk Validation Group added to risk management process in Appendix B Inclusion of Chief Operating Officer (COO) to replace Director of Operations (DoF) associated with business risks and COO with business continuity risks.	C. Rawlings
Jul 2009	Revisions made to accommodate the changes to the Trust's Management and Committee structures Risk Scoring Matrix (Appendix C) revised and re-issued Board Secretary now responsible for the BAF	C. Rawlings
Sep 2009	Objectives revised and provided in appendix D	Executive Team
Jul 2010	Minor changes made to: reflect operational structure and responsibilities and the extended life of the European Risk Management Council (ERMC); clarification of the Executive Team role in receiving new significant risks; Addition of Fraud risk identification; amendment to the escalation process; approved by Executive Team	C. Rawlings
Jun 2012	Revisions made to reflect operational structure, Monitor requirements and to separate this document out into a strategy and separate 'policy'. Monitoring / KPIs improved.	C. Rawlings
Sep 2012	Clarification of 6.3 training. Minor change approved by Chairman	C. Rawlings
Jul 2014	Revision and explanation of the risk management framework Widespread changes to the process and responsibilities to reflect the new Trust structure Description of the new approach to the Board Assurance Framework Revised risk scoring matrix	C. Rawlings

Date	Amendment	By:
Feb 2015	Revised likelihood definitions and formatting of Appendix 3 Risk Scoring Matrix	J. King
Apr 2015	Minor update following annual review, titles, committees and implementation plan updated.	J. King
Nov 2016	Minor amendments to reflect the changes to the Trust governance structure and Trust Risk Officer post	W. Huxley-Marko
Apr 2017	Amendments to escalation process for adding risks to the Corporate Risk Register	C. Geddes
May 2017	Amendments to objectives, references and risk description. Additions made to reflect changes to structure.	S. Lloyd
Apr 2018	Amendments to roles and responsibilities, the addition of risk profiling, updated objectives and updated references.	S. Lloyd C. Geddes V. Morris
Aug 2019	Amendments to risk description, escalation process, changes to reflect current governance structure, addition of frequency of review, authority for managing risks and monitoring process.	D Johnson
July 2023	Amendments to font, correction of typing errors and inclusion of 'residual risk log' description	K.Apps and S.Sugar
July 2023	Amendments to Risk Appetite	R. O'Connor S.Sugar
December 2023	Policy rewritten to align with Foundation Group reporting and governance arrangements	S Shingler

Table of Contents

1 SCOPE AND PURPOSE

All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary). Breaches of adherence to Trust policy may have potential contractual consequences for the employee.

The Trust's aim is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

The Board recognises that to deliver their strategic objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: these are cornerstones of building safer, effective, and efficient care for the future.

The Trust will continue to promote and maintain a safe environment for staff, patients, visitors and those required to undertake work on trust premises, to:

- Ensure that risk management is an integral part of Worcestershire Acute Hospitals Trust culture
- Minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy
- Maintain a cohesive approach to corporate governance and effectively manage risk management resources
- Ensure that Worcestershire Acute Hospitals Trust meets its obligations in respect of Health and Safety.

2 INTRODUCTION

Worcestershire Acute Hospitals Trust culture ('The Trust') recognises that successful risk management must be the responsibility of all staff and be comprehensive and coordinated, that proactive and continuous identification and management of risk is essential to the delivery of high quality services. The Trust acknowledges the delivery of healthcare can never be risk free and taking decisions about risk and opportunity is a part of everyday clinical and non-clinical practice and management.

Risk Management must be recognised as a fundamentally integral and central way that the Trust operates and be considered 'good management practice'. It must form part of the overall decision making process and day to day management activities and should not be seen as a separate activity that is carried out once decisions have been made.

The basic standard for a Risk Management system is compliance with the Law as a minimum standard, for example Employment Law, Health and Safety Legislation, Fire Safety.

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the Trust's reputation, its ability to deliver statutory responsibilities, the delivery of objectives and the delivery of safe and effective patient care. It is a key component of general management practice as it aims to ensure achievement of objectives is more likely if:

- Adverse (damaging) events are less likely
- Costly re-work and 'fire-fighting' is reduced
- Capital and resources are utilised more efficiently and effectively
- Performance is improved (including quality, finance for example)
- Decision-making is better informed
- Positive outcomes for stakeholders are increased
- Reputation is protected and enhanced

In summary, **risk** is defined as the uncertainty of achieving an objective that has not yet occurred at the time of writing. In contrast, an **issue** is an event or set of circumstances which is already occurring which poses a concern relating to the ability to deliver objectives.

The Risk Management Framework is supported by the Trust's wider suite of policies, with a clear connection to the following policies:

- Business Continuity Policy
- Claims Handling Policy and Procedure
- Risk Management Strategy
- Concerns and Complaints Policy and Procedure
- Fraud, Bribery and Corruption Policy
- Information Risk Policy
- Health and Safety Policies – to include the Health and Safety Policy and the Infection Control Policy
- Serious Incident investigation Policy
- Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3 DEFINITIONS

Risk Management	Risk Management is the term used to describe the activities required to identify, understand and control exposure to uncertain events which may threaten the achievement of objectives.
Risk	Risk is defined as an uncertain event or set of events, which should it occur, will have an effect upon (i.e., threaten) the achievement of objectives. Risk consists of a combination of the likelihood of the

	'threat' happening and the impact of that threat happening and is described as the combination of: • Cause: If… (something happens) • Event: Then… (this may occur) • Effect: Resulting in…. (The impact)
Issue	An issue is an event or set of events that have already occurred. These can be added to the incident management system for highlighting, monitoring and escalating where needed by selecting "issue" instead of "risk". Issues should be managed as per risks noting planned actions, mitigations, review dates and target dates for closure and should be discussed at Care Group and Divisional Governance and Corporate Meetings
Control	Actions in place to assist in the mitigation of the risk and the achievement of an objective, by reducing the likelihood or impact. For example, a policy or training programme.
Assurance	Assurance is the evidence which describes how effective the controls are. For example, a report summary of incidents may tell us that we have very few patient falls, therefore suggesting that our controls to prevent falls are working effectively.
Risk Appetite	Sets out the levels and types of risk we are prepared to accept, tolerate, or be exposed to at any point in time, in pursuance of our objectives.
Risk Tolerance	The amount (risk level/score) prepared to take to achieve strategic and operational goals.
Risk Register	A record of all identified risks relating to a set of objectives, including their history, status and risk score. The purpose of a risk register is to evidence and drive risk management activities, and it is used as a source or means of risk reporting. The Trust has implemented several types of register that support the overall Risk Management system. These are: • Board Assurance Framework • Trust-wide risks • Divisional-wide risks • Directorate risks • Local (ward and department) risks • Specialty risks
Project Programme Risks	Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the

	approach. Risk registers or logs will still be maintained for risks to programmes or projects, but these are held as part of the project documentation held within the Programme Management Office. However, this project documentation may be referred to as a source of control and/or assurance, within related risks held on the Risk Register.
Strategic Risks	These are reported via the Board Assurance Framework. These include strategic risks which concern the Trust's main purpose and could impact the achievement of key objectives.
Trust-wide Risks	These are reported via the Divisional Risk Registers. These include cross-cutting internal risks over which the Trust has full or partial control and/or that can be managed through internal controls e.g., fraud, health and safety, workforce and data security.
Directorate / Divisional Risks	These are reported via the Divisional Risk Register. These include local/delivery risks that could impact the achievement of divisional and directorate business plans.

4 DUTIES

The day-to-day management of work place risks are the responsibility of everyone in the Trust and the identification and management of risks requires the active engagement and involvement of staff at all levels. Individual staff are best placed to understand hazards relevant to their areas of work and must be enabled to manage risks arising from these hazards, within a structured management framework. This can only be achieved within a progressive, honest, open and 'just' environment where hazards, accidents, incidents, mistakes and near misses are identified quickly and acted upon in a positive and constructive way.

4.1 All Staff

Including Bank, agency Staff and Contractors - have a personal responsibility for risk management and compliance with this policy, including awareness of the risks within their working environment, how their role impacts on those risks and taking reasonable steps to reduce the risk if possible. All members of staff have a responsibility to contribute to the effective management of risk by maintaining risk awareness, identifying, reporting and managing risks as appropriate to their Divisional Directors, Divisional Nurse Directors, Clinical Directors, Directorate Manager or Line Manager. They will ensure that they familiarise themselves with the risk management procedure for the Trust and attend/complete risk management training as appropriate.

4.2 Trust Board members

The Trust Board members have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

4.3 Non-Executive members

Non-Executive Directors have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

4.4 Chief Executive

The Chief Executive has overall responsibility for risk management. As Accounting Officer, the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives and signing the Annual Governance Statement in the annual report and accounts.

4.5 Managing Director

The Managing Director will:

- Ensure delivery of the strategic objectives
- Ensure that employees and the public are properly protected against exposure to risks arising out of or as a result of the Trust's activities

4.6 Chief Nursing Officer

The Chief Nursing Officer will:

- Ensure that the Trust has an effective structure and system in place to manage risks within the organisation
- Chair the Executive Risk Management Committee

4.7 Executive Directors

Executive Directors are responsible for:

- ensuring delivery of the strategic objectives
- identification, control, monitoring and reporting of the risks which may threaten achievement of strategic objectives
- maintaining accurate and up to date risk registers, relevant to their objectives and in addition report through the Board Assurance Framework (BAF)
- providing oversight of operational risks which have been escalated to the Executive Risk Management Committee.

4.8 Corporate Governance and Risk Department

The Corporate Governance and Risk Department is responsible for:

- development and review of the Risk Management Policy
- provision of education, support and expertise in relation to Risk Management
- provision of training on the Risk Management Policy
- monitoring and reporting compliance with the Risk Management Policy
- facilitating the reporting of appropriate risks to the Board, Committees and Executive Groups

- quality checking of risks on the register and subsequent risk management

4.9 Divisional Triumvirates, Divisional Directors, Associate/ Deputy Directors, Divisional Directors of Nursing (or equivalent for non-clinical divisions) and Clinical Governance Leads

- leading and overseeing implementation of the Risk Management Policy at Divisional level which includes effective identification and ongoing review of, controls, monitoring and reporting of the risks which may threaten achievement of Divisional objectives
- facilitating the reporting and where necessary, escalation of appropriate risks to the Divisional Board and the Executive Groups
- maintaining accurate and up to date risk registers, relevant to their Directorate / service objectives.

4.10 Divisional Governance Leads (or equivalent nominated person for non-clinical divisions)

- facilitating implementation of the Risk Management Policy at Divisional level which includes the effective identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Divisional objectives, in accordance with the procedure set out within this policy
- monitoring and reporting compliance with the Risk Management Policy at a Divisional level, as identified by the Corporate Governance and Risk Department

4.11 'Risk Owners' including all Departmental/Ward/Service Managers

All risk registers, which are managed on the Risk Management System (Datix) contain individual risks and each risk is allocated a risk owner, which is recorded on Datix**.** The Risk Owner is responsible for taking appropriate action to minimise its impact and ensuring the risk is kept current, with updates recorded. Risk owners are responsible for:

- identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Directorate objectives, in accordance with the procedure set out within this policy
- maintaining accurate and up to date risk registers, relevant to Directorate objectives

4.12 Chairs of Monitoring Committees

Chairs of Monitoring Committees are responsible for:

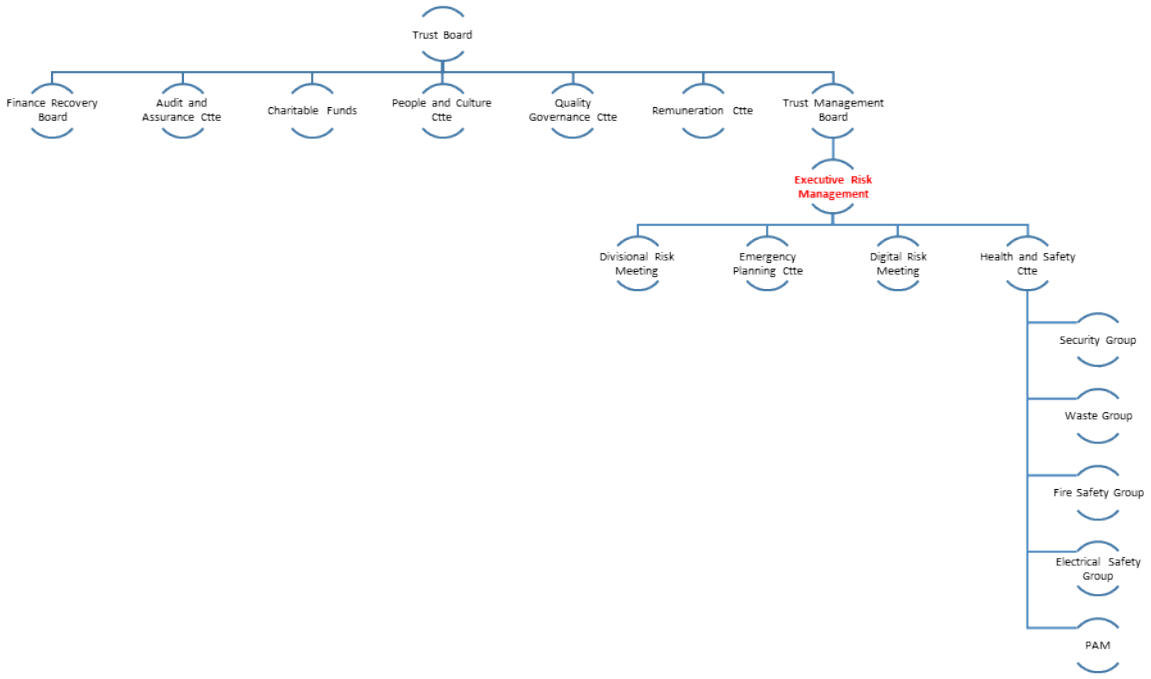
- identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
- reporting, where appropriate to the Executive Risk Management Committee

4.13 Internal Auditors

The **Internal Auditors** are accountable for agreeing (with the Audit Committee) a programme of internal audits, which assess the exposures and adequacy of mitigation of the risks affecting the organisation.

The priorities contained in the internal audit programme should reflect the risks set out in the BAF and the Risk Registers. The reports and advice produced by internal audit should inform the management of risk.

4.14 The Trust Reporting Structure



4.15 Trust Board

The Trust Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. A robust risk management framework ensures the systems and processes of control are in place to deliver the responsibility for implementing risk management throughout the Trust.

The Trust Board is required to produce statements of assurance which declare that it is doing its 'reasonable best' to ensure that the Trust meets its objectives and protects people using services, staff, the public and other stakeholders against all types of risk.

The Trust Board oversees the Trust's strategic risks in the following ways:

- Where a risk is rated 15 or above, the risk will be escalated to the Trust Board following discussion with the Executive Risk Management Committee.
- The Trust Board defines the structure of the BAF to ensure that it drives the Board's agenda and ensures the robust oversight of strategic risk. The BAF is the means by which the Trust Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic objectives. The BAF defines the control systems in place to mitigate strategic risks and confirms the assurances that the Trust Board wishes to receive throughout the year to evidence the effective operation of controls and mitigation of principal risks.
- The Trust Board utilises the BAF as a working document and reviews the BAF structure and content routinely, at minimum bi-annually.
- Members of Trust Board receive the Chair's Reports of the Audit Committee, Quality Governance Committee and Charitable Funds Committee. Through these reports, Trust Board receives a summary of key assurances and risks escalated by the Chairs

of each Board Committees.

The responsibility for monitoring the management of risk across the organisation is delegated by the Trust Board to the following Committees:

- Audit Committee
- Executive Risk Management Committee

4.16 Executive Risk Management Committee

The overall purpose of the Executive Risk Management Committee is to ensure the effective implementation of the Risk Management Strategy and there are core processes in place to manage risks across the organisation. The Executive Risk Management Committee will be chaired by the Chief Nursing Officer and will report on any issue where the Trust Board may require additional assurance or where a Trust Board decision is required.

The Executive Risk Management Committee will:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Trust.
- Coordinate the identification of all risks; Clinical, Health & Safety, IT, Finance, Human Resources, Workforce and Estates and ensure risk assessments are undertaken Trust wide, and that all risks are appropriately evaluated.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Trust-wide.
- Enable risks which cannot be dealt locally to be escalated, discussed and prioritised.
- Through the Divisional Risk Registers review new risks rated Red (15-25) and Amber (12) to consider whether they have been appropriately rated and agreeing action plans to control them.
- Through the Divisional Risk Registers review and monitor risks rated Red (15-25) ensuring action plans are being implemented to control the risks. In addition the Executive Risk Management Committee will review risks rated Amber (12), on a quarterly basis, to consider whether they have been appropriately rated.
- Review the risks on the Divisional Risk Registers to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, the risk will be added to the BAF.
- Review the BAF prior to its presentation to Trust Board.
- Advise the Board of Directors of exceptional risks to the Trust and any financial implications of these risks.
- Monitor the effectiveness of the agreed risk mitigating actions.
- Recommend priorities for resources to manage risks.
- Oversee the work of the Divisional Risk Governance Groups, the Corporate Division Risk Group, the Health, Safety & Wellbeing Committee and the Emergency Planning Committee.
- Review and monitor the implementation of the Risk Management Strategy
- Ensure that all appropriate and relevant requirements are met to enable the CEO to sign the Annual Governance Statement
- Approve documentation relevant to the implementation of the Risk Management Strategy

4.17 Divisional Risk Meetings

The overall purpose of the Divisional Risk Meetings is to ensure the effective management of divisional risks within the Trust, thereby contributing to the implementation of the Risk Management Strategy. The Divisional Risk Meetings will report to the Executive Risk Management Committee on divisional risks or where a decision may be required.

The Divisional Risk Meetings will:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key corporate risk management issues within the Trust.
- Coordinate the identification of all corporate risks; Health & Safety, IT, Finance, Human Resources, Workforce and Estates and ensure risk assessments are undertaken Trust wide, and that all risks are appropriately evaluated.
- Ensure appropriate actions are applied to Trust-wide risks.
- Enable risks which cannot be dealt locally to be escalated, discussed and prioritised.
- Through the Divisional Risk Registers review new risks to consider whether they have been appropriately rated and agree actions to control them.
- Review the risks on the Divisional Risk Registers to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, the risk will be added to the BAF.
- Monitor the effectiveness of the agreed actions.

4.18 Audit Committee

The Audit Committee is responsible for reviewing the adequacy and effectiveness of all risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the Trust Board; and the underlying assurance processes that indicate the degree of achievement of strategic objectives, the effectiveness of the systems and processes for the management of risks, the BAF and the appropriateness of disclosure documents.

4.19 Health and Safety Committee

The Health and Safety Committee supports the Trust in the discharge of its statutory health and safety duties, by setting strategy, monitoring health and safety performance, reviewing audit findings, agreeing plans where required and identify risks and the appropriate mitigating actions, monitoring their effective implementation. It also provides:

- a focal point and source of expertise for the Trust and its employees on health and safety issues and risks;
- a forum where all members can raise issues, concerns and good ideas relating to health and safety in the Trust, for consideration and action as appropriate.

4.20 Monitoring Committees

All risk registers, which are managed on the Risk Management System (Datix) contain individual risks and each risk is allocated a monitoring committee which identifies, manages and oversees risks relevant to their specialist subject, ensuring appropriate action is taken.

5 MAIN CONTENT

5.1 Key Risk Documentation

5.2 Risk Management System (Datix)

All staff are required to enter perceived and real risks onto the Risk Management System (Datix). This process ensures the Trust maintains contemporaneous local and divisional risk registers, underpinning the Trust's overarching BAF. The compilation and maintenance of an up to date and comprehensive Risk Register and BAF is one of the key elements of the Trust's Risk Management Framework.

The Risk Management System is an electronic database that holds the main record of all identified risks to the Trusts objectives and operations. These risks are recorded within individual risk registers allocated to teams, local delivery units, directorates or divisions. Any risks to the delivery of the Trust's strategic objectives are added to the Trust's BAF.

Each of these Risk Registers are dynamic documents readily accessible to all staff with risk management roles. Risk registers contain individual risks which are given a target and current risk rating (which is dynamically updated) along with relevant controls, assurances, gaps and mitigating actions. Actions are detailed to reduce the risk to the lowest acceptable level, or to a level determined as acceptable by the Trust Board and these are included within their relevant risk register. All identified risks will be monitored and reviewed on a continuous basis by the relevant management groups or monitoring committees.

Regular review and updating of all Risk Registers is a routine part of the risk management process. This ensures that new risks that arise will be identified and risks that are no longer relevant can be closed.

5.3 Board Assurance Framework (BAF)

The BAF is a tool via which risks to the achievement of the Trust's strategic objectives are managed and reported to the Board. Risks recorded on Divisional Risk Registers may also appear on the BAF if they have the potential to compromise delivery of Trust strategic objectives. Not every high scoring item on the divisional risk registers will appear on the BAF. The Board Secretary produces the BAF and oversees the relationship between the BAF and the Risk Register in conjunction with the Chief Nursing Officer.

5.4 Risk Assessment Process

A risk assessment is simply a systematic and effective method to identify and examine 'what could cause harm' in the workplace and will help identify the significant risks affecting the Trust, to minimise and remove these and to avoid wasted effort by effectively targeting these, therefore protecting the stability of the organization.

It is a valuable tool that can help professionals and managers improve the safety and quality of care given to the people we provide services to. It is an essential part of any risk management programme.

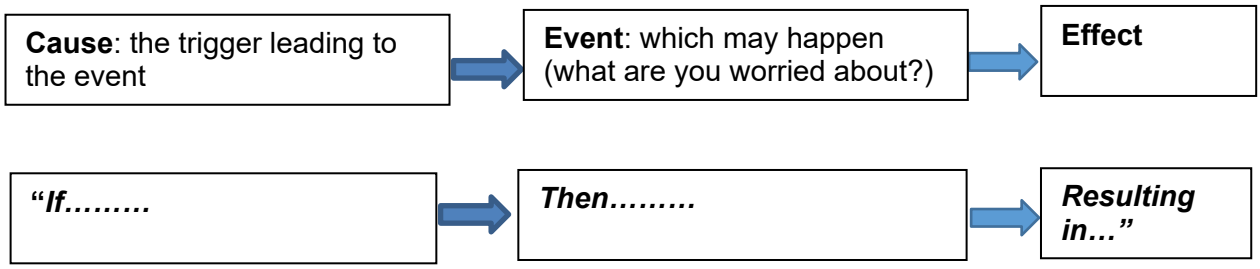
Any individual who identifies a hazard will bring it to the attention of their manager and undertake a risk assessment using the Trust's risk assessment process.

Risk assessment must be entered onto the Trust's risk management system (Datix). Once registered onto the Trust Risk Management system, the risk will be quality checked before

proceeding to the designated approval level. It is important to ensure that all risks are reviewed and updated including current and planned controls, assurances, and any identified gaps.

5.5 Risk Description

Risk is uncertain. There should only be one cause and one event, but the risk may have multiple effects.



Supplementary Information

It is particularly helpful to include actual evidence to support the risk description. This could be the result of an increase in particular incident reports or complaint, poor audit results, unsatisfactory external review or a nationally recognised problem.

5.6 Likelihood and Impact Assessment

To assess the likelihood of the risk, focus on the "If…." section on the risk description.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Time framed	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

To assess the consequence of the risk, focus on the ***"Resulting in"*** section on the risk description using the Trusts risk scoring matrix on Page 19.

It is possible that the risk may have more than one impact, for example financial loss, service-disruption and patient safety. Using the scoring matrix to impact score each of the categories separately and then select the one that has the highest consequence.

To identify the initial risk score, multiply the result of the likelihood assessment and the result of the consequence assessment. The score is to be calculated before the introduction of controls and remains unchanged once calculated.

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

5.7 Current Controls and Assurances

Consider what existing controls and assurances are in place.

Existing controls Should make a risk less likely to happen and/or reduce the impact if it does happen. Controls can also be a contingence to be enacted should the risk happen

Existing gap in controls Any part of a control that has a breach, for example, training is the control, but no attendance at training is the gap in control.

Existing assurance Assurances provide information or evidence about the effectiveness of the controls. An assurance description needs to state what the source of assurance is and more importantly information the assurance is providing and, if possible, the time period to which it relates.

Identify your current risk score (likelihood x consequence as described above), taking in to account existing controls and assurances and whether the controls have reduced the likelihood or impact of the risk.

5.8 Target Risk Rating

Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved and what further resources may need to be allocated to reduce the risk. This is included on the risk assessment form as the Actions. The Actions is the fundamental driver of mitigating a risk and requires timeframes and action owners.

To achieve the target risk rating, Actions MUST be evident.

Risk consequence descriptors examples:

Domains	Consequence Score (Severity Levels) - Examples				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Safety **Patients, staff or public (physical /psychological harm)**	• Minor Harm • Requiring no/minimal intervention or treatment. • No time off work	• Short term injury or illness, < 1 month. Requiring minor intervention • Increase in length of hospital stay by 1-3 days • Requiring time off work for >7 days	• Semi-permanent harm, 1 month to 1 year. Requiring professional intervention • Increase in length of hospital stay by 4-15 days • An event which impacts on a small number of patients Requiring time off work for 8-14 days • RIDDOR/agency reportable incident	• Major permanent loss of function – for a patient unrelated to natural course of illness/underlying condition/pregnancy etc. • Increase in length of hospital stay by >15 days • Requiring time off work for >14 days	• Unanticipated death, multiple permanent injuries. • An event which impacts on a large number of patients – eg breast screening errors.
Quality	• Peripheral element of treatment or service suboptimal	• Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on.	• Non-compliance with national standards with significant risk to patients if unresolved • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted on • Gross failure to meet national standards
Complaints	• Informal complaint/inquiry	• Formal complaint (stage 1) • Local resolution	• Formal complaint (stage 2) • Local resolution (with potential to go to independent review)	• Multiple complaints/ independent review	• Inquest/ombudsman inquiry
Human **Resources**	• Short-term low staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory/ key training	• Non-delivery of key objective/service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training /key training on an ongoing basis
Statutory Duty and inspections	• No or minimal impact or breech of guidance/ statutory duty	• Breech of statutory legislation	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action Multiple breeches in statutory duty • Improvement notices	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Severely critical report

Reputation	• Rumours	• Local media coverage	• Regional media coverage	• National media coverage for <3 days. Increased level of political & public scrutiny.	• National media coverage for >3 days. • MP concerned (questions in the House) • Total loss of public confidence • Chair/CEO &/or Exec team removal.
Service Delivery	• Service disruption that doesn't affect patient care - >1 hour	• Short disruption to services that affects patient care - >8 hours	• Sustained period of disruption to services - >1 day to 1 week	• Intermittent failures in a critical service - >1 week	• Breakdown or closure of a critical service.
Financial Loss	• No or minimal impact on cash flow • Loss of <0.1 percent of Trust's annual budget • Some adverse financial impact affecting the ability of the service to operate within its annual budget. • Low risk of claims.	• Readily resolvable impact on cash flow • Loss of 0.1–0.25 per cent of Trust's annual budget • Noticeable adverse financial impact affecting the ability of the directorate to operate within their annual budget. • Claims up to £100k	• Individual supplier put Trust "on hold" • Loss of 0.25–0.5 per cent of Trust's annual budget • Significant adverse financial impact affecting the ability of the division to operate within their annual budget. • Claims £100k-£250k	• Major impact on cash flow • Loss of 0.5–1.0 per cent of Trust's annual budget • Uncertain delivery of key objective. • Significant adverse financial impact affecting the ability of the organisation to achieve its annual financial plan. • Claims £250k-£500k	• Critical impact on cash flow • Loss of >1 per cent of Trust's annual budget • Non-delivery of key objective / specification. • Significant adverse financial impact affecting the long-term financial sustainability of the organisation • Claims >£500k
Business objectives and projects	• Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Environmental impact	• Minimal or no impact on the environment	• Minor impact on environment	• Moderate impact on environment	• Major impact on environment	• Catastrophic impact on environment

5.9 Risk Source

A range of information sources can be used to identify risks. These include, but are not limited to: adverse events, incidents, near misses, serious incidents, investigation reports, complaints, claims, risk assessment, audit/internal control reports, assurance framework, CQC standards, legislation, financial reports, workforce reviews, survey reports and stakeholder reviews.

Although the above list is not exhaustive, it provides an indication of the various sources of information used to identify risks and types of risk that may impact upon the delivery of services. It is important to be rigorous in the identification of sources and impacts as the risk treatment strategies will be directed to sources (preventive) and impacts (reactive).

It is particularly helpful to include actual evidence to support the risk description. This could be the result of an increase in particular incident reports or complaint, poor audit results, unsatisfactory external review or a nationally recognised problem. This information can be added to the 'Supplementary Information' section on the risk assessment form.

5.10 Update and Management of Risks

The management of a risk is the key to mitigation, therefore risk rating makes it easier to understand the Trust-wide risk profile. It provides a systematic framework to identify the level at which risks will be managed and overseen in the organisation; prioritise remedial action and availability of resources to address risks; and direct which risks should be included on the Trust's risk register. The table below provides guidance on the urgency of actions to mitigate the risk and clarifies reporting and oversight arrangements.

Rating of risk	How the risk should be managed – *All risks should be added to the Risk Register on Datix straight away and be manged through this means.*
Extreme (15-25) Risk to be reviewed on a monthly bases*	**Requires immediate and active management with robust contingency plans (Action Plan)** High impact / High likelihood: risk requires immediate active management to bring down the likelihood of the risk, thus allowing the activity to continue. A robust Action plan must be put into place, with realistic timeframes and allocated Action Lead to mitigate/reduce the risk likelihood. ***Must Do's:*** Inform/escalate and discuss the risk immediately with the Divisional Tri, Directorate Manager, Speciality Manager and Governance & Risk Co-ordinator. This risk will need to be monitored through Specialty, Directorate and Divisional Governance Meetings monthly until the Likelihood score is reduced.
High (8-12) Risk to be reviewed on a one to two monthly basis*	**Contingency plans** A robust Action plan must be put into place, with realistic timeframes and allocated Action Lead to mitigate the risk straight away and this needs to be monitored through Specialty, Directorate and Divisional Governance. ***Must Do's:*** Inform/notify and discuss the risk with the Governance & Risk Co-ordinator, Speciality Manager, and Directorate Manager and finally the Divisional Tri/Quad through the Divisional Governance Meeting monthly. Risk to be reviewed one to two monthly at Specialty and Directorate Governance Meeting
Moderate (4-6) Risk to be reviewed three monthly basis*	**Good housekeeping** Will require risk mitigation through an Action Plan, this will reduce the likelihood, but the main area is good housekeeping to ensure the impact (likelihood) remains low. Reassess frequently to ensure conditions remain same and do not escalate. ***Must Do's:*** Inform the Governance & Risk Co-ordinator and Specialty Manager and review through Speciality Governance Meetings at least three monthly.
Low (1-3) Risk to be reviewed on a six monthly basis*	**Review periodically – Theses risks generally sit under Local Risks** Risks are unlikely to require many mitigating actions but status should be reviewed frequently to ensure conditions have not changed. ***Must Do's:*** Inform Governance & Risk Co-ordinator, Ward or Department Manager and Specialty Manager and Review through Speciality Governance Meetings at least three monthly.

** This is the official review timings of risk - however you must never lose sight of risks at whatever level they sit at, as risks can significantly change (escalate or de-escalate) on a daily, weekly and monthly basis, dependant of the service need, sources of information (Incidents, SI's, Never Events, Near Misses, Complaints, Claims, Health and Safety), new National Guidance and front door activity.*

Irrespective of the score it is important that the key individuals responsible for advising and coordinating specific risk issues are kept informed of new risks or changes to existing risks (this is not an exhaustive list and advice should be sort by whomever the expert is where the risk is identified or has an impact).

All risks must be reviewed at the appropriate meeting for oversight, progress check and challenge as required. For example, any risks on the Divisional Risk register should be discussed at the Divisions Governance meetings.

If concern is raised that a risk can no longer be managed within their area, this needs to be formally escalated for consideration. This can be undertaken electronically using the escalation tab. It is then for the risk owner to discuss and determine whether it is appropriate to accept that risk onto the register.

When risks are reviewed as part of the governance structure within the Specialty, Directorate or Division, the following questions should be incorporated during the review:

- Is the risk still relevant (what changes have occurred in the internal/external environment)?
- How do I know the controls have been effective – have there been any internal or external reports to provide assurance?
- What progress has been made in managing the risk?
- Given the progress (or not), does the risk score need revising?
- Are any further controls required, if so what should these be?
- Are the actions still relevant or are there any further that are required?

5.11 Control Considerations

Terminate the risk. The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently. However, this option is limited and rarely an option in the NHS (compared to the private sector), where many activities with significant associated risks are deemed necessary for the public benefit, this may be possible for some non-core activities or some actives that have so much risk involved it is not deemed in the best interests of the organisation, staff, patients or contractors. The Executive Management Team are the only designated people who can agree to terminate a risk.

Tolerate/accept the risk. Applies to risks within the tolerance threshold or those where the costs of treatment far outweigh the benefits. If the decision is made to tolerate the risk, consideration should be given to develop and agree contingency plans, business continuity plans or recovery plan arrangements for managing the consequences if the risk is realised. The Executive Risk Management Meeting are the only means to agree tolerating a risk, whereby they will make the risk 'Accepted'.

Transfer the risk. Risks may be transferred in their entirety* or in part, for example by conventional insurance or by subcontracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets or Estates. It should be noted that responsibility can be transferred, accountability rarely can and therefore the risk continues to need close monitoring. * It is important to note that reputational risk cannot ever be fully transferred.

Treating the risk. This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level.

5.12 Actions

Actions must be documented within the risk on the Risk Register and be SMART (Specific, Measurable, Achievable, Realistic and Time-bound), have a nominated owner and progress monitored by the appropriate risk forum and provide:

- Containment action (lessen the likelihood or consequence and apply before the risk materialises), or
- Contingent actions (put into action after the risk has happened, i.e. reducing the impact, must be pre-planned).

5.13 Assurance

Assurances confirm that the controls in place are effective and having the anticipated impact in reducing and mitigating risks. For example, intelligence data such as incident reports may indicate that a control that is in place is not effective. A gap in assurance is where there is no source of evidence to assess the effectiveness of a control.

Any identified gaps in controls or assurances might require additional controls or action to be taken to reduce the risk. The Trust Board expects all reasonable steps to be taken by all staff and particularly managers to reduce impact and likelihood of risk, particularly for those risks that are rated moderate and high risk.

The most objective assurances are derived from independent sources and these are supplemented from non-independent sources such as clinical audit, internal management reports and self-assessment reports. If there is a lack of relevant reviews, or concerns about the scope or depth of reviews this should be recorded on the Risk Assessment form as a gap in assurance.

Internal sources of assurance	External sources of assurance
• Internal audit reports • Performance reports to Board and its Committees • Local counter fraud work • Clinical audit • Staff satisfaction surveys • Staff appraisals • Training records • Results of internal investigations • Serious Incident reports (SI's) • Complaints records • Infection Prevention Control reports • Annual Health Check self-assessment • Information governance toolkit self-assessment • Patient advice and liaison services (PALS) reports • Human resource reports • Internal benchmarking • Local Security Management Specialist (LSMS) work • Patient environment action team (PEAT) reports • Health and safety reports • Maintenance records	• External audit • Audit Commission • NHS Resolution Risk Management Standards • Strategic health authority reports/reviews • Care Quality Commission hygiene code reports • Care Quality Commission inspections and reviews • OFSTED • HSE Reports • Royal College visits • Deanery visits • External benchmarking • Accreditation schemes • National and regional audits • Peer reviews • Feedback from service users • Feedback from CCG • External advisors • Local networks (for example, cancer networks) • Investors in People • Patient Reported Outcome Measures

5.14 New Risk Approval and Validation

Once new risks have been added onto the Risk Management System (Datix), all risks should be approved at Specialty and Directorate Risk/Governance Meetings prior to final approval at Divisional Risk Meetings.

5.15 Closing a Risk

If it is identified that a risk is no longer required to be managed on the risk register, this needs to be formally discussed and agreed (as per the meeting structures described above) and documented on the risk. Once it is agreed, the rationale for closure will need to be submitted onto the risk management system by the risk owner.

5.16 Risk Appetite

Risk appetite is the level of risk the Trust Board is willing to tolerate, based on the types of risks faced and the environment in which the Trust operates. The Trust will measure, monitor and adjust as necessary, the actual risk position of individual risks against the agreed risk appetite.

The Trust Board will adopt a risk appetite statement, reviewed annually, setting out the level of risk it is willing to accept in seeking to achieve its purpose and strategic objectives.

The Trust's risk appetite statement will be made available on the Intranet, and will make clear the Trust Board's expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable.

The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk. The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls.

6 TRAINING

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this framework will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trusts Statutory and Mandatory Training Policy which can be accessed on the Learning and Development pages on the Trust intranet.

Specific training will be provided in respect of high level awareness of risk management for the Board. Risk awareness sessions are included as part of the Board's development programme.

Training will be available on risk assessment, particularly the scoring or grading of risks and how to use the risk register.

7 IMPLEMENTATION

This policy will apply to all staff and will be available on the Trust Intranet for information.

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trust's monitoring arrangements for this document.

Registered Audit Reference Number: [Insert reference number here]

Aspect of compliance or effectiveness being monitored	Monitoring Method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group/ committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
An annual audit of Risk Management and annual reviews of the BAF and the Statement on Internal Control.	Internal Audit undertakes a risk- based Programme of audits agreed with the Trust which provides independent assurance.	Internal Audit	Annually	Audit Committee	External Audit
Full breadth of risks identified	Monitor the range of risk descriptors on department, divisional and departmental risk registers.	Risk Management Team	Monthly and Bimonthly	Executive Risk Management Meeting, and Specialty, Directorate and Divisional Governance Meetings	Risk Facilitator

9 RELATED TRUST DOCUMENTS: POLICIES / PROCEDURES / GUIDELINES

- Business Continuity Policy
- Claims Handling Policy
- Concerns and Complaints Policy and Procedure
- Fraud, Bribery and Corruption Policy
- Information Risk Policy
- Health and Safety Policies – to include the Health and Safety Policy and the Infection Control Policy

10 REFERENCES

- Management of Risk in Government January 2017
- NHS Audit Committee Handbook Version 4 2019
- Code of Governance for NHS Provider Trusts 2022
- NHS Providers - the essentials of risk management - 2023

11 EQUALITY IMPACT ASSESSMENT

The Equality Impact Assessment has been completed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

12 APPENDICES

Appendix 1 – Categories of Risks
Appendix 2 – Equality Impact Assessment Tool

Appendix 1- Categories of Risks

Risks to patients

- The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

Organisational risks

- The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

- The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.

- A range of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

Reputational risk

- The Board of Directors models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

Opportunistic risks

- 6. The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Integrated Business Plan, whilst respecting and abiding by its statutory obligations.

- Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure safety and quality is maintained.

Appendix 2 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Transgender	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**12/03/2024**
Title of Report:	Board Assurance Framework and Risk Appetite
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Executive Risk Management
If Other, provide details:	
Lead Chief Officer/Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Board Assurance Framework 2024/25 as at 29 February 2024 Risk Appetite

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WAHT's strategic objectives for 2024/25, plus the analysis of the recent Risk Appetite process for information.

2. Recommendation(s)

The WAHT Trust Board is invited to:

- Approve the BAF, identifying any gaps in risk to delivery of the Trust's 10 Point Plan in 2024/25.
- To note the Board's Risk Appetite.

3. Chief Officer/Executive Director Opinion[1]

The BAF is a live document which details the risks of achieving the Trust's 2024/25 10 Point Plan/Strategic Objectives. This document will be continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives.

There are ongoing improvements with this data, its analysis and presentation with the introduction of the Trust's new risk management framework and the hosting of the BAF on the risk management system (DATIX). These improvements also meet the recommendations from an internal audit to ensure an improvement in effective risk management processes and governance. Going forward, the 2024/25 BAF will also reflect the direction of travel: the consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.

Following a recent process, the resulting analysis of the Trust Board's 'Risk Appetite' using the ICS methodology sent to all Board members, is attached for your information. This Risk Appetite will inform the Trust's business cases and strategic objectives going forward.

Wells Jo
11/03/2024 12:32:41

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:	
☒ *Focus on Flow*	☒ *Think/Act as a Lead Provider*
☒ *Governance*	☒ *Improve Staff Experience*
☒ *Home First Mindset*	☒ *Tertiary Partnerships*
☒ *4ward Improvement System*	☒ *Leadership and Structures*
☒ *Elective Care: No Delays*	☒ *Strategic 'Big Moves'*

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5483	23/02/2024	BAF 2024 - Leading the NHS on Carbon Reduction	There is a risk that, as an anchor institution, the capital investment, resource and approval required to achieve the NHS Greener Plan and the 'Big Move' carbon reduction is not available, leading to an inability to meet compliance with the 10 point plan and national targets.	Minor	Almost certain	10	High	Chief Strategy Officer	• Sustainability grants • Green Steering Group • Foundation Group Support	• Capital planning	• Lack of capacity to prepare or respond to grant requests in a timely way • Lack of capital funding • Lack of resource to provide programme support • Not being awarded sustainability grants when available	• Over commitment and/or reduction in SALIX funding • Over commitment of capital funding schemes prioritised to operational or remedial work		31/05/2024	10	High	6	Moderate
5474	19/02/2024	BAF 2024 - Culture	There is a risk that, if we fail to sustain a positive change in organisational culture and communicate the 4ward improvement system, the trust will fail to have the best people and be unable to deliver safe and effective high-quality compassionate treatment and care.	Moderate	Likely	12	High	Chief People Officer	• People and Culture 3-year plan • Behaviour Charter • 4ward Improvement • FTSU Guardian and Champions • Staff Inclusion Networks • 4ward Advocates	• JNCC • Freedom to Speak Up • Culture Steering Group • NHS Staff Survey	• Enduring and stable leadership • Staff engagement and confidence in FTSU and other processes • Effective leadership at all levels • Clear and universal understood vision for organisational culture.	• Variability in ward to board implementation • Poor response to the NHS Staff Survey		30/04/2024	15	Extreme	6	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5475	19/02/2024	BAF 2024 - Health and Wellbeing	There is a risk of significant negative impact on staffs' health and wellbeing (including sickness absence, low morale), their experience and retention due to operational pressures, industrial action and workloads.	Moderate	Likely	12	High	Chief People Officer	• Staff Health and Wellbeing Service (which includes free counselling) • National NHS well-being support apps Clinical psychologist support • Health and Wellbeing Brochure/Bulletin • Effective interventions in response to well-being issues • Menopause support group. • Health@work service available to meet requirements of the Trust. • Wellbeing Plan	• JNCC feedback • Finance and Performance Executive • Board Integrated Performance Report • ICS 'great place to work' project group • Best People • Steering Group	• Speed and delivery of ICS-wide review of occupational health services • Inability to plan rotas around ongoing industrial action and other staff absences	• Expediency of future Occupational Health and Wellbeing Services structure and their ability to meet the Trust's requirements and wider across the ICS		30/04/2024	15	Extreme	9	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5480	22/02/2024	BAF 2024 - Digital Strategies to Support 'Big Moves'	There is a risk of a delay to the delivery of benefits and the future capital funding of digital infrastructure to support 'Big Moves' due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.	Major	Possible	12	High	Chief Digital Officer	• Digital Governance Framework to address: training; workforce; oversight • Risk management • Project management (including scope of delivery) • Annual business planning cycle	• Digital strategy group	• Change management and training of staff. • Staff engagement • Work pressures and availability of staff to be released to attend training • Lack of resilience in resource plans • Impact of the introduction of digital strategies across all stakeholders • Uncertainly of national priorities and funding for delivery of digital strategies • Competing digital priorities internally/system-wide • Oversubscription of digital initiatives against base resources	•	2	31/05/2024	16	Extreme	12	High
5484	23/02/2024	BAF 2024 - Maturity of PLACE	There is a risk that, due to the immaturity of PLACE, PLACE is unable to achieve their objectives or provide sufficient system assurance to reduce inequalities and improve sufficiently the home first mindset to provide support to more people at home.	Moderate	Likely	12	High	Chief Strategy Officer	• Frailty strategy • Revised governance and repurposed integrated PLACE delivery groups • Primary and secondary interface group • Being well strategy • Fuller action plan	• New PLACE Board (from April 2024) chaired by CEO • New Integrated Delivery Board (from April 2024) chaired by HWHCT CEO • Health Inequalities Programme Board with HI champions	• Lack of co-designed PLACE plan • PLACE development director vacancy • Emergency pathway approach eg frailty, LTC • Lack of coherent demand and capacity plan/use of single bed base	• BI resource to support PLACE-level management oversight • Clarity on roles and responsibilities (emergent)		31/05/2024	15	Extreme	6	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5486	23/02/2024	BAF 2024 - Partnership with large specialist providers	There is a risk that tertiary partnerships will be unable to improve existing local, regional and system-wide fragile services resulting in a failure to improve patient outcomes.	Moderate	Likely	12	High	Chief Strategy Officer	• Clinical services strategy • WM Diagnostic network • SM Pathology network • WM Cancer Alliance • Fragile Services CMO/COO forum at ICS and Foundation Group level	• Elective, Cancer & Diagnostic Delivery Group • ICS Programme Board • SM Partnership Board • ICS CMO/COO forum	• Identifying areas of opportunity for future tertiary partnerships • Tertiary partnership work programme • Delivery of partner performance targets • Impact of delegation of specialist commissioning to ICB	• Refreshed CSS 2024 to clarify strategy and review strategic partnerships to support strong MDT working • Lack of clear commissioning oversight by ICB		31/05/2024	12	High	6	Moderate
5492	27/02/2024	BAF 2024 - Capital Investment to support delivery of the 10 Point Plan	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivery and investment in key estates and digital infrastructure plus Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to a worsening of the condition of the Trust's estate and/or an inability to procure essential ICT systems and medical equipment resulting in adverse impacts on healthcare delivery.	Moderate	Likely	12	High	Chief Financial Officer	• Capital planning and prioritisation of key schemes and equipment • Holding contingency funds for adhoc emergency requirements • Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	• Project teams and programme board structure in place for major schemes • Estates and Facilities Delivery Board • Capital Planning and Delivery Group • Business case approval process in line with Standing Financial Instructions • Financial reports to Board	• Ability to determine emergency capital spend requirements • Approval of capital fund applications • Capital funding provided is not sufficient to meet whole requirement • Uncertainty regarding level of future funding resource	•		15/05/2024	15	Extreme	9	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5481	22/02/2024	BAF 2024 - Digital Resilience	There is a risk to the achievement of the Trust's 'focus on flow' and 'Big Moves' objectives plus overall service delivery due to unsupported IT hardware, unfunded lifecycle maintenance and lack of ongoing investment in digital infrastructure resulting in system failure and cyber security attacks.	Catastrophic	Possible	15	Extreme	Chief Digital Officer	• Cybersecurity action plan • Trust and Digital division risk management process • Perimeter level cyber security mechanisms • Risk-based approach to cyber and infrastructure funding • Monitoring mechanisms and resource to monitor cyber events • Exercises eg phishing, desktop business continuity • Business continuity plans • Capital planning programme	• National Digital Maturity Score • Data Security Protection Toolkit • Contract monitoring reported to Digital Strategy Group • EPRR Core Standards	• Oversubscription to digital/systems against baseline support levels and resources • Uncertainty of funding • Effective asset management process and controls • Staff training to enhance skills and awareness of cyber risks	•	3	22/03/2024	20	Extreme	10	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5473	19/02/2024	BAF 2024 - Workforce	There is a risk to achieving the Trust's 10 Point Plan due to: staff shortages; being unable to recruit to clinical, nursing and support staff vacancies; and, failure to achieve staffs' full operating capabilities - resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	Major	Possible	12	High	Chief People Officer	• Workforce Plan • Recruitment Plan • Retention Plan • Staff Offer • Agency Reduction Plan • e-rostering • Use of NHS Professionals • International Recruitment	• Best People Steering Group • Board Integrated Performance Report • Finance and Performance Executive • Integrated People and Culture Report	• Governance process to allow Advance Practitioners to fulfil their maximum operating capabilities • National shortages of clinical staff, both medics and registered nurses • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes • Uncertainly of the impact of industrial action • Clear workforce plan that addresses opportunities within the ICS • Agenda for change does not support competitive salaries required for some roles (eg digital and informatics posts)	• Expediency of ICS-wide initiatives • National long-term plan		31/03/2024	20	Extreme	12	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5479	21/02/2024	BAF 2024 - Ability of System to Manage Flow Across the Urgent and Emergency Care Pathway	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places unrelenting pressure on the Trust's urgent and emergency care pathway increasing the risk and scale of patient safety incidents, poor patient experience and quality of care.	Major	Likely	16	Extreme	Chief Operating Officer	• System-wide Silver Meetings • Winter Plan	• System-wide Gold and Silver Meetings	• Additional financial burden as a result of inability to mitigate additional activity at the 'front door' • Winter plan/pathway initiatives untested	• System oversight of discharge delays and capacity • Availability of Quality Impact Assessments to support surge and escalation activity • Plan to address mission creep to 'business as usual'.		22/03/2024	20	Extreme	8	High
5485	23/02/2024	BAF 2024 - Operational Capacity Plans and Delivery	There is a risk that the Trust will be unable to achieve its productivity and activity plans as a result of factors not limited to: staff shortages; pace of improvement; industrial action; access to outsourced and insourced capacity; and, sub-optimal urgent pathways. These factors, either individually or collectively, will severely impact on productivity and operational capacity plans that deliver safe elective, cancer, emergency and critical care.	Catastrophic	Likely	20	Extreme	Chief Operating Officer	• Escalation plans Group and system-wide mutual aid • Ring-fenced elective pathways • Increased use of the Alex site to support elective surgery • Increased diagnostic capacity provided	• Daily reporting and escalation • Finance and Performance Executive reports • Trust Board Integrated Performance Report • RTT and cancer PTL reviews	• Ongoing impact of industrial action Increase in non-elective activity leading to capacity constraints	• Expediency of estates/site improvements • Staff engagement • Clearly documented VFM assessment of additional capacity that may be required.		20/03/2024	25	Extreme	10	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Open actions	Review date	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5491	27/02/2024	BAF 2024 - Delivery of Financial Plan	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) and productivity required; impact of inflationary pressures; and, risks to achieving the full income target and the 10 point plan. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and a shortfall in cash to meet obligations.	Catastrophic	Likely	20	Extreme	Chief Financial Officer	• Financial strategy aligned to a sustainable clinical strategy • Recovery plan • CPIP devolved as part of divisional budget for identification and delivery • CPIP targets agreed by divisions • Established process for identification and monitoring of CPIP delivery • Activity plan implementation • Enhanced financial controls • Appointment of Turnaround Director	• Oversight by Finance Recovery Board • Monthly Finance and Performance Executive review of CPIP delivery • Integrated performance report to Trust Board • ICS Finance Forum - NED-led to oversee system financial performance • System Investment and Expenditure Ctte - Management-led oversees adherence to the enhanced financial controls	• Clinical strategy • Financial strategy • Recovery plan • Action plans in place for medical and nurse agency reduction • National inflationary pressures • Process of early identification and capture of full CPIP plan • Lack of recurrent efficiencies within the programme • Trust policies and processes require strengthening to ensure compliance	• Absence of work on a sustainable clinical strategy • Trust medical and nurse agency reduction routine review of action plans and compliance with controls • Trust policies and processes require strengthening to ensure regular monitoring and reporting • CPIP plans not fully identified to meet targets CPIP Audit Report • Impact of newly-formed Improvement Board		29/03/2024	25	Extreme	10	High

Risk Levels / *Key Elements*		**0. NONE - Avoid** Avoidance of risk and uncertainty is a key system objective	**1. LOW- Minimal** 'As low as reasonably possible' (ALARP) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**2. MODERATE – Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**3. HIGH – Open** Willing to consider all potential delivery options and accept a degree of inherent risk while also providing an acceptable level of reward (and VfM)	**4. SIGNIFICANT – Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**5. SIGNIFICANT – Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
FINANCE	***How will we use our resources?***	Avoidance of financial loss is a key objective. We have no appetite for financial loss. We are only willing to accept the low-cost option as VfM is the primary concern. Tight controls in place with limited devolved decision taking authority.	We are only prepared to accept the possibility of very limited financial risk. VfM is the primary concern. Strong central control with limited devolved decision taking authority.	**We are prepared to accept possibility of some limited financial risk. VfM is the primary concern but willing to consider other benefits or constraints. Resources are generally restricted to existing commitments. Strong central control is the default but some devolvement of decisions is accepted.**	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not being the overarching factor. Resources are allocated in order to capitalise on opportunities. We carefully balance central control with devolvement of decisions.	We will invest for the best possible return and accept the possibility of increased financial risk. Resources allocated without firm guarantee of return. We tend to devolve decisions with lower levels of inherent risk.	We will consistently invest for the best possible return for stakeholders, recognizing that the potential for substantial gain outweighs inherent risks. Our default is to devolve decisions where possible, only keeping central control for decisions with the highest levels of inherent risk.
REGULATION	***How will we be perceived by our regulators?***	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of some limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	**We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.**	We are willing to accept decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders
PEOPLE	***How will we develop our people?***	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approached to workforce recruitment and retention are not a priority and will only be adopted if established and proved to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	**We are prepared to accept the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention and developmental opportunities for staff.**	We will pursue workforce innovation. We are willing to take risks which may have impact on our people but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but is worthwhile due of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
QUALITY	***How will we deliver safe services?***	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely necessary.	Our preference is for risk avoidance. However if necessary, we will take decisions on quality where there is a low degree of inherent risks and possibility of improved outcomes and appropriate controls are in place.	**We are prepared to accept the possibility of short term impact on quality outcomes with potential for longer-term rewards.**	We are willing to take decisions on quality where there may be higher inherent risks but potential for significant longer-term gains.	We seek to take high risk decisions on quality in pursuit of significant gains and mitigation to our other risks.
REPUTATION	***How will we be perceived by the public and our partners?***	We have no appetite for any decisions that could lead to additional scrutiny or attention on the organisation. External interest in the organisation viewed with concern.	Our appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	We are prepared to accept the possibility of limited reputational risk as long as appropriate controls are in place to limit the risk.	**We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.**	We are willing to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
INNOVATION	***How progressive and innovative do we want to be?***	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or established and proved to be effective in a variety of settings	Tendency to stick to the status quo, innovations in practice generally avoided unless really necessary. Systems/technology developments limited to improvements to protection of current operations & practice.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	**Innovation pursued –desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery.**	Innovation is the priority– consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**12/03/2024**
Title of Report:	**NHS Resolution CNST Fees 2024-2025**
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	
If Other, provide details:	**CAG Signed by CFO and Managing Director**
Lead Chief Officer/Director:	**Chief Finance Officer**
Author:	**Michael White, Business Advisor CDE&F**
Documents covered by this report:	**Contract Award Governance Report (CAG) for CNST fees**

1. Purpose of the report

To award a contract for the 2024/25 financial year, recognising that the contract award creates an unavoidable cost pressure of £1.8m for 2024/25. In order to ensure compliance with the Trust's SFIs, this contract will require Trust Board approval.

Clinical Negligence Scheme for Trusts Fee Element	CNST 23/24 £	CNST 24/25 £	Change £	Change %
General Contribution	10,413,110	12,835,457	2,422,347	23.26%
Standard Maternity Contribution	10,129,580	9,574,437	-555,143	-5.48%
Maternity Incentive Contribution	1,012,958	957,444	-55,514	-5.48%
Sub-Total Maternity	11,142,538	10,531,881	-610,657	-5.48%
CNST Total Fee	21,555,648	23,367,338	1,811,690	8.40%
Risk Pooling Scheme for Trusts (RPST) Fee Element	Fee 23/24 £	Fee 24/25 £	Change £	Change %
Liabilities to Third Parties Scheme (LTPS)	215,139	204,463	-10,676	-5.00%
Property Expenses Scheme (PES)	38,741	48,318	9,577	24.72%
RPST Total Fee	253,880	252,781	-1,099	-0.44%
NHS Resolution Grand Total Fee	21,809,528	23,620,119	1,810,591	8.30%

2. Recommendation(s)

The Trust continues with the CNST Insurance Scheme for the 2024/25 Financial Year.

Wells Jo
11/03/2024 12:32:41

3. Executive Director Opinion[1]
The CAG report has been shared and discussed with both the Chief Finance Officer and the Managing Director (budget holder).
4. Please tick box for the Trust's 2023/24 Objectives the report relates to:
☐ ***Best services for local people***
☐ ***Best experience of care and outcomes for our patients***
☒ ***Best use of resources***
☐ ***Best people***

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust
Contract Award Governance Report

Subject	**Title of Contract: NHS Resolution CNST Fees 2024-2025**
	Trust Contract Ref No: C120260
	Period of Cover: 1.04.24 – 31.03.25
	Trust Participants: Worcestershire Acute Hospitals NHS Trust

Nature of Report	**For Approval**	☒	

Decision Required	To confirm by acceptance, signature of the decision made regarding the agreement to award contract.

			Reference Number:
Procurement Exercise	**WAHT Competitive Quote**	☐	
	WAHT Competitive Tender	☐	
	OJEU Tender	☐	
	Framework Agreement	☐	
	National Contract (i.e. Supply Chain)	☐	
	Extension of Legacy Agreement/Contract	☐	
	NHS to NHS	☒	

Contract Award Recommendation	The Trust continues with NHS Resolution CNST.

Capital Budget	☐	**Revenue Funding**	☒	**Income Generation / Offset Scheme**	☐

Contract Value	**Excluding. VAT**	**£23,620,119**
	Including. VAT	Intra NHS Charge, so VAT not payable.

Saving / Cost Pressure	**Cash Releasing**	☐	
	Non Recurring	☐	
	Cost Pressure	☒	**£1,810,591**
	Not Applicable	☐	

Contract Terms & Conditions	**Approved**	☒	
	In Progress (i.e. full and final terms to be agreed post award/legal support required)	☐	
	Framework Terms & Conditions	☐	

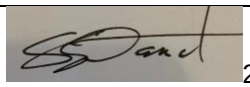
Expenditure - Non Pay Expenditure

The Scheme of Delegation states the levels of expenditure individuals are allowed to commit. It must be noted though that it is not just the limit of delegated authority that should be considered before making expenditure it is also the overall budget position and whether proper procurement processes have been followed and best value gained before committing to the expenditure. This applies equally to revenue and capital expenditure. The correct procedure must be followed when making the decision to commit any expenditure regardless if it is an existing or new supplier or under a new or old contract or agreement.

Delegated Matter	Value	Authority Delegated to	Notes and Comments
Authorising Requisitions	Up to £3,000	Budget Manager	Approval Process: • TME • Finance & Performance Committee • Trust Board
	Up to £20,000	Budget Holder	
	Up to £50,000	Divisional Management Team	
	Up to £75,000	Director of Estates & Facilities, Deputy COO, Director of People and Culture, Director of Strategy.	
	Up to £100,000	Voting Executive Directors and Deputy Director of Finance	
	Up to £250,000	Chief Finance Officer	
	Up to £500,000	Chief Executive	
	Over £500,000	Trust Board	

Business Case Required	**Yes** ☐	**No** ☒

If 'No' complete 'Selection and Award Approval' & 'Contract Award Approval' process.
If 'Yes' complete 'Business Case Approval Committee Route' process.

Selection and Award Approval		
Title	Name	Signature
Business Advisor	Michael White	20.12.23
Director of Procurement	Sanjeev Narwal	 20.12.23
Company Secretary	Erica Hermon	12.01.24

Contract Award Approval (up to £250,000)		
Title	Name	Signature
Chief Finance Officer	Neil Cook	Approved 12.01.24

Contract Award Approval (between £250,000 & £500,000 and/or 5 year+ contract term)		
Title	Name	Signature
Managing Director/Chief Executive	Stephen Collman/Glen Burley	Approved (add date & evidence)

*As outlined in "*Expenditure – Non Pay Expenditure"* table included within this document, any Contract value above £500k requires approval from Trust Board and endorsement (signature) of the CFO or CE.

General Information	Report Author/s	Michael White
	Report Date	20.12.23

Outline Report

Background

- The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.

- The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year.

- Individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" (WTE) clinical staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions.

- When a claim is made against a member of CNST, the NHS body remains the legal defendant. However, NHS Resolution takes full responsibility for handling the claim and meeting the associated costs, regardless of value.

- Maternity Incentive Scheme - Obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12% of clinical claims by number, but accounted for 62% of the total value of new claims submitted, at a value of almost £6.0 billion.

- The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. The Maternity Incentive Scheme supports the delivery of safer maternity care through an incentive element to Trusts' contributions to the CNST. The scheme rewards Trusts that meet ten national safety actions designed to improve the delivery of best practice in maternity and neonatal services.

- The ten safety actions have been agreed with the national maternity safety champions in partnership with the Collaborative Advisory Group (CAG). Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved. Such a payment would be at a much lower level than their original 10 per cent contribution.

- The Maternity Incentive Scheme is a self-certification scheme, with all scheme submissions requiring sign-off by the Trust Board following conversations with the Trust's Commissioners, and all submissions also undergo an external verification process sense-checked by the Care Quality Commission (CQC).

- For the 2024/25 financial year, if the Trust were able to demonstrate compliance with the 10 Maternity Safety Actions, then the Trust would be able to recover the element of their contribution to the CNST Maternity Incentive Fund (£957,444) and would also receive a share of any unallocated funds. This funding cannot be put forward as a PEP scheme and must be reinvested in ensuring safety within the maternity service as per national requirements following

the Ockenden report. The Trust's current level of compliance with the 10 Maternity Safety Actions for the 2024/25 scheme submission (to be ratified at the February 2024 Trust Board) is currently 9/10 meaning the full incentive will not be achieved. Investment in additional staffing resource to support the achievement and management of CNST into 24/25 means that there is an increased likelihood of achievement of standards. However there remains a risk of non-achievement as standards are amended annually.

- The Trust's 2024/25 funding allocation will contain an inflationary uplift. It is to be determined whether this will be sufficient to cover this level of increase in the CNST Premium. We will continue active collation of all inflationary pressures assessing against allocations and seeking support via our ISC for any shortfall.

Current Position

The Trust utilises the risk pooling service from NHS Resolution as is the situation for all Trusts in the NHS. The total value of fees payable to NHS Resolution for 2023/24 was £21,809,528.

Fees notified to the Trust have increased for the 2024/25 financial year – Appendix A breaks down the fees by clinical specialty.

Clinical Negligence Scheme for Trusts Fee Element	CNST 23/24 £	CNST 24/25 £	Change £	Change %
General Contribution	10,413,110	12,835,457	2,422,347	23.26%
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NHS Resolution Grand Total Fee	21,809,528	23,620,119	1,810,591	8.30%

Contract Recommendation

The Trust continues with the CNST Insurance Scheme for the 2024/25 Financial Year.

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APPENDIX A

Specialty Cost Changes 23/24 to 24/25	Fee 23/24	Fee 24/25	Change	% Change
	£	£	£	
Accident & Emergency	1,578,652	2,044,037	465,385	29.48
Acute Internal Medicine	11,955	13,984	2,029	16.97
Anaesthetics	300,234	383,110	82,876	27.60
Blood Sciences	4,798	5,524	726	15.13
Cardiology	440,104	567,484	127,380	28.94
Cardiac, Vascular, Respioratory and Sleep Sciences	2,722	4,406	1,684	61.87
Vascular Surgery	212,266	248,292	36,026	16.97
Cellular Sciences	1,536	2,018	482	31.38
Chemical Pathology	6,309	7,530	1,221	19.35
Clinical Engineering	83	97	14	16.87
Clinical Neurophysiology	2,499	3,571	1,072	42.90
Clinical Oncology	172,384	237,413	65,029	37.72
Medical Oncology	90,610	147,628	57,018	62.93
Radiology	521,110	651,857	130,747	25.09
Orthodontics	9,901	12,001	2,100	21.21
General Dental Practice	274	351	77	28.10
Dermatology	39,133	46,062	6,929	17.71
Endocrinology	119,785	154,435	34,650	28.93
Gastroenterology	227,149	299,342	72,193	31.78
General Medicine	313,584	405,348	91,764	29.26
General Practice GP	0	699	699	#DIV/0!
General Surgery	1,352,103	1,505,980	153,877	11.38
Operating Theatre Staff	16,571	14,381	-2,190	-13.22
Geriatric Medicine	55,650	81,127	25,477	45.78
Acute Elderly & General Care	28,765	34,946	6,181	21.49
Gynaecology	327,483	448,145	120,662	36.85
Haematology	78,751	73,108	-5,643	-7.17
Clinical Haematology	9,249	10,977	1,728	18.68
Histopathology	166,222	183,428	17,206	10.35
Infectious Diseases	20,593	31,608	11,015	53.49
Infection Sciences	2,092	2,391	299	14.29
Medical Microbiology & Virology	82,562	96,575	14,013	16.97
Medical Physics	412	448	36	8.74
Neurology	117,733	164,762	47,029	39.95
Neurosensory Sciences	2,564	3,245	681	26.56
Neurosurgery	335	0	-335	-100.00
Nursing Episode	17,425	23,271	5,846	33.55
Other Qualified Nurses	8,301	9,906	1,605	19.34
Dietetics	2,024	2,438	414	20.45
Orthoptics/Optics	988	803	-185	-18.72
Diagnostic Radiography	13,936	16,947	3,011	21.61
Therapeutic Radiography	2,593	2,930	337	13.00
Speech and Language Therapy	1,123	1,443	320	28.50
Other Qualified ST&T Staff	2,392	3,456	1,064	44.48
Occupational Therapy	821	1,006	185	22.53
Ophthalmology	328,744	374,862	46,118	14.03
Oral and Maxillo Facial Surgery	93,952	130,829	36,877	39.25

Specialty Cost Changes 23/24 to 24/25	Fee 23/24	Fee 24/25	Change	% Change
	£	£	£	
Oral Surgery	5,348	6,809	1,461	27.32
ENT	246,716	289,813	43,097	17.47
Paediatric Cardiology	28	0	-28	-100.00
Paediatrics	679,779	751,622	71,843	10.57
Palliative Medicine	3,054	2,902	-152	-4.98
Registered Pharmacists	119,252	123,285	4,033	3.38
Pre-registration Pharmacy Trainees	12,413	14,520	2,107	16.97
Other Qualified Pharmacy Staff	100,235	104,695	4,460	4.45
Physiotherapists	195,846	235,011	39,165	20.00
Plastic Surgery	178	212	34	19.10
Psychological Therapy	5,923	6,960	1,037	17.51
Applied Psychology	6,469	12,355	5,886	90.99
Nephrology	645	8,613	7,968	1,235.35
Rehabilitation	19	0	-19	0.00
Respiratory Medicine	128,989	136,376	7,387	5.73
Rheumatology	33,964	42,171	8,207	24.16
T&O	1,675,285	2,127,148	451,863	26.97
Urology	298,464	384,579	86,115	28.85
Non UK Provider Specialty not known	2,757	4,193	1,436	52.09
Allied Health Professional Episode	32,855	44,093	11,238	34.20
General Medical Practice	0	4	4	#DIV/0!
Admin & Estates Staff	28,937	31,421	2,484	8.58
Health Care Assistants and Support Staff within LDP	20,745	28,359	7,614	36.70
Other Health Care Assistants	6,535	8,836	2,301	35.21
Unqualified ST&T	7,843	8,360	517	6.59
Unqualified Nursing, Midwifery and Health Visiting S	3,659	4,551	892	24.38
Midwife Episode	7,836	2,591	-5,245	-66.93
Ambulance	864	1,776	912	105.56
Total Fee	**10,413,110**	**12,835,456**	**2,422,346**	**23.26**

Increased contributions in 9 specialties make up 71% of the increase in General Contribution Costs;
A&E £465k; T&O £452k; General Surgery £154k; Radiology £131k; Cardiology £127k; Gynaecology £121k;
General Medicine £92k; Urology £86k; Anaesthetics £83k.

There has been a 2% increase in the WTE Risk Weights calculation by specialty between 23/24 and 24/25.
There have been no changes made to the FCE Risk Weights calculation by specialty between 23/24 and 24/25.
There has been a 2.7% reduction in the Trust's Registered Births Data for 24/25.

Maternity Data

Category	23/24	24/25
Obstetrics WTEs	48	54
Midwives WTE	205	205
Registered Births	5,010	4,875

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**12/03/2024**
Title of Report:	Audit & Assurance Committee Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Choose an item.
If Other, provide details:	
Lead Chief Officer/Director:	Select Director
Author:	Colin Horwath
Documents covered by this report:	Audit & Assurance Committee Report

1. Purpose of the report

The purpose of the following report is to bring to the attention of the trust board, matters of significance discussed by the audit and assurance committee at its meeting in February 24.

2. Recommendation(s)

Note the matters for particular attention.

3. Chief Officer/Executive Director Opinion[1]

Matters for particular attention.

Head of internal audit opinion.

The internal auditors presented the progress report and updated the committee on their process for determining the Head of Internal Audit opinion at the year end.

They highlighted a number of issues which may mean that they are unable to give a significant assurance opinion.

1) Our risk management strategy is out of date, and at the time of the review had not been considered by the Board. Similarly the Corporate Risk Register had not been considered by the Board. A number of improvement recommendations had been made.
   Ms Hermon assured the committee that an action plan was in place to implement the necessary changes.
2) There had been a nil reliance report issued last year.
3) Two reports were on the agenda for consideration which had limited assurance opinions.

They also highlighted the review they had undertaken of our processes for responding to our recommendations. That had been significant improvement in this area, but they would keep it under review.

Internal Audit report on Complaints.

The auditors had given a limited assurance opinion on this area. A number of weaknesses had been identified, including delays in responding to complaints, non compliance with Trust policies , and keeping complainants informed.

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

Ms Smith assured the committee that the recommendations had been accepted, and resource introduced to provide additional support. Progress had been made since the report was issued,and the situation would be monitored going forward.

Internal Audit report on Theatre Governance.

The auditors had given a limited assurance opinion on this area.

They particularly flagged failure to take minutes of theatre governance meetings, the need to review local safety standards and a lack of evidence relating to debriefs.

Mr Berlet assured the committee that the recommendations had been accepted, and an action plan prepared. Many of these actions had already been completed. He also assured the committee that whilst this was an important area, he did not consider patient safety had been compromised.

Other Matters

The committee received a report from the internal auditors on counter fraud.

It was assured that no significant incidents of fraud have been reported during the financial year. The counter fraud specialist commented that he receives a good level of cooperation from the Trust, and that our internal processes are sound. Fraud, bribery and corruption policy was approved.

The committee received a report from the chief finance officer on the trusts going concern position, which the committee considered and endorsed the recommendation that the trust is a going concern.

The committee received a report on the timetable for the preparation of 2022/23 financial statements. The timetable for submission of unaudited accounts is 24 April . Final submission of the audited accounts and completion of the annual report is due by 28 June.

Ms Hermon advised that governance arrangements are being reviewed to ensure alignment within the foundation group.

The committee asked for a report regarding cyber security, following the presentation the Board received on this high risk area.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☐ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**12/03/2024**
Title of Report:	People & Culture Committee Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Choose an item.
If Other, provide details:	
Lead Chief Officer/Director:	Select Director
Author:	Karen Martin
Documents covered by this report:	People & Culture Committee Report

1. Purpose of the report

The purpose is to bring to the attention of the Trust Board matters of significance discussed by the People & Culture Committee (PCC) at its meeting of February 2024.

2. Recommendation(s)

Note the matters for particular attention.

3. Chief Officer/Executive Director Opinion[1]

MATTERS FOR PARTICULAR ATTENTION

Culture review – Theatres – PCC were briefed on the actions and outcomes in hand following a commissioned external review into the culture and behaviors across Theatre departments of WAHT. The review took place in response to a range of issues from different routes including FtoSpkUp, grievances, survey findings etc . There was some concern the review and the plan from its finding had taken a considerable amount of time however PCC were pleased to hear about the departmental work, support for staff and developments underway. Given the plethora of concerns raised previously PCC requested the team return to update as part of the future workplan.

4Ward Improvement System – PCC were pleased to hear of the ongoing review in to the improvement system and its implementation. Proposals to enhance engagement and awareness whilst optimizing time commitments were discussed. PCC discussed achieving a balance between virtual and f2f engagement as neither one would be sufficient alone. It was also noted that further work was needed to embed the principles of improvement, example cited the theatres review had not referenced improvement actions.

Staff survey – PCC were concerned to receive report on the initial NSS findings and particularly the low response rate. It was clear that areas showing poor results aligned with those on the heatmap from other indicators including casework and raising concerns. It was agreed that Divisional teams/reps would join the PCC on rotation to provide assurance on actions and improvement work.

LGBTQ+ network – In order to support the staff networks in place across the organisation and raise awareness PCC now receive an update from each network on a rotational basis.

Midwifery students education plan – PCC were briefed on work underway to ensure numbers of students were aligned to capacity and capability across the organisation. An over placement of students had been identified following a previous survey. This was ow addressed with positive progress against the plan

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agreed between the Trust and HEE.

OTHER MATTERS

PCC has agreed to move its meetings back to F2F and rotate venue. Feedback to date has been positive and this will be reviewed regularly to ensure optimal efficacy.

PCC, in line with wider governance reviews and good practice, will review its membership to ensure appropriate optimal representation. There will be particular focus on inclusion of operational representation given the impact of the PCC agenda

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:	
☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☐ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

Minutes for Quality Governance Committee

Thursday, 25th January 2024 at 10.00 am – 1.00 pm
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director	
Required Attendees	Sarah Shingler	Chief Nursing Officer	√
	Julie Booth	Deputy Director IPC	√
	Rachel Dunne	Deputy Chief Nursing Officer - ICB	√
	Rebecca Fox	Deputy Director of Midwifery	
	Justine Jeffery	Director of Midwifery	√
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	√
	Helen Lancaster	Chief Operating Officer	**Apols**
	Vikki Lewis	Chief Digital officer	√
	Michelle Lynch	Associate Non-Executive Director	√
	Edwin Mitchell	Associate Divisional Director - SCSD	**Apols**
	Richard Oosterom	Associate Non-Executive Director	√
	Nicholas Purser	Surgery Governance Lead	**Apols**
	Alison Robinson	Deputy Chief Nursing Officer	√
	Rosemary Smart	Public Patient Forum	√
	Susan Smith	Deputy Chief Nursing Officer	√
	Sue Sinclair	Associate Non-Executive Director	√
	Jules Walton	Deputy CMO – Quality, Governance & Professional Standards	√
	Clare Bush		√
	Simon Adams	Healthwatch	√

Item	Title
QGC/23/1	**Welcome and Apologies for Absence**
	Dame Julie welcomed all present at the meeting and gave thanks to Ms Sinclair for Chairing the last meeting.
QGC/23/2	**Declarations of Interest**
	There were no new declarations of interest raised.
QGC/23/3	**Minutes of the last meeting**
	The minutes of the meeting held on the 30th November 2023 were confirmed as a factual representation of the meeting and approved.
QGC/23/4	**Action Schedule**

	Progress on the outstanding actions were reviewed and updates received. In regard to the closed bed cleaning action, Dame Julie queried whether the steps taken would be adequate and the needs met. Ms Shingler replied that routine audits were undertaken and reported through TIPPC Committee and reviewed by this Committee on a quarterly basis.
QGC/23/5	**Escalations from Chief Medical Officer and Nursing Officer for items outside of standard report / not on the agenda**
	Pressures at the Front Door Ms Shingler advised that pressures continued. 10 corridor spaces had been opened on the Worcester site, long waits continued, some in excess of 8 hours. Overall, handover delays are reducing. Any waits over 8 hours are classed as a Never Event. There was concern regarding the number of escalation areas that are open over and above the Winter Plan. There are only 2 toilets on Aconbury 0 and the Trust was therefore breaching mixed sex due to having to walk through bays in order to reach the toilets. There are no bathroom facilities. Current outbreaks of covid and flu were reported and it was a poor experience for patients with the number of patients behind boarded reaching 30. Harm was also being reported and would be discussed in detail later in the agenda. Dame Julie advised that the Trust had been having to board patients for an extended period of time and that it was not ideal for staff or patients. Ms Shingler added that the length of stay on the ward was between 8-10 days and a number were double incontinent and unable to bathe adequately. Mr Oosterom asked how the system was providing support. Ms Shingler informed that a number of conversations were ongoing. The biggest concern was the lack of shared risk of decisions being made across the system that are placing patients at risk. Patients requiring side rooms was increasing lengths of stay. Ms Booth advised that patients require an LFT prior to transfer. Ms Shingler was completing a review of the risk relating to side rooms and transfers. The new arrangements around the risk register will keep the Board sighted on the extreme risks. Dame Julie encouraged escalating the risks to the system. **IPC** Ms Shingler advised that the Trust currently had 58 covid cases. Flu numbers were reducing. Measles is however an emerging risk. divisions have been preparing how to manage any cases that may occur. No cases have been reported so far in the trust. Mr Kamalarajan advised that the majority of children who develop measles will have a viral illness that can be managed at home and do not require hospital attendance, but that message hasn't been managed well. Ms Booth informed that there were a number of Public Health messages being communicated but the hard-to-reach communities are more problematic. Ms Sinclair asked whether there was any PCR testing available for measles. Ms Booth replied that PCR swabs could be undertaken here but are sent to Heartlands for testing. Oral saliva kits are only tested once per week, it was therefore symptomatic assessment. Mr Adams offered assistance with communications. Ms Dunne informed that some local communications have been sent to GPs and offered assistance with reviews of cases and sharing of lessons learnt.

	Dermatology Ms Walton advised that the last substantive consultant left the Trust in July 2023. There are 3 main pathways within the Dermatology service. 2 week waits are being managed through an insourcing provider, however there are some missed follow-ups which have been discovered. There is currently no Biologics service but the service was planned to recommence next week with an insourcing company. A degree of harm had been reported due to delayed prescription of medication for biologics. An inpatient referral process had been secured with Birmingham. The lack of face to face reviews was a cause for concern. A lead provider model was being explored with Wye Valley Trust through the Foundation Group with a view to starting in April. Ms Lynch queried whether the insourcing companies had checks completed in terms of directors. Ms Walton replied that it had. Governance was not previously in place and had been delayed. Ms Shingler replied that there is now a process of approval of CAGs in place to ensure that providers are satisfactory. **Urology** Ms Walton advised that there were issues with cancer performance reported and other areas of concerns focused on bladder and kidney cancer pathways. An external review had been commissioned and the report was awaited. Verbal assurance provided following the review reported no immediate patient safety concerns. 12 incidents had been reported, with varying degrees of harm. A round table had been held with the teams to identify themes from the harm seen. The MDT processes are not robust enough and issues were reported with the escalation process. Rapid actions were being put in place whilst the external report was awaited. Dame Julie observed that the external review identified no immediate harm, though the teams were receiving a number of reports of harm. Ms Walton replied that a whole process mapping exercise would be completed as the information did not triangulate. Ms Sinclair queried who conducted the external review. Ms Walton informed that the review was undertaken by the GIRFT Lead for Urology and an independent Urologist. The Trust Cancer Lead is also involved in the review. Mr Oosterom asked whether the issue was capacity related and whether the effect on patients that were waiting for too long was known. Ms Walton replied that capacity was an issue and would be reviewed as part of the mapping process.
QGC/23/6	**Best Services for Local People**
QGC/23/6.1	**Managing the Risk in Emergency Departments**
Wells Jo 11/03/2024 12:32:41	Ms Shingler advised that senior clinicians in ED had raised concerns regarding the level of risk and the escalating risk being seen. The report was presented to provide assurance to clinicians that the Board are sighted on the challenges faced day to day. There are strong governance processes in place in the division, however there are 4 extreme risks on the risk register. Issues had been reported in relation to the Rapid Offload Policy and the waiting room due to overcrowding. A rise in sickness was reported with staff, particularly in relation to stress and anxiety.

	The GIRFT team completed a review last week and were very clear that the longer patients stay over 4 hours, the opportunity for harm trebles. Dame Julie stated that the Board recognise the difficulties being faced by staff and that they are making the best decisions in very difficult circumstances. Thanks were also extended to the teams. Ms Sinclair referred to the risk assessment and noted that 2 actions dramatically dropped the consequence and queried whether it was correct. Ms Shingler replied that if the corridors and waiting rooms were staffed, the risk of harm reduces. Decisions were made daily as to whether the risk could be mitigated. Ms Bush informed that as long as the patients were getting treatment, many were satisfied with the location that they were in. Dame Julie advised that the situation had been normalised and reiterated that it is not acceptable. Mr Oosterom advised that it was not sustainable. Mr Oosterom queried the measures being taken as a system to reduce the unnecessary attendances and expressed concern over the longer term risk to patients. Ms Shingler replied that the Single Point of Access had been introduced and was having some impact. Discharges week on week have reduced which was the focus of the transformation work. Teams are working closer with the system and used frailty as an example of fundamental changes that needed to be made. A business case was being drafted and seeking support from the Foundation Group. Ms Lynch noted the issues with staff sickness and wellbeing. Ms Bush informed that the sickness level was relatively low and the team worked well. A wellbeing wheel was available but staff relied more upon each other. Wellbeing days have been held and support provided by psychology. Ms Sinclair encouraged a review of the risks as the consequences appeared low in a number of areas. **Action.**
QGC/23/6.2	**Maternity Services Safety Report**
	Ms Jeffery presented the report and highlighted the following key points: • Bookings had increased. • A number of inefficiencies of bookings were under review. • Workforce and training KPIs in relation to maternity and neonatal mandatory was good overall. Trajectories for Trust mandatory training had been adjusted to 6% per month which would be challenging. • Perinatal mortality rate is below the national average. • 9/10 CNST declarations have been submitted. • CQC report has been received with a 'good' rating. • Baby Friendly Assessment has taken place and final report awaited. • Await report from the MVP visit to the maternity hub. • Ms Jeffrey escalated that the Foetal Medicine Team and the Antenatal Screening Team are feeling significant pressures. The Antenatal team had reported a staffing gap issue and data cleansing issues. The Foetal Medicine Team had reported a 25% increase in referrals for 2 consecutive months. No harm had been reported.
Wells Jo 11/03/2024 12:32:41	**Resolved that: The report was noted for assurance.**
	Maternity Staffing Report
	Ms Jeffery advised that there was no meeting held in December, therefore the November papers had not been reviewed by the Committee.

	Safe Staffing was presented with an assurance level of 5, which was a reduction in the previous level. This was due to red flags regarding the sickness absence rate and delays in the induction of labour pathway. The following key points were highlighted: • Turnover continues to be on a downward trend. • 14 wte midwives due to start in February/March. • MCA vacancy rate is reducing. • Supernumerary status of shift leader in delivery suite was not achieves, however one to one care did achieve. • Each shift was safe, however the delays in induction of labour is increasing month on month. A number of patients were waiting 24 hours. Ms Sinclair noted that there was no coroner referral to a case which was marked as catastrophic. Ms Jeffery replied that any death was rated as catastrophic and that the coroner would be involved if there were any concerns. Mr Kamalarajan advised that the case was discussed and considered with the teams and was satisfied with the decision not to refer to the coroner due to the number of issues that were presented upon birth.
	Resolved that: The report was noted for assurance.
QGC/23/6.3	**Perinatal Incident Report**
	Ms Jeffery presented the report with an assurance level of 6. 5 new cases were reported in November and 3 in December. No themes have been recognised. One case is part of an ongoing police investigation. Action plans were detailed within the report. A summary table at the beginning of the action plans would be included within future reports to ensure timely progress was being made.
	Resolved that: The report was noted for assurance.
QGC/23/6.4	**National Patient Safety Strategy (NPSS) Annual Summary January 2024**
	Ms Walton presented the summary with an assurance level of 5. progress was being made across 13 national patient safety domains. 3 areas were highlighted where more work is required: • Virtual wards • Reduction in planned pharmacy levels • Antibiotics for colorectal surgery. Plans were in place for each of these elements. Mr Oosterom queried how the effects were being measured and improvements were being made. Ms Walton replied that outcomes would be reviewed moving forward to ensure that improvement was being made.
	Resolved that: The report was noted for assurance.
QGC/23/6.5	**Patient Safety Incident Reporting Policy**
	Ms Walton advised that the report was presented for oversight of implementation across the Trust. The policy may change as the processes are worked through. Approval to proceed was sought. Ms Sinclair queried if there were any concerns around the national direction that we cannot attribute levels of harm and how it fits with duty of candour. Ms Walton replied that similar conversations had been had and were ongoing.

	Ms Smart queried how staff were trained to deal with incidents. Ms Walton informed that there was a training framework with levels of training required at a national level. Ms Shingler advised that the new framework would be implemented from 18th February.
	Resolved that: The Patient Safety Incident Reporting Policy was approved.
QGC/23/6.6	**Nurse Staffing Report**
	Ms Shingler reported that paediatric staffing was safe throughout December. Neonate staffing was noted not to be compliant against BAPM a target of 100% but acuity deemed that staffing was safe. Staffing on adult areas was safe, which is testament to the team given the number of escalation areas open. A significant reduction in framework agency usage was reported, which makes wards safer. Vacancy rates continue to reduce, now standing at 4.59%. Sickness absence was also reducing month on month. Bank and agency fill rates increased marginally in December up to 91.1%. Nurse/Bed patient ratio had been reviewed. The national and NICE guidance in relation to this ratio is 1 nurse looking after 9 patients in general ward areas. Some of our surgical wards are operating above that average and a review would take place against acuity and bed configurations.
	Resolved that: The report was noted for assurance.
QGC/23/7	**Best Experience of care and best outcomes for patients**
	Experience
QGC/23/7.1	**Integrated Performance Report**
	Ms Lewis advised that as there was no Trust Board meeting held in January, it was agreed that the report would not be required. Verbal updates had been provided at the Trust Management Board. Quality work was progressing, though small pockets of concern remained in some areas. Mr Oosterom cautioned that it was important to receive an operational performance update due to the impact on a number of areas and patients. **Action VL/SS.**
QGC/23/8	**Best Experience of care and best outcomes for patients**
	Governance
QGC/23/8.1	**Wards of Concern – Escalation and Review Process**
	Ms Shingler advised that she had become aware that there wasn't a process to identify wards that were of concern. The report outlined that there is now a comprehensive standard that has been put in place, linked to the Care Excellence Accreditation Programme. The first panel of reviews were scheduled in February. A key metric dashboard had been created to highlight areas of concern. Current areas of concern which were receiving support were: Ward 15 (Alex), Laurel 3 and TNOB. Updates would be included within the CNO report on a quarterly basis. Dame Julie asked for clarification that once the electronic system had been rolled out, a number of indications would be automated. Ms Lewis replied that they would. Dame Julie and Ms Sinclair thanked Ms Shingler for the work undertaken.

	Resolved that: The report was noted for assurance.
QGC/23/8.2	**Revised Quality Governance Arrangements**
	Ms Shingler advised that the report had been omitted form the pack. The quality arrangements had been reviewed by Ms Shingler and Ms Walton. It was proposed that the Clinical Governance Group was stood down and 3 groups established in its place to review the following: • Regulatory standards and external visits • Patient Safety Action Group • Clinical Effectiveness & Audit. It was proposed that the new arrangements commence from February. The report would be emailed to Committee members for review and comment if required. Mr Oosterom queried if consideration had been given to using time effectively. Ms Shingler replied that there had been debate at Trust Management Board. The previous meeting did not have the right membership and the agenda so full there was limited time for full scrutiny, the CCG meeting also duplicated the role of QGC with 80% of the papers being presented to both meetings. Membership would differ depending on the agenda.
	Resolved that: The Governance Arrangements were in approved in principle, pending circulation to the Committee.
QGC/23/8.3	**Improving Quality Roadmap**
	Ms Shingler had developed an Improving Quality Roadmap with teams to allow standardisation the progress being made from an assurance point of view. Domains included in the Roadmap: • Staff Development • The fundamentals of care work • Sustain and Improvement (quality boards) • Patient Voice • Governance and Reporting. Reports against the framework would be presented to the Committee on a quarterly basis.
	Resolved that: The report was noted for assurance.
QGC/23/8.4	**Fundamentals of Care Quarterly Update and FOC Committee TOR Approval**
	Ms Shingler advised that all audits across the domain would be undertaken on a digital app which the team had developed. The Terms of Reference were presented for approval.
	Resolved that: The Terms of Reference were approved.
QGC/23/8.5	**Revised Harm Review Policy**
Wells Jo 11/03/2024 12:32:41	Ms Walton updated that a revised policy had been created in relation to harm. Teams were better linked and included cancer pathways and escalations. Dame Julie asked how the outcomes are measured from the interventions to establish if there has been harm. Ms Walton replied that currently, the Trust was very reliant upon self-reporting. There was a lack of full oversight of the outcomes within our services. It was a work in progress.

	Resolved that: The Revised Harm Review Policy was approved.
QGC/23/9	**Clinical Governance report**
	The report was taken as read.
QGC/23/10	**Committee Escalations**
	Trust Board
	A&E and the harm to patients and staff. Urology pathways IP&C update including measles. Dermatology.
QGC/23/10.1	**Other Committees**
	No further item for discussion.
QGC/23/11	**Any Other business**
	Ms Smart expressed concern regarding the neck of femur pathway and asked for an update. Ms Walton replied that she was meeting with the CD next week to discuss. An update would be provided shortly. Ms Walton added that in relation to the measles, there is a risk within the adult population up to the age of 30.
QGC/23/12	**Reflections on the meeting**
QGC/23/13	**Close**
	The meeting closed at 11.45am.

Enc A

AUDIT AND ASSURANCE COMMITTEE

Minutes of the Meeting held on Tuesday 14 November 2023 at 9.15am held via MS Teams

PRESENT:		
CHAIR:	Colin Horwath	Non-Executive Director
MEMBERS:	Simon Murphy	Non-Executive Director
	Karen Martin	Non-Executive Director
IN ATTENDANCE:	Stephen Collman	Managing Director
	Erica Hermon	Company Secretary
	Neil Cook	Chief Finance Officer
	Lynne Walden	Head of Financial Planning and Financial Services
	Jo Wells	Deputy Company Secretary
	Emma Masters	Internal Audit
	Paul Westwood	Counter Fraud
	Helen Lancaster	Chief Operating Officer (for item 086/23)
	Julie Masci	External Audit
	Kristina Woodward	Internal Audit
	Leanne Hawkes	Internal Audit
	Sanjeev Narwal	Director of Procurement (for item 089/23)
	Hugh Morrow	Lead Pharmacist (for item 091/23)
APOLOGIES:	Tony Bramley	Non-Executive Director

079/23 **WELCOME AND APOLOGIES FOR ABSENCE** **ACTION**

Mr Horwath welcomed all to the meeting. There were no further items of business identified.

080/23 **DECLARATIONS OF INTEREST**

There were no new declarations of interest. Declarations are available on the Trust's website.

081/23 **MINUTES OF MEETING HELD ON 28 SEPTEMBER 2023**

The minutes of the meeting held on 28th September 2023 were approved.

Ms Hermon referred to the Board Assurance Framework and informed that the BAF will be hosted on Datix and actions managed in line with risk management.

RESOLVED THAT: The minutes of the meeting held on 28 September 2023 were approved.

082/23 **Matters Arising and Action Schedule**

reviewed the action schedule and updates were noted.

The Code of Governance agenda item was taken as the next item due to presenter availability.

External Audit

083/23 **External Audit Progress Update**

Ms Masci informed that regular meetings were taking place with Mr Cook. Planning work would commence in the new year. The Audit Plan would be presented to the Committee in March.

Changes to the audit team were proposed. Ms Morgan-Bower is on maternity leave and Ms Masci would be rotating off the team. Mr Andrew Smith would be the new audit partner and Ms Zoe Thomas was rejoining the team. Focus would be on maintaining continuity and supporting the Trust, keeping a focus on implementation of recommendations.

Mr Horwath thanked Ms Masci for her support to date and welcomed the new members.

Internal Audit

084/23 **Internal Audit Progress Report**

Ms Masters presented the report and highlighted the following key points:

- Field work to commence on Monday.
- Reports have been issued.
- Theatre governance review is being drafted.
- Job planning review nearing completion.
- Meeting taken place with anti-crime colleagues.
- Improvements had been made with recommendation tracking since the last Committee. An 83% implementation rate was reported.
- Only 2 recommendations were now overdue.

Ms Hermon asked for clarification of assurance. Ms Hawkes replied that the 83% will be used in general and would be reviewed in the round. Follow up rates would be reviewed next year but was currently 11%. Ms Hermon would review the delays, how they could be addressed and discuss offline with Mr Collman. **Action.**

Mr Horwath queried whether the Trust was on track. Ms Hermon and Mr Collman would review the processes and delivery in order to meet the standards. **Action.**

Mr Horwath observed that there were two limited draft audit reports and queried the process of dealing with limited assurance reports. Mr Cook replied that the managing lead director would be approached to present the feedback on the report to the Committee. It would be helpful to understand the process across the Foundation Group. Ms Hermon would review with the Group and feed back. **Action**.
Mr Horwath agreed with the approach of leads attending the Committee to present and expressed concern around budgetary planning.

Mr Horwath referred to the Terms of Reference in relation to financial systems, in particular the process for leavers. Mr Horwath added that there were over payments and there was a need for the right level of scrutiny. Ms Masters replied that a review of overpayments would be undertaken to review the themes. Additional testing was agreed.

RESOLVED THAT: The report was noted for assurance.

Counter Fraud

085/23 **Counter Fraud Progress Report**

Mr Westwood presented the report and updated that a self-assessment against standards had been completed along with a review of the policy, which is a healthy picture against the standards.

Appendix A provided an overview of prevention notices and have been actioned.
Appendix B outlined the benchmarking data.

International Fraud Awareness Week was coming up and Communications would be sent out to staff as reminders on how to report fraud within the Trust.

Investigations:

- In regard to the bank account misuse, the team had met with the police and it had been confirmed that the bank identified further checks to be undertaken. The case is now with the CPS for a charging decision for theft.
- One case would be heard at the Crown Court in December.
- Dr Blanshard was assisting with one case and had provided additional information. The next steps were being decided.
- A request of information has been submitted regarding working off sick.
- More information had been requested following a referral received but no secondary employer provided.
- 2 cases will be closed and handed back to HR due to a lack of information.
- One secondary employer had been approached and confirmed that the staff member had not worked for them during the periods referred to, therefore the case had been closed.

A National Fraud Initiative is under review and there was nothing to report.
Company House matches are in progress.

Mr Horwath queried whether there were any concerns regarding the matches to company house. Mr Westwood replied that there was nothing specific to report in terms of investigation or concern.

Mr Horwath thanked Mr Westwood for the encouraging improvements.

RESOLVED THAT: The report was noted for assurance.

086/23 **Urgent & Emergency Care Major Refurbishment Programme**

Ms Lancaster joined the meeting to present the updated report detailing the scope of the review and lessons to be learnt.
The methodology was outlined and papers were being compiled.
Timescales were set out within the report. The draft report was expected by the end of January.

Ms Hawkes added that an independent consultant was being bought in to lead the work.

Mr Murphy supported the direction of travel but was keen that it included external context to form part of the review.

Mr Collman would provide updated narrative regarding briefing the Board and lessons learnt as part of the governance review to Ms Hawkes.

Ms Lancaster advised that the external elements were now somewhat dates and queried the approach with NHSE. Mr Horwath replied that there should be accountability at all levels throughout the system, though it was recognised that there were some practicality issues. Mr Collman advised that often conversations were not minuted and suggested that Board members who were present at the time assisted to capture the context. Mr Murphy agreed as there was a pressurised challenge.

Ms Hawkes asked that a list of key people to interview was shared with her.

Mr Horwath advised that getting the balance of forensics and learning will be a challenge. Ms Lancaster encouraged keeping the scope tight. The key objective is around how we are learning to be better prepared, managing the project and what we would do differently.

The Committee was in agreement and supportive of the proposal.

Ms Hermon and Ms Lancaster left the meeting.

RESOLVED THAT: The proposal was supported.

087/23 **Value for Money Report**

Mr Cook advised that there had been some progress in completion of the actions and there had been benefit from this approach in the audit.

Mr Cook suggested linking in with some of the other Committees as it may be helpful with tracking actions. Mr Horwath welcomed the proposal.
Executives were asked to respond to queries.

RESOLVED THAT: The report was noted for assurance.

088/23 **Losses and Special Payments**

Ms Walden presented the report for noting. For the period of 27th February to 19th October 2023, the Trust recorded losses and special payments totalling £162k. The majority of costs related to pharmacy.

There were 35 claims for loss of patient property, totalling £19k. Some of these claims were outside of policy.

1 staff exit package was reported.

Debts totalling £9k have previously been approved by the Committee.

Mr Horwath referred to payments made to patients and asked whether we are consistent with other Trusts. Ms Walden advised that another Trust in the Foundation Group have asked for our policy, but she had not liaised with the others. **Action.**

RESOLVED THAT: The report was noted for assurance.

089/23 **Review of Tender Waivers**

Mr Narwal joined the meeting to present the report.

The number of waivers had increased from the previous year. 59 had been received, 17 of which accounted for £19m of the value.
The biggest areas were Estates, SCSD, Digital and Corporate.

Predominant spend related to the Clynisis LIMS solution.
There was a provision of security services at the Alex and Fire inspection services across the Trust were under review to bring back in house.

A number of big spend areas are around software spend. It was found that some departments have implemented software themselves without discussion with IT and procurement. Governance arrangements had been put in place with IT to manage them under a formal agreement.

Work was underway with divisions to bring a number of items under one umbrella, though there were difficulties with a framework. The process would be reviewed with the Foundation Group in terms of training and assurance.

Mr Murphy queried whether it was a cultural issue where things are implemented without including other teams. Mr Narwal replied that Covid was a driver. There was a new, proactive procurement team and the differences were being seen with engaging with teams earlier, though the volume of work is problematic.

Mr Horwath advised that additional commentary within the report would be helpful in terms of the root causes of the issues and actions being taken to prevent them.
It was difficult for the Committee to be assured but it was understood that work is underway to address poor performance.

RESOLVED THAT: The report was noted for assurance.

090/23 **Code of Governance**

Ms Hermon introduced the Code of Governance and the steps being taken to ensure we have full compliance. The report had been shared with Executives.
A self-assessment of the Trust was being undertaken and the Trust would be expected to report on the content in the Annual report.
Support was sought to obtain evidence of compliance.
There would be changes around ICB, partner working and governance arrangements.

Members were asked to be aware of the new Code and the implications on the Trust.
A Board Evaluation had been planned.

Evidence was required by the middle of January for March completion.

A summary would be provided at the next committee to outline the gaps and sign off the approach. **Action.**

Mr Horwath queried if there were any concerns of gaps at this stage. Ms Hermon replied that there was not at this stage. Ms Hermon would circulate the paper with a deadline of 10th December for review.

RESOLVED THAT: The report was noted for assurance.

091/23 **Head of Pharmacy - Losses**

Mr Morrow attended the meeting to present the report with an assurance level of 6. The target is to achieve less than 0.5% and the Trust had achieved 0.35% this year. Progress had been made on actions from the previous report and changes made.

There was wastage of the influenza vaccine last year and there were 2 seasons of vaccines in the same financial year. This year, there has been no wastage to date. The order for this year had been reduced and the uptake of the vaccine is still an issue at the Trust.

Mr Horwath commended the successful achievement of the target and was pleased to see improvements and learning from lessons. Committee was assured that the team were doing their best to minimise waste.

Assurance level 6 was accepted.

Mr Morrow left the meeting.

RESOLVED THAT: The report was noted for assurance.

092/23 **Standards for Business Conduct Policy**

Ms Hermon informed that there was assurance that the Trust was complying fully with the provider licence.

Declarations of Interest from all eligible staff and those who have not submitted a form should be submitted on the website. Ms Hermon had liaised with 360 colleagues about making the process more robust.
The Policy would be updated to extend the number of staff who are eligible to complete a declaration. An online form was suggested and presented to Committee. Assuming there was approval and engagement with 360, the form would be presented to TME prior to distributing the declaration to staff. The uptake is currently low and this is not unique with the Trust. It was anticipated that the online form would improve uptake as it was easier for staff to complete and submit.

Ms Martin was supportive of the proposal and would reduce the risk.

Mr Horwath encouraged tracking and monitoring of progress. There would be consequences for non-compliance. Executives needed to be fully supportive of the proposal.

Mr Westwood would review the draft policy and provide feedback. **Action.**

Mr Collman stated that 360 assurance is key and how best to implement it would be discussed at TME.

RESOLVED THAT: Committee approved the proposed changes to the Standards for Business Conduct Policy subject to comments following a review by Audit.

For Information

093/23 **Any Other Business**
None noted.

094/23 **Committee Escalations**
VFM report to other Committees.
UEC to Trust Board.

095/23 **Reflections**
Mr Horwath advised that Admin Control training has been offered and all members were welcome to join.

Mr Collman encouraged including conversations around BAF throughout the agenda.

All audit committee Chairs had met and reflected on the ICB register. Trust risks would be compared with the ICB.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Tuesday 5th December 2023 at 10:00
Flower Day Room, Working Well Centre

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members	Tina Ricketts	Director of People & Culture
	Simon Murphy	Vice Chair
	Christine Blanshard	Chief Medical Officer
	Colin Horwath	Non-Executive Director
	Neil Cook	Chief Finance Officer
	Sue Sinclair	Associate Non-Executive Director
	Sarah Shingler	Chief Nursing Officer
Attendees	Ella Jackson	EA to Director of People & Culture *(minutes)*
	Justine Jeffery	Director of Midwifery
	Bianca Edwards	Assistant Director of People
	Liz Faulkner	Assistant Director HR Corporate Services
	Rich Luckman	Assistant Director of Culture
	Reena Rane	Senior Improvement Specialist & BAME Network Chair
	Melanie Stinton	Freedom to Speak Up Guardian/Lead 4ward Advocate
Apologies	Dame Julie Moore	Non-Executive Director
	Richard Haynes	Director of Communications & Engagement
	Joanne Kirwan	Deputy Chief Finance Officer
	Stephen Collman	Managing Director
	Sarah Troth	Advanced Clinical Practitioner- Lead for 'Out of hours hospital at night, practitioning team'

Ref		Action
054/23	**Chairs Welcome and Apologies for Absence**	
	Ms Martin welcomed all to the meeting and the apologies received were acknowledged.	
055/23	**Quorum and Declarations of Interests**	
	There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website. Ms Martin confirmed that: a) A Quorum of the P&C was present. b) There were no declarations of interest.	
056/23	**Minutes of the previous meeting**	
	The minutes of the last meeting held on the 3rd October 2023 were reviewed and agreed as a true and accurate record.	

	RESOLVED – that the minutes of the meeting held on 3rd October 2023 be approved.	
057/23	**Matters Arising and Review of ongoing Action Log**	
	The ongoing action log was reviewed and updated accordingly.	
058/23	**Staff Story – Fatigue for Night Workers**	
	Presented by Ms Ricketts following apologies from Sarah Troth. Ms Ricketts gave the presentation following apologies from Sarah Troth and explained that there is ample evidence and research into staff's ability to care for patients when working nights and the benefits of taking 20-minute powernaps. There appears to be inconsistency within the Trust, with some Ward Managers supporting their staff to take powernaps, and others not. The implications were explained if staff are not allowed to take powernaps, including negative effects on their health and wellbeing. Ms Ricketts advised that Sarah Troth has joined the Trust's Health and Wellbeing Steering Group to ensure actions are taken in response to her research. The group were developing an assessment for staff Health and Wellbeing, similar to the Covid Risk Assessment used during the Pandemic. The key obstacle for staff trying to take a powernap is the lack of a designated quiet and safe space. Charitable funds have been secured to address this. The risk of staff fatigue on nights and 12-hour shifts has now been added to the Corporate Risk Register and an e-learning programme is being developed to educate staff and their line managers on fatigue management. A Fatigue Risk Assessment is also being developed and will be incorporated into handovers and Occupational Health one-to-ones. The group is committed to challenging the culture on wards where staff are not allowed sleep breaks, and this will be regularly reviewed to identify hotspot areas. The impact on sickness absence will also be monitored as there is thought to be a correlation with Night staff often being too tired to go into work the next day. Ms Martin asked if the Trust has permanent Night Workers and if so, how many. Ms Shingler responded that there are permanent Night Workers on all wards. **Action: Ms Ricketts agreed to provide Ms Martin with the percentage of Night Workers in the Trust.** Ms Martin mentioned that Night Workers will have a Health and Safety Risk Assessment already in place and asked if the Trust are seeing any incidents related to Night Working. Ms Shingler advised that Sarah Troth has recently investigated incidents related to Night Working and that this is now built into the incident review process to consider whether a staff member involved was on a Night Shift. Ms Shingler advised that staff are not aware what they can and can't do when working a Night Shift, for example not taking a powernap or taking longer than needed, which causes a safety risk. Ms Shingler clarified	

	that the aim is to educate staff and their line managers with clear communication and for this to be reviewed in 6 months' time. Dr Blanshard asked what the NMC's stance is on this matter, explaining that the BMA fully supported the Junior Doctor's Fatigue and Facilities charter to improve their rest facilities. Ms Shingler responded that the RCN does have guidance to encourage Nurses to take rest breaks, but the NMC does not. Ms Shingler advised that she has scheduled visits in the new year to ward areas in the early hours of the morning to inform this work and increase awareness. Ms Shingler further clarified that a 20minute powernap is supported and the aim is to provide staff with a safe space to do so. Mr Horwath was surprised at the variation across the organisation and asked what action will be taken to ensure policies and guidance are communicated effectively. Ms Ricketts advised that a policy is being created to champion consistency and recognised that ensuring staff are educated on the matter is a key issue. Mr Horwath asked what the Trust can do if following the circulation of the policy, staff are still being prevented by their line managers from taking powernaps. Ms Ricketts responded that all staff are required to adhere to Trust policy. **Action – Update on Fatigue Management for Night Workers in 6 months' time.**	
059/23	**Director of People & Culture Report**	
	Ms Ricketts presented the report and explained the purpose is to notify the committee on key national, regional and local issues relating to people and culture. NHS England have published a useful report setting out expectations for line managers in relation to people management. The report and framework clearly identify the roles, responsibilities, and expectations, of line managers. This will be embedded in the organisation moving forward through the Trust's Line Management Development Programme, job descriptions and policies. Ms Ricketts explained that NHS England have requested each Integrated Care System provide an example of a skill-mix case and to better utilise Get It Right First Time to ensure workforce efficiency. Ms Ricketts advised that this will be discussed in more depth under item 9 Cost Effective Workforce Report. Further to a report published by the GMC, Ms Ricketts summarised that the Trust will be reliant on overseas medical staff for the foreseeable future due to the length of time required to train medical staff in the UK. This will need to be taken into account when considering how to support those colleagues transitioning to the UK in the future. The Trust has signed up to the new Sexual Safety in Healthcare Charter that has been launched nationally. The Trust will be embedding this work into the Behavioural Charter going forward. Ms Ricketts shared that a review has taken place into the culture in	

Theatres at the Alex which highlighted key issues such as this and will be discussed later in the meeting.

Ms Ricketts added that there are now further resources available to support colleagues with Menopause.

Mr Murphy added that the change in policy regarding international healthcare workers not being able to bring dependants into the country will also have an impact and possibly affect the age profile of International Nurses. Ms Ricketts informed that some partners of international healthcare workers undertake work in the Trust, for example in administration roles.

Ms Martin asked if there were any gaps to be concerned about regarding line managers. Mr Luckman advised that the heatmap does highlight some areas for concern and that the work from NHSE is welcome, but still quite high level and requires further details such as values and behaviours. Mr Luckman explained that the emphasis is on the quality of conversations that line managers are having with their staff, and that lack of time is having the biggest impact on this. Mr Luckman advised that any gaps can be addressed with additional guidance and content from the 4ward Improvement System can be brought into the Managers Essentials programme.

10:13 Mr Cook joined the meeting.

Dr Blanshard raised that most Junior Overseas Graduates also do not meet the required threshold to bring family over to the UK. Further to the review into sexual safety that Ms Ricketts previously mentioned, Dr Blanshard agreed that there appears to be an unhealthy culture in Theatres both at WRH and Alex sites. This is often termed as “banter” or “joking”, but often crosses the threshold into sexual harassment and makes colleagues feel uncomfortable. Dr Blanshard suggested this is also taken into account for the organisational development work.

Ms Martin advised that she has often had feedback from staff when visiting Theatres, that they have raised incidents on Datix but have not had any updates on progress or communication. Ms Martin suggested work needs to be done to close the loop.

Ms Sinclair noted that staff are within close proximity in changing rooms in particular whilst undressing, and this can lead to inappropriate behaviours. Ms Sinclair emphasised the Trust is not alone in identifying these behaviours among staff. Dr Blanshard clarified the main concern identified is regarding verbal “banter”.

Ms Stinton noted that it is not just one staff group in particular, but that all are involved. Ms Ricketts clarified that the external review was initially undertaken following an investigation into racial discrimination in Theatres, and in response to the investigation’s findings, another review has been undertaken into sexual harassment. The first review was undertaken by Globis.

Ms Ricketts expressed disappointment in the length of time taken from investigation, to receiving the report’s findings. The report was

	submitted to the 4ward Culture Steering Group in November for oversight. The staff involved are aware the review is taking place; all staff have received letters thanking them for their participation and then offered further meetings in addition to support their wellbeing.	
060/23	**Best Services for Local People**	
	BAME Network update Ms Rane introduced herself as Senior Improvement Specialist and Chair of the BAME Staff Network. Throughout the Covid Pandemic, Ms Rane was Vice Chair of the Network, and later took on the role of Chair in May 2023 with her primary focus being to increase engagement. Ms Rane explained that the Network had a positive 2019 but struggled for engagement afterwards and post Covid. Ms Rane lead the Network in participating in the Trust's planned Culture Month celebration.125 new members joined the Network from the 3 day BAME showcase during Culture Month. Ms Rane advised that the Network has now launched a Career Progression Support Group to coach fellow BAME colleagues invited to interviews to help them with interview tips, techniques, and support. This can be especially helpful for International Nurses. Two Vice Chairs have now been appointed and have a plan to increase the visibility of the Network by covering all three sites between themselves and the Chair. Charitable funds have been requested for a monthly Culture and Diversity Programme across all three sites and the Network is also working closely with the ICS and EDI Midlands Group, to organise a Cultural Study Awareness Day for allies. Ms Rane is also nominating the Trust at the Midlands Diversity awards. It was raised that BAME colleagues are encountering difficulties when talking in their own language in their breaktimes. Ms Rane felt that it should be supported but suggests that BAME colleagues are courteous and consider if there are other colleagues in the room at the same time and how this might make them feel. There is a new drive for the #saymyname campaign. The campaign aims to increase awareness following feedback that some colleagues do not try to pronounce BAME members' names correctly or ask to shorten their names to something easier to pronounce. Ms Martin suggested that data would be helpful to highlight where the diversity and inclusion challenges are, for example employee relations and recruitment data. **Action: Ms Rane agreed to include the data in the next BAME report** and informed that BAME members account for roughly 16.8% of staff across the Trust, however only 2.5% are bands 8a and above. Mr Horwath asked Ms Rane how well she feels the BAME community is represented. Ms Rane advised she is receiving feedback that staff	

	do not like the term “BAME”. Some colleagues do not feel they identify with the term and raised that it could be contradictory to the aim of inclusion. Following this feedback, the Network are reviewing alternative names for the group. Mr Murphy complimented the BAME group’s showcase during Culture Month and noted how positively it was received by staff and members of the public walking by, in particular the cultural dances. Mr Murphy asked what the recruitment policy is in terms of BAME colleagues taking part in shortlisting and interviews. Ms Rane responded that for recruitment to a band 8a role or above, a BAME recruitment champion should take part in shortlisting and interviewing. It was also noted that this is not always embraced by recruiting teams, with the view of just being a “tick box exercise”. Ms Rane advised that most BAME colleagues are not reaching a band 6 role in the first place, in order to then progress to band 8a. Mr Murphy suggested that learning from other Trusts might help and Ms Rane responded that the Cultural Diversity Programme from the ICS could help for non BAME colleagues to hear lived experiences. However, Ms Rane suggested that a key driver would be more Executive colleagues engaging in the Network meetings and festivals to promote visibility and show their support and allyship. Some feedback had been received that colleagues felt the BAME celebrations during Culture Month were only for BAME colleagues to participate in. Ms Rane stressed this is not the case and explained that the more people take part and engage, the better. Ms Shingler added that the new Career Framework being launched in the new year will help to ensure that all staff with the appropriate level of competencies will have equal access to opportunities. Mr Murphy agreed that promoting career progression within the organisation will also improve recruitment and retention and the Trust’s reputation as an employer. Ms Stinton raised that she has recently received a Freedom to Speak Up concern via Worcester University regarding an International Nurse’s experience at the Trust. Ms Shingler advised that the monthly meetings with the University are being strengthened so that any further concerns in the future will be raised with the Chief Nursing Officer at the earliest opportunity.	
061/23	**Freedom to Speak Up Report** Ms Stinton presented that there have been 35 Freedom to Speak Up concerns raised since the Chester case which is a significant increase. There are some recurring themes around the Capacity team. The majority of which are regarding attitudes and behaviours, and civility and respect. Freedom to Speak Up training will be mandated and ready to launch in the new year, and the Freedom to Speak Up policy has been submitted to the policy working group.	

	Ms Stinton plans to hold bespoke Freedom to Speak Up training in partnership with the Health and Care Trust in order to train more champions. Ms Martin asked if the data in the report can be broken down into categories for example, by protected characteristics, ethnicity and staff group, in order to make clear what the challenges are. Ms Martin queried if staff are aware what the themes and numbers are, and that the Trust meet to discuss the issues raised. Ms Stinton responded that this could be communicated more effectively, and the Behavioural Charter Working Group will report on responding to Datix's as well as concerns raised by line managers. **ACTION: Ms Stinton to arrange for communications across the Trust to highlight FTSU themes and the actions being taken to address them.** Ms Jeffery suggested an app for line managers to quickly and easily input when conversations of concerns have taken place and noted that if initial conversations with a member of staff about their behaviours are effective, then they do not progress down a more formal route. An app could also provide staff with regular updates on concerns they have raised formally. Mr Murphy informed that at the Freedom to Speak up session he recently attended which was facilitated by the Integrated Care System, there was feedback that there aren't enough Freedom to Speak Up staff visible and questions regarding how Freedom to Speak Up Guardians direct queries to the right place and feed back to line managers. Dr Blanshard expressed concern regarding the number of Freedom to Speak Up concerns that are being raised anonymously and proposed that if there was a positive culture where staff felt able to raise concerns, then Freedom to Speak Up Champions and Guardians would not be needed. Ms Martin suggested that cascading the message through line management, dilutes it by the time it reaches certain staff groups. CB noted people are not feeling free to speak up particularly raising anonymously. Ms Martin also emphasised that when staff mention detriment, this needs to be investigated and addressed. Ms Stinton informed that some staff groups who do not feel free to speak up are often in smaller pockets of professions and have expressed fear that it would impact their ability to secure a job somewhere else. Ms Ricketts added that now with the Rumour Mill, themes can be captured to complement the report. Ms Ricketts raised her concern regarding the 31% response rate to the Annual Staff Survey. This response rate is lower than last year, one of the lowest in the country and highlights a need to focus on staff engagement. Ms Stinton added that surveys are now sent to those involved when a Freedom to Speak Up concern is resolved, and response rates are low for this too.	

	10:33 – Reena Rane joined the meeting.	
062/23	**Best Experience of Care & Outcomes for Our Patients**	
	High Performance Culture Report Ms Ricketts presented the report and summarised what the Trust has been working on throughout the year to improve the culture. It was acknowledged that it has been a challenging time recently for staff with the Trust moving into the Foundation Group and taking on learning from other Trusts. General feedback from colleagues is that they feel they are consistently being told where they need to improve, with little focus on what they are doing well. In a high-performance culture there is clear direction and communication with line managers and staff feel supported by their line managers both in terms of their wellbeing and their career progression and development. Everyone's contribution to their team is recognised and staff feel they have autonomy and are supported in being innovative. There are 7 ingredients proposed for inclusion into our year 3 plan in developing a high-performance culture. Mr Horwath suggested adding that the benefits of a high-performance culture, although are largely internal, also positively impact on a better quality of care and outcome for patients. Dr Blanshard added that effective leadership is also a key ingredient in embedding and developing the purpose of a high-performance culture. **RESOLVED: that the 7 ingredients are approved for inclusion into the 3 year plan.** **ACTION: Ms Ricketts agreed to include more detail on the culture ingredients at the the next meeting.** Ms Ricketts also raised that the Trust has roughly 7000 members of staff, but only one person on formal performance management review. She observed from joining meetings with the other Trusts in the Foundation Group, that the Trust does not sufficiently celebrate and communicate what they are doing well for example Cancer performance. Ms Martin gave examples such as Thank you Thursdays, Staff Recognition Awards and Long Service Awards as ways the Trust shows appreciation for staff. Ms Martin suggested the group consider what they can do to make this more meaningful for staff. Mr Murphy informed that a recent post on the Staff Facebook group showed the Trust's Oncology team winning an award and agreed that action is needed if staff are not feeling appreciated.	

	Ms Shingler shared that she has incorporated a celebration section into the weekly CNO huddles that she holds with her team. Ms Shingler agreed that the Trust was not very good at celebrating success at Board level. Ms Jeffery advised that following a positive CQC Maternity report a meal out has been arranged for the Division to celebrate. Ms Jeffery added that a small number of her team do not appreciate the Thank You Thursdays and Staff Awards; they just want the right number of staff, the equipment they need and for people to be polite. Whereas some members of her team really appreciate the Trust's efforts to say thank you and it does make them feel appreciated. To the comment regarding performance reviews, Ms Jeffery countered that poor behaviour should be identified and addressed before it progresses to the performance management stage. Ms Jeffery queried where informal conversations of concern are being monitored. Ms Martin noted that Board members have a role to play in speaking up and ensuring positive celebrations of success are given the appropriate attention. Ms Shingler explained feedback is being received that the Trust is not addressing certain individuals within the organisation. Ms Shingler stressed that performance management programmes are a positive thing and that they also send the message out to staff that the Trust will not tolerate poor behaviours. Mr Cook emphasised that when discussing having the capacity in order to achieve goals, it is important to ensure goals are realistic and achievable. Ms Ricketts agreed and noted that she was surprised by the number of line managers that are not familiar with setting SMART targets that are realistic.	
063/23	**Best Use of Resources**	
	Cost Effective Workforce Report Ms Ricketts presented the report and informed that it includes the latest information available on the Model System. The purpose of the report is to highlight what could be done to improve the £ run rate of the Trust with regards to its workforce.. In comparison to the peer median of Trusts of a similar size and with a similar level of turnover, the data reports that we have more Midwifery and Medical staff than the peer median, with more band 5, 6 and 7s than others. This analysis also shows that we have a higher number of Consultants compared to other Trust, and raises the question of whether we have too many, or whether we should be getting more activity from this staff group. The Trust has been an outlier for its reliance on temporary staffing for years, and therefore needs to improve planning in lead-in periods and holding staff accountable for the consequences of poor planning.	

	All vacancies for Medical staff are currently being reviewed, including how the posts are being covered in the interim and whether the cover needs to continue. Ms Ricketts confirmed that recent business cases are being reviewed to explore if they are still being covered by temporary staff and if so why. There is high turnover among staff in corporate, estates and facilities, with a high sickness absence rate across all staff groups. The Trust's ratio of clinical to non-clinical staff is 10:1 compared to an average of 7:1 in other Trusts. This is a likely consequence of holding non-clinical posts each year impacting on our capacity and capability to transform our services. Ms Ricketts informed that workforce reviews need to be undertaken and these will be agreed through the financial turnaround board including in which order they are undertaken. Ms Martin shared her concern, noting the report identifies non-clinical capacity issues as highlighted earlier in the meeting. Ms Martin asked if the workforce reviews will be included in the Trust's plan and Ms Ricketts advised it will be included in this year's planning round. Mr Horwath suggested an overarching review of what is being undertaken currently and what effect it is having would be helpful. Mr Horwath referred to the ratio of clinical to non-clinical and suggested this may be a cause and effect issue and could affect productivity. Ms Ricketts confirmed that the Corporate Services benchmark report previously shared with the Committee was further evidence of a reduced non-clinical capacity within the Trust. Mr Cook commented that with sickness being red across the board, there is no surprise that associated bank and agency spend is high. **ACTION – Ms Martin suggested a workforce development plan is brought to the February meeting**	
064/23	**Best People**	
	Integrated People & Culture Report The Trust has 7 priorities for this year and work has been ongoing to address these. There has been improvement in staff turnover and the Trust is now below its target of 11.5%. Vacancy rates have also been improving and we have enough candidates in the pipeline to meet our workforce plan. There has been positive work within the Staff Networks and good progress with leadership development. There are hotspots in terms of agency usage and the Trust is not seeing the traction needed in order to meet the 6% target. The Trust is currently at 9.2% but has an action plan in place. The Trust continues to be an outlier with regards to sickness absence.	

Ms Ricketts informed that work is ongoing with Dr Blanshard and Ms Lancaster in relation to out of date job plans and a consistency panel has been put in place.

Mr Luckman presented the leadership update, explaining that there were 403 places available on the training and 574 people have expressed interest so far. Larger rooms are being secured to allow for bigger cohorts and additional classes have been added to accommodate the demand. Mr Luckman advised they are almost reaching the target of 45% of Nursing and Midwifery delegates. 51% of delegates are band 6 and 33% are band 7 which is positive news as these groups were highlighted a few years ago as being underserved in terms of progression opportunities. Evaluation is ongoing regarding the impact of the course and statements are being gathered from delegates.

Ms Faulkner presented the update on bank and agency and reported that medical usage is predominantly due to vacancies and work has been undertaken to investigate what vacancies there are and how they are being covered. For Nursing & Midwifery, sickness is a key issue in addition to vacancies. Nursing have made good progress to review their bank and agency spend; the volume is high but this is closely monitored.. The Agency Reduction Plan has been shared with NHSE and the ICB.

At the previous People & Culture Committee, further details was requested in relation to workforce PEP schemes. Ms Faulkner shared that slides 82 and 83, provide the “Bottom up” plans for each Division. Also included in the report are the “top-down” schemes developed in conjunction with the CSU. The Trust is starting to see some traction on these schemes but not to the extent or scale hoped.

Ms Martin asked for feedback from the Committee regarding whether they are content to continue with the contract with NHS Professionals for bank and agency staff.

Ms Faulkner responded that she feels NHSP provides a sufficient service but that the Trust has a large part to play in terms of managing its bank and agency usage. Ms Faulkner added that in terms of supply at lower costs this could be improved, but also recognised NHSP would be taking into account the local market.

Dr Blanshard advised that the Medical service provided during the week is adequate but that this is lacking on weekends. It was raised that generally if Consultants call in sick on a weekend, those on shift call their colleagues and arrange the cover between themselves. Ms Ricketts clarified that a 7-day service is provided.

In response to a question from Mr Murphy regarding the zero-rated audit report on medical agency controls Mr Cook stated that a further review of the standing operating procedure was required as retrospective approval was still being requested.

	Ms Edwards presented the update for sickness absence rates and reported that a deep dive had taken place in August, but that absence rates have continued to rise every month and are now at 6.1%. Urgent Care had a spike in sickness absence in October and this is thought to be related to the opening of the new UEC the same month. The S10 category for Stress and Anxiety accounts for almost 30% of all sickness absence. For Surgery in particular, 40% of their sickness was stress related last month. Staff can self-refer to NOSS for support, but there is also an additional in-house service offered by Health Psychology. In the new service, all staff on sick leave under the S10 category are contacted by the Staff Psychology team and offered a one-to-one support session. Of the sickness absence across the Trust 4.1% is long term. All long-term sickness cases have been reviewed to ensure that staff are receiving the right support from their managers. Ms Edwards informed that they are also working with Occupational Health to organise Sickness training as they have received feedback that some of the referrals from line managers were not of the right quality. Ms Jeffery raised that following a review of sickness absence within her Division, it was noted that there was no separate code for bereavement leave and that this would then be included under code S10 Stress and Anxiety. Mr Cook raised that bank and agency shift fill rates have seen a 20.1% increase for shifts that would have otherwise been previously left unfilled. Ms Shingler advised that the fill rate would have been low previously and Ms Jeffery explained the consequences of shifts not being filled; an increase in sickness absence, turnover, being unable to release other staff for training. Ms Shingler added that there will have been near misses or low harm where shifts haven't been filled and noted that safe staffing levels have been agreed based on national recommendations. It is expected there will be an increase in demand for bank and agency in escalation areas and this will increase further during winter. Ms Shingler also informed that the number of complaints being submitted is increasing monthly. Mr Murphy agreed that when attending Maternity Safety Champion Walkabouts in the past, it was evident when the ward was fully staffed and that he could see and feel the difference. Ms Shingler explained that a reduction is being observed in agency spend for the funded establishment in the next staffing report.	
065/23	**Safe Staffing Report – Nursing** Ms Shingler presented the report and highlighted a significant reduction in off-framework agency use to 80%. The Registered Nurse vacancy rate was 7.26% for September, and this has now reduced further to 4.1%. Healthcare Support Worker vacancies have also reduced to 8.72%. Agency usage for unfunded areas has been calculated.	

	Mr Horwath queried how and why the Trust would be carrying out work that is unfunded. Ms Shingler explained that additional areas are opened in order to offload patients from Ambulances, and this requires putting in additional staff to cover these areas for example, to staff Medical SDEC overnight or the A&E treatment room. Dr Blanshard suggested pausing elective activity to utilise the ward spaces and surgical nurses in order to support throughout winter. Although it was recognised this would negatively impact on cancer care and patients waiting for elective surgery. Mr Cook advised that a risk-share arrangement is needed going forward with the ICB and clarified for Mr Horwath that additional capacity is authorised by the Director on call. Ms Shingler presented that the 20% increase in fill rate for agency staff, is a positive as the Trust is needing to open additional areas to cope with demand.	
066/23	**Safe Staffing Report – Midwifery** Ms Jeffery briefed the Committee regarding an increase in sickness attributable to bereavements, Covid and Flu. There has been a decrease in turnover and vacancy rate, and all new starters that were expected to arrive have done so except for 2 that should be arriving imminently. There has also been an increase in Maternity leave. Sickness absence rates have reduced in the Maternity Support Worker group but are still problematic. Ms Jeffery informed that the Division is currently recruiting to this staff group. Ms Jeffery explained that the data shows that if staff are going to leave, they will do so within their first year of employment. Therefore, additional support has been put in place for new starters to ensure they are well supported through their first year with the Trust. Supernumerary status has not been achieved and this was the fourth month that this was not achieved. One-to-one care in labour was achieved. There was a decrease in the time that the ward was able to meet acuity without having to rely on additional areas. 7 staffing and 8 Medication incidents were reported but there was no harm to patients. Two International Midwives arrived in November and are settling into their roles well, with another arriving in December. The Trust is currently advertising to recruit Midwives, and two Masters students will be joining in February along with more Band 6s. Mr Cook noted that Women & Children Division has been a key driver for bank shifts. Ms Jeffery responded that the Division are using less than 2 WTE and that PA shifts are less expensive than previously. Ms Jeffery added that shifts are utilised to maintain safe staffing levels.	

	Mr Cook raised that sickness absence is very high for the non-registered staff at 10.74%. Ms Jeffery explained that this was a significant reduction and that two members of staff who were on long term sick have now left the organisation. However, some staff remain on long term sick leave and this is predominantly due to S10 Stress and Anxiety.	
067/23	**Well-Led – Equality, Diversity & Inclusion Annual Report** Mr Luckman presented the report for approval prior to publication on the Trust's website and explained the report includes workforce Equality, Diversity and Inclusion data and patient experience. The report covers Freedom to Speak Up, talent development, compassionate and inclusive leadership, information and education and strengthening the staff inclusion networks. Mr Luckman advised that building confidence for staff to speak up is the first priority. The Trust's response rate to the annual Staff was 31%, with the worst in the country being 24%. Mr Luckman advised that this level of engagement will impact how close we get to our aspirations. Survey results will be released in February/March 2024 and will be reported back to the Committee. **RESOLVED: Report approved by the group for publication on the Trust's website.**	
068/23	**Apprenticeships Report** Mr Luckman shared that the report demonstrates the passion and dedication by Libby and Rachel in the apprenticeship team. Aligning into the people and culture framework. A celebration event was held in November for those who have completed their apprenticeships in the Trust. Project Search was launched in September which aims to support young Neurodiverse people getting into work. 8 interns have started on the programme and have placements organised within the Trust, rotating every school term. A few interns have good prospects of securing work within the Trust at the end of the programme. An update on progress will be brought back to the Committee in the new year. Ms Ricketts also advised that work has been commenced with the Shaw Trust, aiming to assist the long-term unemployed Neurodiverse to get back into work.	
069/23	**Governance**	
	People & Culture Risk Register Ms Ricketts presented the Risk Register and the recommendation to close three risks: • Recruitment function capacity	

	• Injury at work in relation to Covid 19: this is no longer having the same impact on the health of staff as it did in the height of the Pandemic. • HR Case work: the time taken is improving. Ms Ricketts presented four changes to risk ratings: • Retention: staff turnover is now at 11.5%, so the proposal is to reduce this risk. • Consultants Industrial Action: proposing the reduction from 16 to 12 due to the recent pay offer for the consultant body. • Staff engagement: proposal to increase this risk following poor engagement, particularly with the Staff Survey. • Surgery Division: following recent HR casework, dignity at work cases and the impact on the wider Division, the proposal is to increase this risk to 16. **RESOLVED: The committee approved the above changes to the Risk Register.** Mr Horwath queried the risks that have seen no movement since last reporting period and suggested that all should have open actions. Ms Ricketts explained that a deep dive was conducted in summer to review the movement of all risks and agreed to provide more detail moving forward in relation to the risk profile..	
070/23	**Any Other Business (AOB)**	
	People & Culture Workplan – *for information.* Ms Ricketts agreed to review the workplan following today's meeting and ensure that suggestions from the committee are covered within the schedule.	
	Date of Next Meeting	
	The date of the next meeting is 6th February 2024	

WAHT Finance Recovery Board

TERMS OF REFERENCE

Remit	The purpose of the Finance Recovery Board (FRB) is to provide a formal forum for the collective ownership and oversight, by senior clinical and non-clinical leads, of the Financial Recovery Plan
Accountability Arrangements	The FRB is established in accordance with the Trust's Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, responsibilities and reporting arrangements of the FRB which is a sub-committee of the Trust Management Board (TMB). The FRB is accountable to the Trust Board and is authorised by the Board to ensure that performance is effectively managed and controlled within the Trust. It is authorised to investigate any activity and seek any information including from any employee and/or instructing professional advisors. All employees are directed to co-operate with any request made by the FRB. The FRB is authorised by the Trust Board to decide upon and require officers to implement appropriate action to ensure achievement of, or to correct deviation from, the Financial Recovery Plan. The Financial Recovery Board will make decisions based on the delegated authority of those in attendance as set out under the scheme of delegation and other views as may be delegated by the Trust Board from time to time.
Responsibilities	The overall duty of the FRB is to provide assurance to the Trust Management Board and, in turn, the Trust Board that the Trust is monitoring performance against the Financial Recovery Plan. The FRB will report on any issue where the Trust Board may require additional assurance or where a Trust Board decision is required and will: • Determine the membership, priorities and term of the FRB stepping up and down as appropriate. • Receive status update (dashboard) from the PMO covering all CPIP and run-rate improvement schemes

	• Aim to prevent the realisation of adverse impacts through early identification of risks and issues. • Receive remedial proposals where significant variation exists from plans to deliver the elective activity / income. • Receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources. • Provide assurance to the Trust Management Board and Board that the programmes of work are being progressed as required and will escalate any significant concerns or variance to plan that have the potential to adversely impact delivery of the Trust's plans. • Test the assumptions and mechanics of the plan providing assurance to FPE / Board that the plan is reasonably based including triangulation with activity / performance and workforce metrics. • Ensure that an action plan with specific ownership is created for each component of the plan and is tracked to completion. • Seek formal assurance from SROs that financial controls on key drivers of the deficit are operating effectively through regular reports. • Agree status reporting and items of escalation to TMB/Trust Board/ICB & NHSE. • Ensure that Quality Impact assessments are considered as appropriate.
Membership / Attendance	Members of the FRB are: • Foundation Group Chairman • Non-Executive Directors • Foundation Group Chief Executive Officer • Managing Director • Chief Financial Officer • Chief Operating Officer • Turnaround Director (Temporary) • Chief Strategy Officer • Chief People Officer Members are expected to attend all meetings with deputies only being permitted by exception and must be capable of responding to actions to avoid delay to progress.

	In attendance: • Other staff may be invited to attend as required • ICB CFO (observer) • NHSE Finance Lead (observer) • Those from outside the Trust with relevant experience and expertise, where this is considered necessary. • Programme SROs and other key supporting officers may be invited to meetings as required to allow focus on particular areas of escalation / concern requiring TDB intervention.
Chair	The meeting will be chaired alternatively by a Non-Executive Director and the Managing Director.
Quorum	The quorum for the transaction of business is four members (not including deputies) including one Non-Executive Director.
Reporting Arrangements	Relevant elements will feed into the Integrated Performance Report to the Trust Board. The FRB will formally report to Trust Management Board with verbal updates provided at the earliest opportunity after the FRB meetings.
Frequency of Meeting	NED-chaired meetings of the FRB will be held monthly (at month end) in the first instance to gain assurance on the overall programme and traction on delivery. The Chair may call an additional or special purposes meeting if they consider one is necessary. An Executive led meeting will be held on the mid-point of the month during which the Turnaround Director will provide a highlight report on progress, risks and issues and capture action notes and key actions for progressing in between the intervening period.

Administration	The CFO's EA will organise the collation and distribution of the papers and keep a record of actions/matters arising to be carried forward. Papers will be issued 48 hours before and in exceptional circumstances tabled as necessary given the live status of the programme.
Date Approved	WAHT Board
Date Review	To be reviewed annually. Next review due by: November 2024

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council
HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HSE	Health & Safety Executive

HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MASD	Moisture Associated Skin Damage
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document
PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review

RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur