Quality Governance Committee Assurance Report – 29 June 2023

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore – Non-Executive Director	Dame Julie Moore –Non-Executive Director	Rebecca O'Connor, Director of Corporate Governance

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**QGC BAF Risks**	2, 3, 4, 11, 17, 18, 19, 20

Executive Summary

The Committee met virtually on 29 June 2023 and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Safeguarding Annual Report	Statutory requirement	Oversight and approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Maternity Safety Report	Level 5	Maintained	2, 4, 9, 10
Patient Flow	Level 3	N/A	19, 20
Learning from Deaths Q4	Not reported	N/A	4
Safeguarding (Adults and Children (Q4 and annual report)	Level 6	N/A	4
Medical Devices (Equipment) to include Safety alerts (Q4)	Level 4	N/A	4
Medicines Management (Q4)	Level 4	N/A	4
Clinical Audit / BOPP 2023-2024	Level 4/6	N/A	4
Management of Key Documents and NICE Guidance (Q4)	Level 6	N/A	4
GIRFT (Q4)	Level 4	N/A	4
Patient Experience & Engagement: Care that is a positive experience for patients & carers Report (Q4)	Level 5	N/A	2
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
End of Life Care (annual report)	Level 6	Maintained	4

Item	Level of Assurance	Change	BAF Risk
Legal Report Update (Including Reg 28)	Not reported	N/A	
CGG Report	Not reported	N/A	

Quality Governance Committee Assurance Report

Executive Summary

The Committee met virtually on 29 June 2023 and the following key points were raised:

Item	Discussion
CNO/CMO escalations	**NHSE IPC visit** – issues with the zonal kitchen within the PFI contract were discussed and it was confirmed the area is now closed. Immediate cleanliness actions were put in place. The root cause was the areas were not in use and thus cleans not in place, but understanding was that this should have happened. Contract monitoring issues have been discussed and a deep clean has taken place. Change of food macerator and flooring are to be finalised but actions are in place. With evidence of delivery of actions, it was anticipated that we will maintain our enhanced status with NHSE. Zonal kitchens have been reviewed cross site and no red flags have been raised and regular reviews are in place. The contractual implications have been discussed. The wider action plan will be reported back to Committee. **Insourcing** – RMG chair's actions were noted due to industrial action. The risks in relation to insourcing were discussed and the proposed approach to develop the governance arrangements were commended. **Industrial action** – junior doctors strike was noted and plans are in place to address the issues as large numbers of junior doctors are expected to strike. The current risk assessment is scored at 25. Acute, general and speciality medicine are of most concern. Consultant industrial action will also be taking place and we expect Christmas day levels of cover. This is also currently risk assessed at a level 25. **Silver Accreditation** with veteran aware status **Never event** – misplaced nasogastric tube. Case reviewed at SILG and believe this is human error. Usual investigation process will be followed with checks for any themes. **Dermatology** – service vulnerability and leadership was discussed. Work with the ICB and Wye Valley for mutual aid was noted, with support on the basis of a reciprocal relationship **Audiology –** national media coverage was noted. NHSE have established a regional command. First tranche of patients have been reviewed externally and there will be a recall for further testing of circa several hundred and plans are underway to broker mutual aid. **Urology** – RAS commissioning was discussed and the UHCW MDT arrangements were discussed. The current backlog, case mix, scope of practice and GIRFT deep dive were discussed along with mutual aid arrangements
Improving Patient Flow	Paper from private board and the discussion was shared. The Trust is demonstrating the actions are in place to align with the recommendations. The movement of actions will be set up support the new UEC and plan for winter pressures. The programme will be managed using the 4ward improvement system. The major programmes of work will be established with supporting infrastructure and PMO support, this is critical to move at pace and ICB resource is also sought.
Serious Case Review Update	Alfie's case was noted and multi agency learning was shared for awareness. There was no direct involvement of the Trust. Disguised compliance was noted as a specific issue to focus upon.
Maternity Safety Report	The report was taken as read and the key points were noted. Level 5 assurance. Booking 12 +6 are not sustained and single patient access is being developed. Perinatal mortality remains below the national average. No Still births or neonatal deaths were reported. An SI and a moderate incident are being reviewed. Training is meeting trajectory. CNST funding received with the aim to deliver the scheme which is ambitious. Staffing is positive re vacancies. MSWs hotspot is being addressed by new starters. Challenges in medical staffing but mitigations are in place. Complaints are down in month. CQC inspection is awaited. Ockendon actions should be delivered by July. Exit criteria for national programme was noted. Scrub nurses in theatres were discussed

Quality Governance Committee Assurance Report

Item	Discussion
Learning from deaths	The content of the paper was noted. The new format of the report was noted and this is now focussed on learning and not activity. Thanks were given to clinical lead Dr Ed Mitchell whose work was commended. The process of mortality review are now far more linked to palliative care. The ED data was considered and the link to those spending more than 12 hours in the department. Speciality reviews would be linked to the patient flow programme and separately for better crisis care and use of respect forms for those at the end of their life. The impact of spending the last day of your life in an emergency department was reflected upon.
Safeguarding report	Volume and complexity for both adults and children has increased. Report linked to the 4ward behaviours and all statutory and legal obligations have been met including liaison with LSCB, SAB, Prevent and DV. Modern slavery statement will be published. CQC feedback from the November inspection was positive in respect of staff recognising abuse. Training and capacity has been increased. MHA detentions contract allow 20 – but we had 77, this has been escalated. ICB and partnership working assurances were outlined. Suicide audit and surveillance was noted. LPS safeguards have now been put on hold. MCA assessment and best interests decision making are being developed further.
Medical devices	The report was noted and no alerts to raise. Arrangements for the purchasing of medical devices and maintenance was noted.
Medicines optimisation	The report was noted and no escalations were raised.
Controlled drugs	The report was noted and no escalations were raised. Good audit compliance and no significant incidents were noted
Clinical audit	New clinical effectiveness manager has been appointed. The Trust's approach to compliance and reporting was discussed and this is now aligned with other Trusts. The Trust are developing its forward audit plans and progress all for which we are eligible with the exceptions of one where we don't do this element of care. The local audit programme has been rationalised to prioritise key audits to provide enhanced support to the quality improvement priorities.
NICE	The report was noted and no escalations were raised.
Key documents	The report was noted and no escalations were raised.
GIRFT	Improvement activity was outlined and deep dives were discussed. The impact of late starts/early finishes were noted and this is being linked to the theatre productivity programme, however overall engagement can be variable across the specialities. This will be considered in respect of how GIRFT triangulates to the divisional Performance Review Meetings. The need for consultant level data was discussed but also the differences between case mix and speciality. The challenges are cultural and multi factorial but the Trust benchmarks well overall.
Integrated Performance Report	Operational performance, cancer and urology has been discussed. Flow performance and waiting times were slightly improved. LOS remains static. RTT position 104 weeks at 0, 78 weeks good progress targeting 0 by end of June/July, 65 weeks outperforming trajectory, 0 by March 24. Cancer 2WW breast and 28 day special cause improvement. Diagnostic 83% waiting less than 6 weeks with special cause improvement. Discharges yesterday had 114 discharges in one day. We have grip on elective and plans for cancer, we are looking at roadmap to step down from tier one to tier two. Benchmarking on LOS, fractured NOF had the 4th lowest in the region. Committee welcome the positive trajectory and improvements being made.

Quality Governance Committee Assurance Report

Item	Discussion
IPR quality	IPC and quality indictors noted. Ongoing IPC challenges with Cdiff, MRSA and MSSA were noted. Learning processes are in place. Facilitated a full deep clean at the ALX following the book lice situation and IPC cases have reduced. Covid and norovirus numbers have reduced. PDU area at WRH was discussed, there are multifactorial issues including flow, cleaning and IPC; outbreaks have been of concern. A number of quality measures are being out in place to support and progress will be reported. Complaints have been be an ongoing concern, primarily related to the waiting lists and experience. Surgery has a backlog to address and support has been offered with targets not met. F&FT feedback is positive and these boarding were considered. A review of boarding will be undertaken with the regional chief nurse. F&PT app connectively in maternity was discussed and the support to help completion. Level 4 assurance was approved
Patient experience	Patient experience feedback and comments has been maintained. Complaints were noted along with increased PALS contacts. Volunteers are being utilised and support the work of the Trust. Progress with #callme was welcomed. Level 6 assurance was approved
EOLC	The EOLC annual report was noted. There were significant improvements with the Peony Room and fundamentals of care training and expected death training. Taking part in the national audit. Continuing to develop EOLC and focussing on roll out of the voices bereavement questionnaire. A dashboard is being developed against the key quality measures. Challenges remain with fast rack discharges due to a lack of community palliative care and this should be progressed as a system priority at the ICB.
Legal	The report now includes lessons learned and this is shared across divisions. A regulation 28 report has been received since writing.
CGG report to TME	The report was noted. The new clinical governance approach was noted. The engagement and clinical input was excellent with clear accountability, passion and strong assurance.
Escalation to Trust Board	NHS workforce plan (to be announced tomorrow), safeguarding annual report
Reflections	Committee were pleased to note progress in a number of areas.

People & Culture Committee Assurance Report – 6 June 2023

Accountable Non-Executive Director	Presented By	Author
Karen Martin –Non-Executive Director	Karen Martin –Non-Executive Director	Rebecca O'Connor, Director of Corporate Governance

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	9, 10, 11, 14, 15, 17, 22

Executive Summary

The Committee met virtually on 6 June and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
No escalations made		

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
H&W ICS Workforce Report	Outcome - Level 4 Process – Level 4	-	9, 10, 14, 15
Integrated People & Culture Report	Outcome – Level 4 Process – Level 4	Reduced assurance due to under achievement on workforce PEP in 22/23	9, 10, 14, 15
Staff Health & Wellbeing	Level 5	Maintained	9, 10, 14, 15
Education, Learning and Development	Outcome – Level 3 Process – Level 4	Maintained	9, 10, 14, 15
Safest Staffing Report – Adult/Nurse Staffing	Level 6	Maintained	9, 22
Safest Staffing Report – Midwifery Staffing	Level 6	Maintained	9
People & Culture Risk Register	Level 6	N/A	9, 10, 14, 15, 17, 22
Terms of Reference	Level 6	N/A	9, 10, 14, 15, 17, 22

People & Culture Committee Assurance Report – 6 June 2023

Executive Summary

The Committee met virtually on 6 June and the following key points were raised:

Item	Discussion
Action log/ escalation	Noted upcoming junior doctors industrial action on 14 June; the minimum levels of cover are being reviewed. There are concerns regarding the acute medical take and once rotas are complete there will be a decision made regarding electives. Planning to continue cancer and P1 activity, although a number of potential 78 weeks breaches scheduled for this time which we will endeavour not to cancel
H&W ICS Workforce Report	ICS report was noted. 17,729 staff across primary and secondary care. Themes mirror our internal focus including retention, attraction to the area, workforce planning and inclusion. System development is ongoing but benefits are not yet fully realised. The strategic framework will be refreshed to ensure focus on the areas that will add most value. WAHT learning regarding recruitment will be shared and system partners have joined our improvement workshops. Overseas recruitment was discussed and it was confirmed the Trust only uses ethical providers on a fixed term basis.
Integrated People & Culture Report	Two steering groups are in place 4ward looking at culture and leadership and the Best People group. Workforce growth and associated impact of activity was discussed alongside a bridge showing the basis of the growth e.g. business cases. Future reports will include the impact of the investment on quality as well as activity and a baseline of the workforce. Divisional accountability was discussed and how they will be held to account through PRMs to provide onwards assurance to TME and Board Committees. Establishment control policy and associated SOPs will be considered at a workshop in July. Key workforce performance indicators were reviewed. Turnover remains above target and job planning would be added to the summary table. Bank and agency was discussed and the Trust's positive comparative position in the system was noted alongside the impact of covid during 20/21. The increase in 22/23 was due to impact of increase in urgent care attendance and use of SDEC, but we did not see the level of growth of bank and agency that other partners did. Our plan for 23/24 is in line with the system. Initiatives to manage bank and agency and the plan on the page were discussed. Lessons learned from the internal audit and the SOP have been widely shared, with enhanced governance around bookings and compliance will be checked internally. Good progress was reported. Talent management deep dive outlined the OD project to improve the PDR process. A project team is in place to support teams across the Trust. Compliance in staff survey remains the same and the quality of PDR conversations might be variable. A plan to address this is under development and there is a health and wellbeing element included. Personal development and learning needs were discussed. Subject to TME agreement a small pilot will run to test the proposed approach. The link back to the staff survey was welcomed but this needs a more responsive feedback loop. The importance of a valued appraisal process connecting strategic and personal objectives was stressed.
Staff Health & Wellbeing	The Trust has a comprehensive offer and had held a recent health and wellbeing day. Feedback included access to good value, nutritious food, changing facilities and car parking. A deep dive of sickness absence run rate post covid was noted. Menstruation poverty was discussed. NED feedback in relation to staff walkabouts was generally positive but often related to facilities. Proposed to close the BAF risk regarding the health and wellbeing strategic framework and a new risk will be considered re mental health. The Trust had recently won an award for its health and wellbeing offer. The physical constraints on the site were noted as limiting factor in addressing some of the issues. The importance of releasing colleagues for 4ward improvement training and wellbeing indicatives was noted as key for prevention.

People & Culture Committee Assurance Report – 6 June 2023

Executive Summary

The Committee met virtually on 6 June and the following key points were raised:

Item	Discussion
Education, Learning and Development	There are three functions within the education and training team. The paper proposed a review using HEE funding to review the current offer, identify gaps and propose a redesign to optimise the resource and support multi disciplinary training opportunities and career frameworks. There needs to be a clear offer to staff setting out what is available, where staff from different groups can train together and maximising the use of education centres. The terms of reference, scope, funding and timescale for the review were discussed.
Safest Staffing Report – Adult/Nurse Staffing	The reduction in HCA hours noted, 17 incidents with the majority being no or moderate harm. Process to manage safe strafing throughout the day. Safer nursing acuity assessment is being completed in June and July. Positive progress is being made with recruitment.
Safest Staffing Report – Midwifery Staffing	Assurance level of 6. Sickness and turnover are now below trust target. Vacancy rate is at trust target. Pipeline recruitment is ongoing with no delays in the process. Reduction in medical and staffing incidents, with no harm reported. Continuity teams were not used for escalation. Met supernumerary status and 121 care in labour. Meeting acuity prior to escalations. Unify data is better but high sickness in these groups has been reported. Hoping to progress to level 7 assurance following recruitment. Feedback from NEDs visits on staffing progress is positive and welcomed. The honesty and engagement with staff and showing them data has been very effective; the team feels very different and there is sustained improvement. MSW vacancy rates and support staff were discussed. Complaints overall were noted as low.
People & Culture Risk Register	The refreshed risk register was reviewed and approved
Terms of Reference	The ToR will be will considered with the new chair and a work plan developed for approval.
Any other Business	Thanks from Matthew Hopkins on his last Committee meeting. He welcomed the embedding of the 4ward behaviours and culture change journey of the Trust and reflected upon the improvements made in the Trust.

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

Improving Patient Flow - Including Response to the Ian Sturgess Report

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Dr Christine Blanshard, Chief Medical Officer (CMO)		
Presented by	Dr Christine Blanshard, CMO	**Author /s**	Dr Christine Blanshard, CMO Kira Beasley, Business Manager

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Private Trust Board	08/06/23	Discussed
Board Development	27/06/23	Discussed
Quality Governance Committee	29/06/23	Discussed

Recommendations	The Trust Board is asked to support the implementation of the actions detailed within this report to improve patient flow, quality of care and patient experience.

Executive summary	In November 2022 the CQC inspected both of our Emergency departments at the Alexandra Hospital and Worcester Royal (WRH). Although the overall ratings for both departments were upgraded from Inadequate to Requires Improvement, a "must do" for both departments was to improve capacity and flow in the ED to reduce waits and delays. Along with all acute NHS providers we have agreed within our annual plan to deliver the emergency access standard (4 hour target) for 76% of attendances by March 2024. The main barrier to achieving this is delay in admission of patients to inpatient beds. Our emergency departments, particularly at WRH, are constantly overcrowded and often unsafe. Overcrowding is not consistent with Putting Patients First and causes moral injury to staff. Furthermore, overcrowding results in ambulances being unable to offload and therefore attend patients in the community in a timely manner. Managing patient flow out of our emergency departments is therefore a priority for the Trust, its partners, the Integrated Care System and the Local Authority Health Overview and Scrutiny Committee (HOSC). A large number of actions have been suggested as national initiatives or on the basis of external reviews (e.g. by ECIST, GIRFT and most recently

Dr Ian Sturgess) and have come as suggestions from our staff. Some of these have been implemented in the past but not always in a consistent and sustained way. However, there is now further urgency to make impactful changes in advance of the opening of the new Emergency Department in September 2023. We have therefore gathered all suggested actions into a single overarching patient flow action plan, which will be implemented using the 4ward improvement system.

Principles

- Actions are required across the entire acute and community pathway and at all levels of the system, but the Trust needs to take responsibility for those actions within its sphere of control.
- Engagement of clinical teams and ownership of actions is key to success
- Progress against key metrics is reviewed weekly via the flow group to celebrate success and unblock challenges
- Visual management is used to monitor progress and engage staff

Three key groups of actions:

- Acute Trust front door business. Some were part of the former front door workstream e.g. streaming to ambulatory care; some will need system working support e.g. the development of a single point of access or redirection tool.
- Patient flow cross-divisional improvements, underpinned by 4ward improvement system. This encompasses the admitted patient journey from arrival to being medically fit for discharge. The work will report internally to TME and externally to Home First via a highlight report.
- Discharge – from medically fit for discharge (MFFD) to leaving the acute setting, the main focus of the 4ward improvement system value stream work, sharing and spreading the outputs of the two rapid process improvement weeks (RPIWs) The 3rd RPIW in September will be focusing on therapy referral to therapy discharge. This will report to Transformation Guiding Board.

An overarching vision of what good patient flow looks like has been developed with widespread clinical and operational engagement. An action plan specifically in relationship to the Ian Sturgess review recommendations (appendix 1) has been developed collaboratively with the integrated care system and is included in the paper as appendix 2. The patient flow team will prioritise the high impact actions to be completed in time for the opening of the new Emergency Department.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*19, System Working* *20, Urgent Care*

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

Assurance Level (x)	0		1		2		3	X	4		5		6		7		N/A								
Financial Risk																									
Action																									
Is there an action plan in place to deliver the desired improvement outcomes?	Y																N/A								
Are the actions identified starting to or are delivering the desired outcomes?	Y																								
If no has the action plan been revised/ enhanced																									
Timescales to achieve next level of assurance																									

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
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Paper number	Enc H

Introduction/Background

For many years the emergency departments at the Alexandra Hospital and particularly Worcester Royal (WRH) have seen sustained operational pressures and overcrowding. In February 2020 the CQC rated both departments as inadequate, citing overcrowding, patient safety concerns and poor leadership. Since the end of the peak of the Covid pandemic the departments have remained overcrowded and there have been frequent delays in ambulances being able to offload patients resulting in scrutiny and performance management from the ICB, regional and national teams.

In November 2022 the CQC carried out an unannounced inspection of both EDs and their report, published in April 2023, found that both departments had improved to Requires Improvement, being rated as good for

However the report included the following “must dos”:

- **Alexandra Hospital Urgent and Emergency Ca**re

The provider must ensure they manage the capacity and flow in the ED to prevent patients waiting a long time

The provider must ensure that patients are not waiting a long time in ambulances outside of the emergency department and they work with local systems to improve patient flow

- **Worcestershire Royal Urgent and emergency Care**

The provider must ensure they manage the capacity and flow in the ED to prevent patients waiting too long

The Trust must ensure that patients have timely access to the emergency department in line with national standards

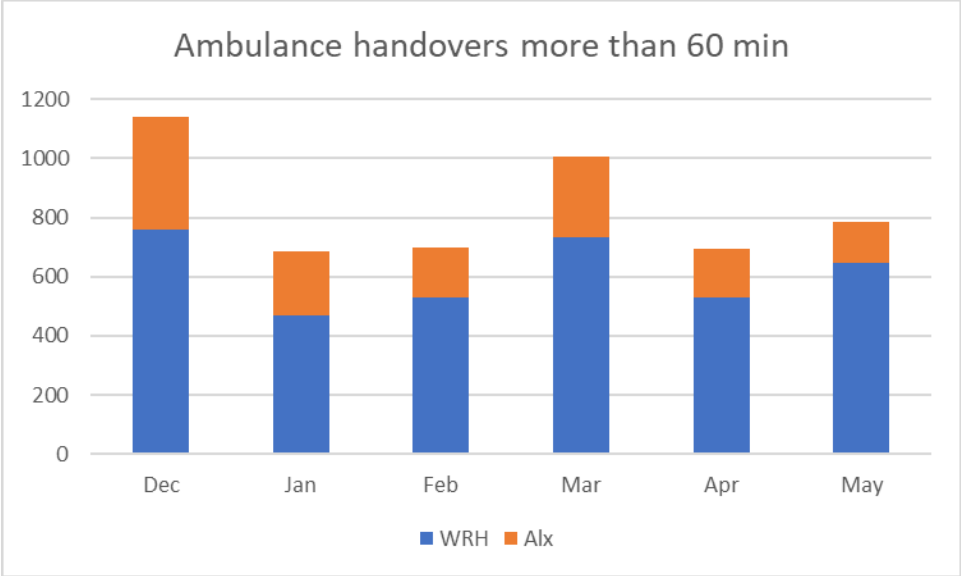
We are also required, by March 2024, to deliver the new NHS constitutional standard that 76% of patients attending emergency departments must be seen, treated and transferred, admitted or discharged in 4 hours. Our current performance at WRH is in the table below.

Month	Worcestershire Royal			
	Overal	NANR	RoA	Con %
Nov-21	56.2%	76.1%	30.2%	31.1%
Dec-21	54.3%	73.4%	29.2%	31.8%
Jan-22	52.9%	71.2%	28.9%	31.2%
Feb-22	51.8%	69.3%	28.3%	31.2%
Mar-22	50.1%	66.6%	25.8%	27.3%
Apr-22	51.3%	68.8%	26.6%	28.8%
May-22	51.7%	68.8%	26.9%	28.1%
Jun-22	51.2%	67.9%	27.0%	28.4%
Jul-22	50.3%	66.5%	26.9%	28.2%
Aug-22	47.6%	63.1%	25.9%	29.1%
Sep-22	48.0%	62.3%	29.1%	31.9%
Oct-22	49.8%	65.9%	27.1%	29.6%
Nov-22	50.0%	65.3%	29.3%	30.0%
Dec-22	49.1%	62.8%	27.8%	28.1%

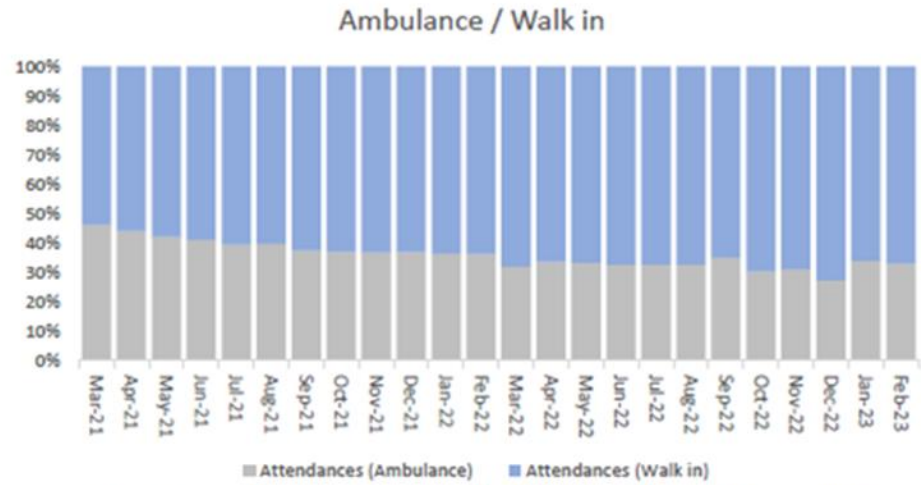
NANR – non Admitted Non Referred – ie. ED element
RoA – Referred or Admitted – ie. non ED element

Con – conversion rate

We have been described as a “challenged Trust” for ambulance handover delays and since December 2022 have been in a performance improvement regime overseen by NHS England. Since then, over hour handover delays peaked at 1,198 during December 2022. These delays have reduced somewhat but remain amongst the worst in the country.



During this time an increasing proportion of our ED attendances have been “walk in” patients, and the clinical evidence is that the acuity of this cohort has been increasing – a higher proportion require admission and a higher proportion die.



Source: Summary Acute Provider Indicator Table (SAPIT) NHS ECIST, WRH ED February 2023

The main factor causing ambulance handover delays is ED overcrowding, resulting in no physical space in the department to place another trolley, or no staff available to see and treat the patients.

At WAHT patients waiting outside on ambulances remain in the care of paramedics and are reviewed every 15 minutes by an experienced ED nurse using a global risk assessment tool (GRAT) to ensure they are not deteriorating whilst held outside. Patients are brought into the department in clinical priority order rather than in order of arrival time, and sometimes patients in the waiting room are brought in ahead of the ambulance patients as they are more acutely unwell.

Among the factors driving reduced handover delays post December, was the ability to see patients within 'Same Day Emergency Care Settings' (SDEC) which contributes to reducing the numbers of patients requiring an in-patient bed. During December 2022, the first floor of the new Emergency Department opened as a large Medical SDEC area and since then has seen around 250 patients per week (during the same period last year this number was approximately 160). This is a promising start; however, more can be done in terms of streaming patients to the area, managing more pathways through this area and maximising the role of the advanced care practitioners.

Similarly, the new surgical SDEC area (opened in the spring) currently sees about 60 new patients per week, mainly general surgery and minor trauma, but has the potential to manage more patients and a wider range of surgical pathways. An expanded gynaecology assessment unit is functioning well.

In addition to these measures, we have opened an additional 29 beds at WRH, initially as a post-ED cohort area for patients waiting a bed on a downstream ward and, when this approach failed to improve flow, as a Pathway Discharge Unit (PDU) for patients medically fit for discharge but awaiting onward care.

Despite this, the emergency departments at WAHT remain permanently overcrowded, with up to 18 patients cared for in corridors, and patients receiving complex care such as intravenous infusions and blood transfusion in corridors and the minor injuries areas.

The impact is:

- Clinical risk
    - Falls
    - Pressure ulcers
    - Mortality – deaths in ED increased from an average of 25 to average of 36 per month
    - Incidents and near misses
- Patients receiving complex care such as intravenous infusions and blood transfusion in corridors and the minor injuries areas.
- Downstream impact – "boarding" patients who are being nursed in a bad placed in a ward corridor area.
- First available bed approach resulting in patients not receiving the right specialist care in a timely manner, and increased numbers of patient moves
- Unable to step down patients from ITU – psychological harm and mixed sex breaches.
- Patients nursed in ambulatory care areas (such as overnight in SDEC) – impact on next day efficiency
- Moral injury and distress for our staff – high turnover of staff in acute and emergency medicine

The main cause of ED overcrowding is "exit block" – patients requiring admission are unable to move to downstream wards because of a lack of available beds. These patients mainly need admission under the medical specialties for conditions such as sepsis, heart failure, chest infections. Exit block is less of an issue for surgical specialties with the

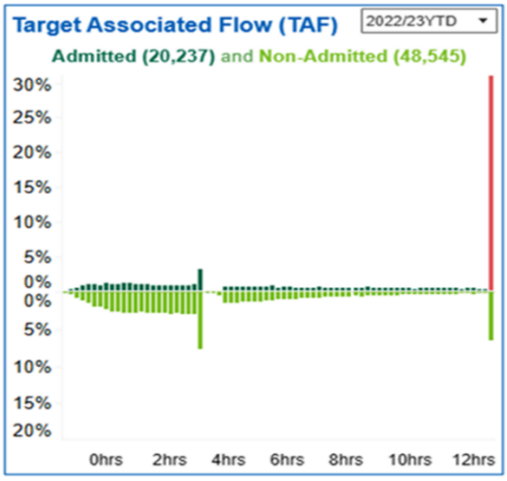
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

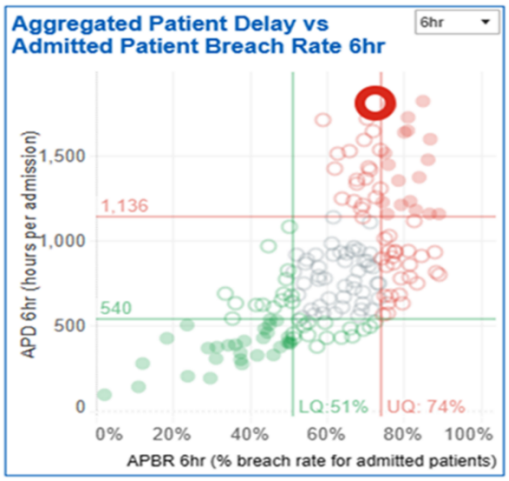
exception of some trauma cases. Up to 97% of admitted patients breach the 4hr emergency access standard.

WRH ED NHS GIRFT data for January 2023



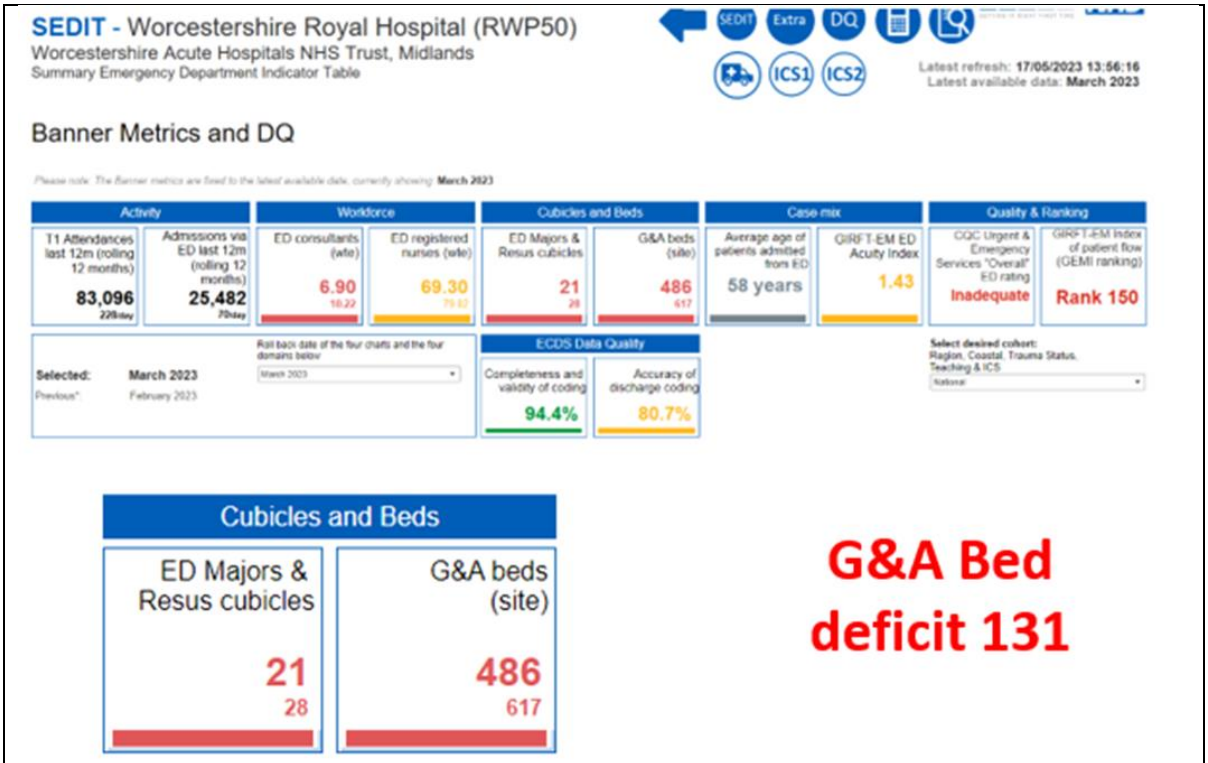
The graph shows that the majority of referred or admitted patients (dark green, red) only leave the ED after 12hrs, indicating significant 'Exit Block' or a non-functional admitted pathway

WRH ED NHS GIRFT data for January 2023



The graph shows that WRH ED is a national outlier in terms of the functioning of the admitted pathway, with an APD6hr of 1804 (English mean 933)

The challenge for WAHT is that benchmarking by GIRFT suggests that there are too few acute and general beds on the WRH site:



This means that despite the fact that we perform well on length of stay (best quartile nationally), stranded patients (those staying more than seven days) and patients who no longer have Criteria to Reside, we have a bed occupancy that (including patients bedded in corridors or ambulatory areas) is consistently above 100% against a national best practice measure of 85% and an ICB target level of less than 92%

Trust Name	7+ LoS occupancy %	14+ LoS occupancy %	21+ LoS occupancy %	% beds occupied by patients NOT meeting criteria to reside
Midlands	42.6%	24.6%	15.7%	11.5%
Chesterfield Royal Hospital NHS Foundation Trust	39.6%	25.9%	12.3%	20.3%
George Eliot Hospital NHS Trust	59.8%	32.1%	17.8%	6.7%
Kettering General Hospital NHS Foundation Trust	52.9%	31.3%	19.0%	6.8%
Northampton General Hospital NHS Trust	57.2%	37.8%	26.4%	23.0%
Nottingham University Hospitals NHS Trust	44.8%	27.0%	17.5%	15.7%

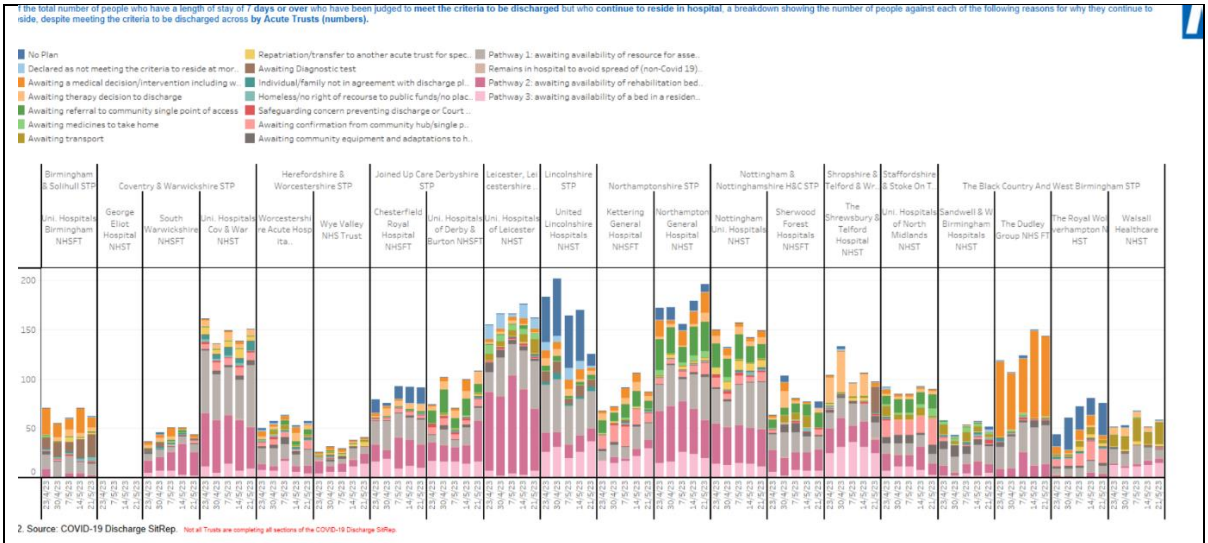
Sandwell and West Birmingham Hospitals NHS Trust	51.3%	32.6%	23.8%	10.4%
Sherwood Forest Hospitals NHS Foundation Trust	45.2%	26.3%	17.1%	16.6%
South Warwickshire NHS Foundation Trust	30.7%	16.6%	9.5%	16.4%
The Dudley Group NHS Foundation Trust	42.4%	23.3%	12.6%	8.3%
The Royal Wolverhampton NHS Trust	41.4%	22.7%	12.5%	11.1%
The Shrewsbury and Telford Hospital NHS Trust	43.8%	24.1%	13.7%	16.5%
United Lincolnshire Hospitals NHS Trust	38.5%	23.6%	16.2%	14.7%
University Hospitals Birmingham NHS Foundation Trust	47.5%	27.0%	17.0%	5.7%
University Hospitals Coventry and Warwickshire NHS Trust	45.4%	26.2%	18.2%	17.1%
University Hospitals of Derby and Burton NHS Foundation Trust	39.7%	22.9%	14.0%	8.3%
University Hospitals of Leicester NHS Trust	40.2%	23.0%	14.5%	10.8%
University Hospitals of North Midlands NHS Trust	42.6%	23.5%	15.0%	8.2%
Walsall Healthcare NHS Trust	37.2%	16.6%	8.3%	15.5%
Worcestershire Acute Hospitals NHS Trust	39.1%	21.2%	13.2%	7.2%
Wye Valley NHS Trust	38.5%	20.6%	13.0%	18.6%

By comparison to other Trusts in the Midlands and nationally, relatively few of our patients are waiting for community beds, care homes or nursing homes, although these patients do have a long length of stay.

Worcestershire Acute Hospitals NHS Trust

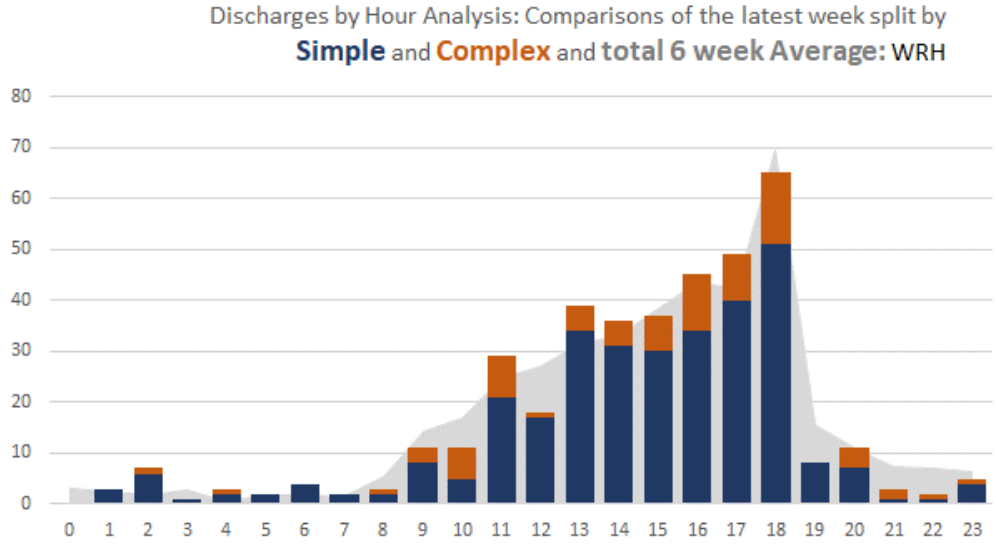
Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H



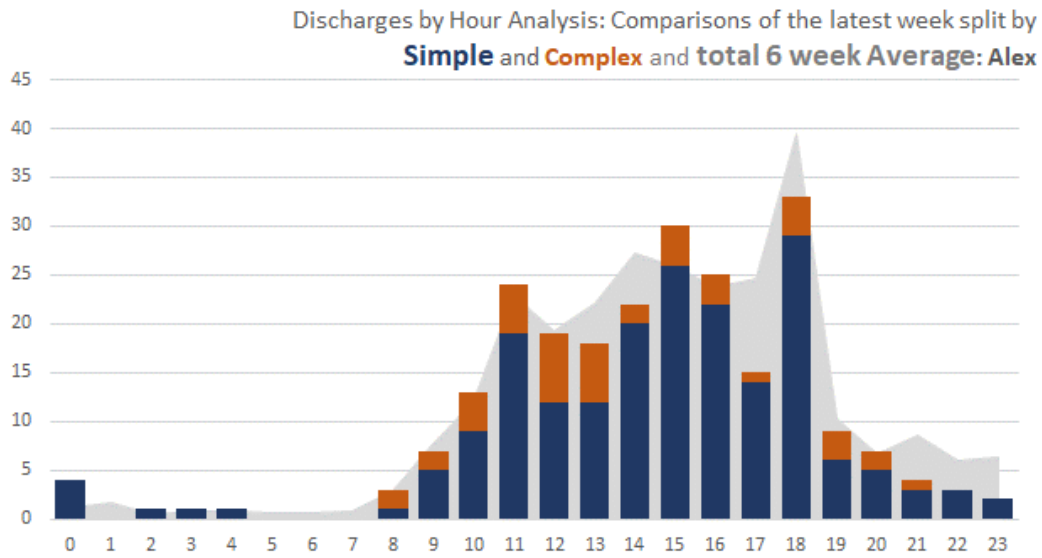
2. Source: COVID-19 Discharge SitRep. Not all Trusts are completing all sections of the COVID-19 Discharge SitRep.

We need to improve timeliness of discharges in the day, which would enable patients to move from ED and assessment areas to downstream wards earlier in the day to make space for that day's attendances, and improve patient experience of going home before darkness. This will be supported by the forward improvement system work on the electronic discharge summary proves and dispensing of take home medications which can improve the time taken to discharge a patient by several hours.



WRH

- **19%** of discharge were made before Midday
- **33%** were made between Midday and 4pm
- **40%** were made between 4pm and 7pm
- **7%** were made after 7pm



AGH

- **22%** of discharge were made before Midday
- **37%** were made between Midday and 4pm
- **30%** were made between 4pm and 7pm
- **10%** were made after 7pm

However, it is unlikely that this will result in less overcrowding on its own, and there needs to be a focus on several areas of the admitted patient pathway to reduce waste and delays. Previous initiatives such as the North Bristol continuous flow model, standardised board rounds, the SAFER bundle, red/green days, criteria led discharge, discharge production boards, end PJ paralysis have been trialled and have failed to be universally adopted and embedded, or were abandoned during covid pressures. Therefore, a different approach is needed.

In early 2023 Dr Ian Sturgess, an independent consultant with a background in general medicine and medicine for the elderly, was commissioned by the ICB to conduct a system review in to length of stay & flow practices across Worcestershire. This was the fourth review he had undertaken in our System, the last being in 2021. He was asked to:

- Define opportunities to increase the volume and speed of discharges including assessment whether we can increase P0 discharges (P0 are discharges to the patient's usual place of residence)
- Define interventions and key gaps to improve flow
- Understand interventions that can reduce medical length of stay
- Assess the frailty pathway
- Review discharge practices and make recommendations to improve the percentage of patients discharged by midday
- Review bed management processes

- Assess the “Lisa Levy” report into the onward care team and ensure that the recommendations are being progressed.
- Review the recent point prevalence audit and next steps in terms of the system bed capacity review
- Review the planned capacity and demand work across the system
- Review the processes for managing long length of stay patients
- Look at the accuracy of discharge reporting

The review entailed examination of our published data and benchmarking, interviews with a small number of clinicians, managers and executives, and observations of ward rounds. Dr Sturgess did not review any patient notes or patients. Many of his observations accorded with our own, and we agreed that there is both the potential and the imperative to make improvements in patient flow, particularly given our constrained bed base and the imminent opening of a new emergency department. However, some of the views expressed within the report have been challenged by colleagues.

This report includes both our response to the Ian Sturgess report and recommendations that have been made by previous reviewers such as the Emergency Care Improvement team (ECIST), the Royal College of Emergency Medicine, Getting it Right First Time (GIRFT), the national delivery plan for recovering urgent and emergency care services, and our own staff.

A number of actions have been identified, with an approximate time frame for implementation to improve flow across our Trust; specifically, the Worcestershire Royal Hospital site.

Principles

- Actions are required across the entire acute and community pathway requiring action at all levels of the system, but we need to take responsibility for those actions within our sphere of control.
- Engagement of clinical teams and ownership of actions is key to success. Each action has a process owner that is supported to put together a team to progress the projects beneath that action.
- The impact of actions on key metrics is reviewed weekly via a multidisciplinary, group flow group with membership form all clinical divisions to celebrate success and unblock challenges.
- Actions may be tested in one or more small areas and refined before sharing and spreading.
- Visual management is used to monitor progress.

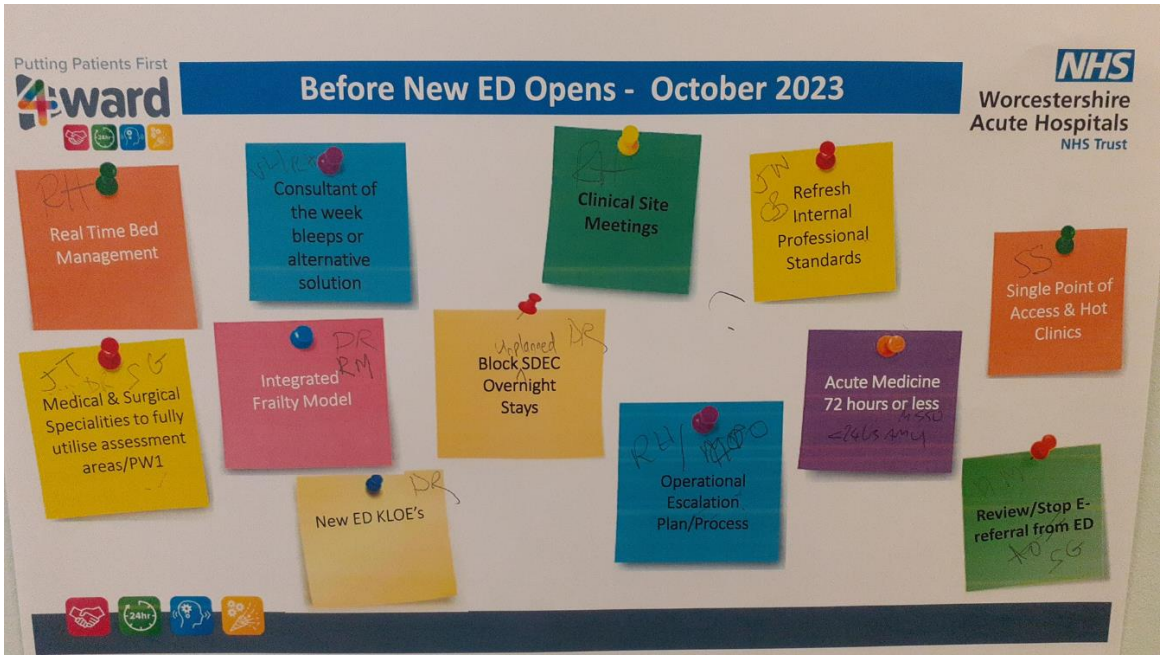
Three key groups of actions:

- Acute Trust front door improvements. Some were part of the former Front Door workstream eg streaming to ambulatory care, some will need system working support eg the development of a single point of access or redirection tool. Some are new initiatives eg development of an acute urology/blocked catheter pathway
- Patient flow cross-divisional improvements, underpinned by 4ward improvement system. This encompasses the admitted patient journey from arrival to being medically fit for discharge (MFFD). The work will report internally to TME and externally to Home First via a highlight report.

- Discharge – from MFFD to leaving the acute setting, the main focus of the 4ward improvement system value stream work, sharing and spreading the outputs of the two rapid process improvement weeks (RPIWs) The 3rd RPIW in September will be focusing on therapy referral to therapy discharge. This will report to Transformation Guiding Board

Actions

Below is the visual management board section showing the high level actions to be delivered before the opening of the new ED and before winter. All have a process owner, measures and deliverables documented in the background and tracked by the programme management team.



Each of these high level objectives aligns to the actions in the Worcestershire Place UEC action plan below, although we have preferred to use the time frames of ED opening and winter (December 1st) as hard end points to support clinical engagement.

Worcestershire Place UEC improvement plan

The urgent care improvements the system is required to deliver are:

- Improve and Maintain Cat 2 response times
- Reduction in lost Paramedic Hours
- Eliminate over 1-hour Ambulance Delays
- Achievement of 76% EAS performance by March 2024
- Reduction in % of patients spending +12 hours in ED
- Reduction in Acute and Community Length of stay
- Reduction in Acute and Community Occupancy Levels
- Improve Discharge Performance Against Targets

Recommendation	Actions Required	Lead/Governance route	Desired Outcome
Action: 1 Create an aspirational clinical vision of flow (agnostic to specialty) that you would be proud of for your nearest relative to experience if they	Acute Trust to produce a draft clinical vison focussed on: - Early decision making in the patients' acute pathways re discharge plan - Reducing deconditioning of patients with reduced length of stay - Develop options for the GIM gaps to ensure daily clinical ownership	Acute Trust CMO/CNO/COO in collaboration with System Partners	• 76% March 24 EAS Achievement • Reduced ED Delays • Reduced % of patients spending 12 hrs + in ED • Clinical and Operational alignment • Clear plan for patient flow

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

suffered an Acute illness/injury. **Delivery: 4 weeks**			
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 2 **Redesign the structure and flow across the interface between Acute Medicine and Specialty Medicine** **Delivery: 6 months**	• Determine the most effective COW handover day/process • Meet with medical consultants to identify clinically driven solutions for patient flow model • Formalise standards for timelines of Specialty Medicine reviews of AMU/MSSU/ED patients • Define 'standard work' for Specialty pathways and onward follow-up • Develop plan for 24/7 staffed Rapid Assessment Area in Acute Medicine • Deliver hourly patient moves from ED to assessment units/specialty wards – reintroduction of ward-based targets and monitoring mechanisms • Implement Specialty based Rapid Access/Hot clinics • Redesign and relocate ambulatory Specialty SDEC activity	Acute CMO/COO	• 76% March 24 EAs Achievement • Reduced ED Delays • Reduced % of patients spending 12 hrs + in ED • Reduced Ambulance Delays • Clinical Engagement and support • Drive patient flow • Reduce time wasted for patients • Reductions in Admissions • Preserve function of assessment areas • Improve management of people living with frailty, reduce LoS and HAFD • Reduce LoS <24 hours AMU, <72 hours MSSU
Recommendation	**Action Required**	**Lead/Governance Route**	**Desired Outcome**
Action: 3 **Implement modern board and ward rounds** **Delivery: 8 weeks**	• Standardised board/ward rounds as per Royal College guidance and any 4ward Improvement Projects • Deliver board round and SAFER patient flow bundle in all areas as per RCP guidance and CQC Patient FIRST • Criteria for Discharge and EDD will be in place for all G&A patients • Clear board and ward round timings in all areas • Monitoring of delivery and outcomes through Performance Group, Divisional PRM's • Utilise the 4Ward programme to accelerate UEC flow within the Acute Trust as one of the three priority workstreams.	Acute Trust CMO/COO	• Reduced occupancy levels • Reduction to 14 Day LOS Patients • Achievement of Daily System Discharge Targets • Achievement of 33% pre midday discharge
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 4 **Clear focus at all levels within the Acute Trust on monitoring, accountability and reduction of internal delays** **Delivery: 8 weeks**	• Redesign framework for monitoring and tracking performance against delays • Implement Performance Group with agreed metric and trajectories for improvement • Relaunch Internal Professional Standards, monitored through Performance Management Group	Acute COO/CMO	• Reduced occupancy levels • Reduction in 14 day LOS Patients • Achievement of System Discharge Targets • Achievement of 33% pre midday discharge • Drive patient flow

	• Clear escalation plan and mitigations with Executive oversight		
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 5 Increase the percentage of patients being discharged from the Acute Trust on PW0 (simple discharge), with particular focus on patients ages over 65 years **Delivery: 12 Months**	• Agree trajectory for improvement from current baseline of over 65 year old PW0 discharges of 68.4% at WRH and 73.5% at AH • Liaise with Foundation Group partners to establish benchmark and identify improvement opportunities	Acute COO/CMO/CNO	• Reduced ED Delays • Reduced Ambulance Delays • Reduced Occupancy levels • 80% of over 65's YO PT's discharged to usual place of residence • Reduction in 14 day LOS Patients • Achievement of System Discharge Targets • Improved management of people living with frailty, reduce LoS and HAFD
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 6 Acute Trust Operations Management Meetings (Clinical Site Meetings) to be re-focussed on actions and accountability in the Divisions for the delivery of the reduction in the bed gap. The Executive Triumvirate should be present at all meetings as should the Exec on-call at level 4 **Delivery: 8 weeks**	• Develop revised format and accountability framework for clinical site meetings based on best practice and defined plans for DTAs • Capacity Framework to include accountability and monitoring of adherence to Escalation Level actions including Executive oversight and presence • Establish weekly internal flow meeting at Flow Accountability Wall (4Ward principles) • Review and relaunch Escalation Policy and actions • Review and relaunch SHREWD escalation module with clear, system wide escalation actions • Measure demand by specialty and performance against required levels through Performance group • Refresh Long Length of Stay process	Acute COO/CMO/CNO ICB UEC Transformation Lead (SHREWD)	• Reduced Occupancy Levels • Reduced 14 day LOS • Achievement of system wide discharge targets • Improved Earlier in Day Discharge
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action 7 Acute Trust to ensure that every patient has EDD and CCD from the point of admission. **Delivery: 3 months**	• Relaunch and embed EDD and CCD in all application areas • Continue to engage with National SPEED audit • Undertake audit and create action plan based on ECIST "every patient deserves a plan" • Establish System wide review of non-delivered EDD's to identify themes	Acute CMO/CNO/COO	• Reduced Occupancy Levels • Reduced 14 day LOA • Achievement of system wide discharge targets
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

Action: 8 Reduction in Hospital Acquired Functional Decline **Delivery: 6 months**	• Develop System wide integrated Frailty model to include GEMS/REACT/UCR/Neighbourhood teams/Virtual Ward/Voluntary Sector • Review and refresh clinical strategy for People Living with Frailty • SDEC areas to upskill expertise in managing people living with frailty • Develop diagnostic and virtual ward pathways for UCR and neighbourhood teams to maximise admission avoidance for people living with frailty • Establish more effective use of the PDU area, with focus being reduction to LOS	Acute CMO/CNO/COO HACT CEO – HFC – prehospital work stream	• Improved management of people living with frailty, reduce LoS and HAFD
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action 9 Implement Specialty based Rapid access/Hot clinics and Maximise SDEC capacity **Delivery:3 to 6 months**	• Commitment System wide to keep SDEC areas as non-bedded areas • Formalise process for Specialty Medicine reviews of AMU/ED patients • Redesign and relocate ambulatory Specialty SDEC activity management pathways • Develop virtual ward activity, determine initial 'high value' opportunities. • Define "standard work" for Specialty pathways and onward follow-up	Acute CMO/CNO/COO ICB Executives	• Reduction in admissions • Improved SDEC utilisation
Recommendation	Actions Required	Lead/Governance route	Desired Outcome
Action 10 System and regional assurance are in place in readiness for the new ED in October 2023 **Delivery – 3 to 6 months**	The Worcestershire System Held an assurance workshop on June 20th to understand readiness for the New ED build opening in October 2023. The following actions were agreed as a result of that meeting. • Development of a Communications and Engagement Plan focussed on raising awareness of the plan and the importance of delivering the recommendations. • Development a strategy to ensure a cultural shift to accepting the priorities and observations contained within recent reviews becoming BAU. • Development of Single Point of Access within Acute Trust for GP/HP – with best practice streaming and alternate pathways that reduces numbers of	ICB Comms Lead working with PLACE Comms Teams ICB Director of OD working with Worcestershire Place HR/OD Leads Acute Trust COO/CMO supporting by system partners Acute Trust COO/CMO Acute Trust	• Plan is understood by all • PACE in delivery • Evidenced by sustainability of improvement • Linked to Improved ED measures – as a result of fewer delays • Linked to earlier elements re SDEC – may want to add • Recruitment of interface clinicians • Implementation/deployment plan • Increased SDEC utilisation • Linked to Improved ED measures – as a result of fewer delays • Acute Trust / ICB Ops Lead • ' As per action' • Improved SDEC/AMU throughout

	inappropriate patients going through ED • Acute Trust to link in with National Colleagues and areas of Best Practice to ensure SDEC offerings are fully utilised • ICB have provided funding to the Acute Trust to support recruitment of GP Interface Clinicians who would further support, enhance and refine the SDEC Offer. Acute Trust to produce implementation plan for the role out of this provision. • Acute Trust to ensure zero tolerance approach from 1st July in ensuring no GP expected patients is processed through the Emergency Department • Determine most appropriate Primary Care Model to support ED. • Acute Trust to provide update on ' Future PAU' Model / Timelines • Health and Care Trust to consider options for Community Based team to work from / operate out of Acute SDEC/AMU area to further enhance the offer and provide quick access to referrals out and supporting assessment area discharge opportunities • Health and Care Trust to 'Fast-Track' development of Community Single Point of Access, consideration for interlinkages with physical offerings – linked to above actions • Health and Care Trust to develop improvements to the MH Offer supporting ED. Consideration to include improved access, improved responsiveness, Improved Streaming – all leading to reduced ED LOS for these patients • ICB to review current Escalation Policies, including EMS Triggers.	COO/CMO Acute Trust COO/CMO Supported by System Partners Acute Trust COO/CMO Acute Trust COO/CMO Health and Care Trust Director of Urgent Care Health and Care Trust Director of Urgent Health and Care Trust Director of Urgent Care ICB UEC Ops Lead, working with system COO's, CMO's, CNO's	• Increased Activity • Increased pre-hospital activity • Increased discharge activity/improved timeliness • Reduced ED length of stay for MH Patients • Reductions to EMS level 4 occurrences • Improvements to timescales for De-escalation
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 11 Integrate IPC processes across		ICB IPC/ Acute CNO/Health and Care CNO	• Fewer delayed discharges as a result of IPC concerns

community and acute trust	• Improved alignment. Reduce delays to discharge due to conflicting IPC Understanding.		
Recommendation	**Actions Required**	**Lead /Governance route**	**Desired Outcome**
Action: 12 Progression of the Intermediate Care Agenda **Delivery 3 to 6 months.**	• Development of Care Navigation Hub - SPA • Stocktake of current Intermediate Care position. • Improvement of Operational Processes for OCT. • Consideration/scoping for creation of local Directory of Services – operated via Care Navigation Hub • Ongoing review of equipment provisions facilitating discharges to ensure aligned to best practice.	Health and Care Trust COO.	• Improved levels of discharges through reduced inefficiencies. • Further reductions to timeliness of complex discharge through reduced inefficiencies. • Improved access to alternatives • Further reducing delays to discharge
Recommendation	**Actions Required**	**Lead/Governance route**	**Desired Outcome**
Action: 13 Community Hospital Flow **Delivery 3 to 6 months.**	• Implementation of MIYA bed management system. • Implementation of Urgent and Intermediate Care Dashboard • Revitalise board round governance.	Health and Care Trust COO. Health and Care Trust CNO	• **Reduction in Occupancy rate from 95% to 85%** • **Reduction in AVLOS from 25 to 19 days** • **Develop Aspirational community DTOC target**

What is the System Contribution to Improving Patient Flow?

Although the Ian Sturgess report focuses on actions for ourselves, there is widespread recognition that overcrowding in our ED, ambulance handover delays and excessive bed occupancy is a system problem and there are actions for system partners in the report. Below I have listed some that may make a significant impact.

Reducing avoidable ED attendances

- Out of hour GP model being recommissioned.
- Additional emergency clinics in primary care
- Winter plan – acute respiratory/hot kids/mental health crisis cafes
- Plans for an urgent treatment centre – still under review
- Maximising effectiveness of minor injuries units
- Development of a redirection tool
- Minimising impact of new West Mercia police policy on not attending mental health crises

Supporting streaming to an appropriate place of care

- Single point of access
- Directory of services and redirection tool

Meeting	Public Trust Bord
Date of meeting	13 July 2023
Paper number	Enc H

Innovative models

- Interface GPs
- New frailty model including virtual wards

Discharge improvements

- Reduce over-prescription of pathway discharges
- Streamlining processes for complex discharges reducing hand-offs

Conclusion

We have a strong imperative to improve patient flow within the trust to reduce ED overcrowding, improving the quality of care for our patients and those waiting for our care. This requires a shared vision of what good looks like – what care we would want for ourselves or our families and widespread engagement of clinicians and operational managers across the Trust. It is essentially a cultural change piece of work, with potentially many small individual changes contributing to the overall improvement goal, and therefore well suited to being undertaken using the 4ward improvement system.

Our experience of recent 4ward improvement system projects suggests that we can use the energy, enthusiasm and expertise of those who are doing the work to improve the work and ensure that across all of our urgent and emergency care pathways we are truly Putting Patients First.

Appendices
Final Feedback HWICB Worcestershire PLACE UEC Improvement Plan 15/06/23

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Nurse staffing report – May 2023 (April 2023 Data)

For approval:		For discussion:		For assurance:	X	To note:	X

Accountable Director	Jackie Edwards, Chief Nursing Officer.		
Presented by	Sue Smith Deputy Chief Nurse	**Author /s**	Clare Alexander Lead for N&M workforce

Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	21/06/23	Noted for assurance

Recommendations	Trust Board are asked for assurance and to note: ➢ Both Paediatrics and Neonatal Unit was deemed safely staffed to RCN / BAPM levels. ➢ Staffing on adult areas was also safe throughout May 2023. ➢ The RCN are currently balloting their members in relation to further strike with the ballot closing in June. ➢ A further Acuity and Dependency (summer) review is scheduled to commence on the 26th June. ➢ Work is going on with Divisions to ensure that current safer staffing app allows for all activity to be captured and for staffing escalations to be coded accurately. This will ensure that a robust understanding of acuity and dependency demands is collected and staffing pressures are accurately understood. ➢ Domestic recruitment is continuing successfully for both Rn's and HCAs and we remain on track with or increased trajectory for the International recruitment pipeline for 23/24. ➢ Use of surge capacity continues to be reliant on the use of temporary staffing solutions.
Executive summary	This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during May 2023 with numerical data presented for April 2023. Key headlines are: • Overall demand for both Registered nurses & Health Care Assistants (HCAs) has risen in April by 12.7% (12,967 hours) from last year, however has fallen by 14% on the previous month as we exit winter. Total filled hours have increased significantly from last year (+21K hours) predominantly through agency (+15k) with bank fill increasing 6k hours. Data is broken down as follows:

- WTE demand has increased by 80 from last year, however has fallen by 122 from last month.
- Overall lead time has increased again on prior month at 41.9 days – supporting increased fill rates.
- Overall cost has decreased by £500k in month, in line with the drop in demand.
- Average hourly agency rate has fallen again (to £37.13) due to cascade work and successful negotiations with agencies.
- Total unfilled hours are 25% lower than this time last year, supporting quality and safety om our inpatient areas.
- Programmed activity (PA) remains in place with governance process and weekly reports shared to highlight usage. With continues grip being seen.

- A strategic plan for temporary staffing would include:
  - A proposal is being drafted along with a risk assessment to present plan for turning off agency HCAs commencing with nights.
  - A review of the agency cascade to maximise the use of agencies which represent both quality care and value for money..
  - Care Support Worker Development (CSWD) program is planned for June recruitment & July / August placement to support seasonal pressures during school holidays.

➢ In May there were 25 insignificant or minor incidents reported with no moderate of significant harms reported related to nursing staffing. These were largely related to near misses due to staff absence rather than patient harm.

➢ There has been continued focus on the recruitment of HCA since November, resulting in us having approx 95.5 HCA successful applicants in the pipeline. There has been a notable increase in applications and job offers made since the beginning of Januar

➢

	Posts offered	Commenced in post
November	15.72	12.87
December	16	14.17
January	15	6.61
February	25	16
March	18	15.82
April	14	13.95
May	20.19	21.2
Totals	123.91	100.62

➢ The vacancy factor (April data): RN 214 at 10.4%, Increased from previous month (the model hospital data has reduced further to 10% as of Jan 2023). HCA 162 at 15.75% (model hospital level

of 9.7%). This is reflective of the additional head count associated with business cases for the new financial year. Priority areas for recruitment are HCA, the highest number of HCA vacancies are within Spec med at 35.1 WTE with Urgent care carrying the highest trained vacancy at 65.2 WTE

- Triangulation of data shows there some variances in the bank and agency usage. Partly accounted for as not all areas reporting vacancy / maternity / sickness would require temporary staffing solutions. Increased overall vacancy also impacted by additional business cases showing on financial systems in April.
  - RN total absence due to vacancy, sickness and maternity = 387 WTE (342 previous month) versus bank agency use of 308 WTE (360 previous month).
  - HCSW total absence due to vacancy, sickness and maternity = 305 WTE (270 previous month) versus bank / agency usage of 226 WE (242 previous month).
- There is a continued focus and commitment to supporting staff's health wellbeing with many different initiatives being highlighted by the communications team (e.g. Worcestershire weekly)
- Establishment meetings with the CNO (CFO also in attendance) have already been held with Specialist Medicine, SCSD and urgent care and remaining reviews with Surgery and Women's and Children's Divisions are planned and will be completed by mid-June.
- It has been agreed that a further acuity and dependency review will take place for inpatient areas across the trust from 26th June – 23rd July 2023. This will be preceded by further training on 'safer care' in June 2023 for all areas to improve compliance and accuracy.
- Adverts have been placed for both the Registered nurse degree apprenticeship (RNDA) at BCU and Worcester to incorporate a 2 year step on / top up option. 4 offers for the 2-year top up have been made so far with a further 6 being interviewed in June and additional interviews for the FDNA (Associates) happening in June also.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF risk 9 -If we do not have a sustainable fit for purpose and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.* *BAF risk 22 There is a risk that services will be disrupted by staff shortages due to possible industrial action by the NHS trade Unions resulting in delay to patient care and poor patient experience.*
Assurance Level (x)	0	1	2	3	4	5	x	6	7	N/A

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position and short term sickness.

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y	x	N			
Timescales to achieve next level of assurance						

Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for May 2023

This assessment is in line with Health and Social care regulations:
Regulation 12: Safe Care and treatment
Regulation 17: Good Governance
Regulation 18: Safe Staffing

Issues & options

Harms

There were 25 incidents related to staffing. All of these were rated as minor or insignificant patient harms in May over a variety of ward areas. No hot spot areas, with no patient related risks reported.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)
"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled*". National rates are aimed at 95% across day and night RN and HCA fill
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where staff were able to do so.

Current Trust Position April 23 data	What needs to happen to get us there	Current level of assurance
	This month has seen HCA fill on days improve which is consistent with overall fill rates reported by NHSP whilst nights have remained slightly over prompted by specialing and change in templates. For registered nursing both day and night fill is stable from last month. In person template reviews have been carried out as planned in May for Urgent Care and Surgery.	6

	Day % fill	Night % fill
RN	99%	99%
HCA	100%	104%

DATA for April 2023

Vacancy trust target is 7%

There is ongoing recruitment to reduce RN vacancies via the domestic and international pipelines. Rolling adverts for specialities have been ongoing. Co-ordinated adverts for speciality HCA recruitment to prevent duplication and promote efficient recruitment is in process.
Further International RN recruitment has taken place in the Philippines in 2023 with areas targeted depending on vacancy and skill set needed.

Current Trust Position WTE April data	Previous month March 2023	Model Hospital data Jan 2023 Benchmarking	Current level of Assurance
RN 214 WTE 10.4% HCA 162 WTE 15.75%	RN 164 WTE 8.19% HCA 140 WTE 14.0%	RN 10.4% HCA 9.7%	5

The increased in head count associates with the transaction of the business cases for the 23/24 financial year is reflected in the increase in the vacancy rates.

Staffing of the wards to provide safe staffing has been mitigated by the use of:

- Inpatient wards have deployed staff and employed use of bank and agency workers.
- Vacancies numbers have led to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
- Urgent Care is continuing to carry the majority of the RN vacancies. (65.2 with the highest HCA vacancy sitting within spec med at 35.1 WTE)

International nurse (IN) recruitment pipeline

For the 2023 / 2024 financial year, a further Health Education England (HEE) bid has been successful for 60 nurses, with an internal business case has being approved, supporting up to a further 150 nurses and midwives in this financial year. In April however, NHSE offered additional funding to trusts with proven track records who are looking to expand numbers and an additional bid for 30 nurses has been put in so reducing costs on internal business case. To support the offers made during the recruitment campaign to the Philippines in February the additional monthly interviews with our partner agency are in progress.

The Trust are currently in the process of sourcing additional accommodation based in Kidderminster in order that our IR recruitment can more actively support Endoscopy expansions on this site.

Domestic nursing pipeline

With the commencement of the 'grow our own' campaign through the Best People programme, we have seen further applicants from Newly registered nurses expected to come into post in Summer / Autumn 23 with 55 jobs being offered from November 2022 to May 2023 and a further 8 RNs being interviewed on June 30th 2023 via the generic advert.

There is an additional qualification cohort coming out from University of Worcester in February 24 and May saw actively engage with this group on the University campus to maximise recruitment.

In May 2023, a total of 20.19 offers were made for HCA posts at AGH and WRH and 30th June 2023 will see further sets of HCA interviews and a further preceptorship with 8 candidates. This job advert is being utilised to filter applications from current trained nurses looking to relocate / apply to WAHT from outside trusts as it allows their recruitment to be fast tracked by using an existing advert.

In order to further support the on-boarding and retention of new HCA the Professional Development Team are amending their induction plan for HCAs to offer the Care certificate directly following Trust induction. The learning and development team have developed an automated booking arrangement for new in post HCAs with the first adapted induction commencing as planned in June 2023.This is to support new HCA colleagues in their role and promote retention.

Pastoral support is in place specifically for HCA from the professional development team and given the feedback from these roles they have now been continued substantively. These staff members will also support the adapted induction and the NHA apprenticeship.

Bank and Agency Usage
April 2023 data

Current Trust Position WTE April 23	Previous Month March 23	Model Hospital data Feb 2023 Benchmarking	Current level of assurance
RN 308 WTE 14.9% HCA 226 WTE 21.9%	RN 360 WTE 18% HCA 242 WTE 24%	RN 6.4% HCA Not available	6

April has seen a decrease in the usage of Bank and agency. This is partly impacted by the reduction in the month of 1 calendar day and the commencement of the new leave year.

Sickness
April 2023 data

Absence due to S27 (Covid Symptoms) has reduced to 0.60%. Model Hospital staff group benchmarks have been refreshed to February 2023 data with Registered Nurses. Long Term Sickness has increased by 0.04% to 3.32% but Short Term has reduced by 0.07.% to 2.48%. Absence due to Stress and Anxiety has increased marginally this month and is high in all divisions except Digital.

Current Trust Position April 23	Previous Month March 23	Model Hospital data September 2022 Benchmarking	Current Level of Assurance
RN 101 WTE 4.9% HCA 105 WTE 10.2 %	RN 101 WTE 5.13% HCA 90 WTE 9.0%	RN 5.5% HCA 7.6%	5

Turnover
April 2023 data

Trust target for turnover 11%.
Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3 – level 7 are available through the apprenticeship Levy.

Current Trust Position April 23 data	Previous Month March 23	Model Hospital data January 2023 Benchmarking	Current Level of Assurance
RN Turnover 10.41 % HCA Turnover 15.4%	RN Turnover 12.08 % HCA Turnover 15.24%	RN Turnover 13.1% HCA Turnover 21%	5

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Recommendations

Trust Board are asked for assurance and to note:

- Both Paediatrics and Neonatal Unit was deemed safely staffed to RCN / BAPM levels.
- Staffing on adult areas was also safe throughout May 2023.
- The RCN are currently balloting their members in relation to further strike with the ballot closing in June.
- A further Acuity and Dependency (summer) review is scheduled to commence on the 26th June.
- Work is going on with Divisions to ensure that current safer staffing app allows for all activity to be captured and for staffing escalations to be coded accurately. This will ensure that a robust understanding of acuity and dependency demands is collected and staffing pressures are accurately understood.
- Domestic recruitment is continuing successfully for both Rn's and HCAs and we remain on track with or increased trajectory for the International recruitment pipeline for 23/24.
  - Use of surge capacity continues to be reliant on the use of temporary staffing solutions.

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Midwifery Safe Staffing Report May 2023

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Jackie Edwards, Interim Chief Nursing Officer		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Justine Jeffery, Director of Midwifery

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	16th June 2023	
Trust Management Executive	21st June 2023	Noted for assurance

Recommendations	The Board is asked to note the content of this report for information and assurance.

Executive summary

This report provides a breakdown of the monitoring of maternity staffing in May 2023. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- COVID SitRep (re - introduced during COVID 19 wave 2)
- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board

Summary of Key Performance Indicators (May 2023)

Metrics	Target	Current position (MW)	Current positon (MSWs)
Sickness rate	5.5%	5.6%	17.7%
Turnover rate (rolling)	11.5%	9.56%	15.8%
Vacancy rate (MW)	10%	10%	29%
Midwife to birth ratio	1:24	1:21	
1:1 care in labour	100%	100%	
Shift leader SN	100%	!00%	

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

	There were 376 births in May. The escalation policy was enacted to reallocate staff internally as required. The continuity teams were not required to support the inpatient team in month. Minimum safe staffing levels were maintained on all shifts in May. The supernumerary status of the shift leader and 1:1 care in labour was achieved in month. There were two staffing and four medications no harm incidents reported on Datix. The suggested level of assurance for May is 6. This level assurance is recommended because sickness absence and turnover rates have reduced/sustained reduction.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*9-If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting poor patient and staff experience and premiu staffing costs.*

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**October 2023**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored to provide assurance.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- COVID SitRep (re - introduced during COVID 19 wave 2)
- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board

In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits.

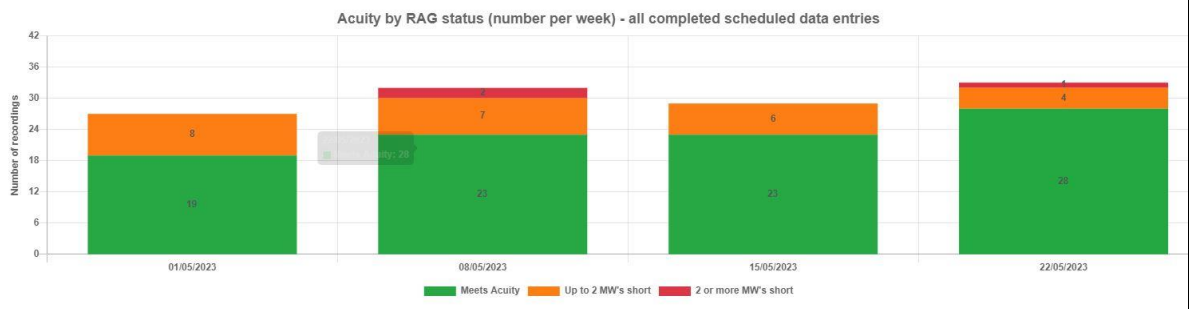
Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 72% of the expected intervals. The diagram below demonstrates when staffing was met or did not meet the acuity. From the information available the acuity was met in 77% of the time and recorded at 23% when the acuity was not met prior to any actions taken. This is an improved position in month.

This indicator is recorded prior to any actions taken. Safe staffing levels were maintained on all shifts in May.



The mitigations taken are presented in the diagram below and demonstrate the frequency (n= 14 occasions) of when staff are reallocated from other areas of the inpatient service. On one occasion a specialist midwife was deployed to work clinically to support. The community and continuity of carer teams were not escalated into the inpatient areas during May.

There were no reports of staff not being able to take breaks and no reports of staff staying beyond their shift time.

Number & % of Management Actions Taken

From 01/05/2023 to 31/05/2023

MA1	Redeploy staff internally	14	93%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	1	7%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	0	0%
MA11	Maternity Unit on Divert	0	0%

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

All of the NICE recommended red flags can be reported within the acuity app and are presented below. The labour ward coordinator reported that they were not supernumerary on one occasion however this was not to provide 1:1 care and therefore they are still considered supernumerary as outlined in the national definition. One delay in care was reported and 1:1 care was recorded at 100%.

Number & % of Red Flags Recorded

From 01/05/2023 to 31/05/2023

RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	50%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	1	50%

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

Antenatal & Postnatal Wards

The ward acuity tool remains unavailable whilst BR plus complete an upgrade of the tool.

Staffing incidents

There were two staffing incidents reported in May via Datix and no harm was recorded. The following incidents were reported:

1. PROMPT training cancelled due to sickness in one community team
2. In sufficient staff on MBC to care for 2 women in labour – escalation policy enacted

It is noted that any reduction in available staff results in increased stress and anxiety for the team. Staff drop in events have continued throughout May to offer support to staff and to update staff on current challenges in maternity services. Attendance remains low - no issues about staffing were raised at the last drop in event.

Medication Incidents

There were four no harm medication incidents in May:

- Missed administration of medicines
- Delay in administering IVAB
- Own medication administered in ward area (not prescribed or known to staff)
- Incorrect prescription
- Medication (CD) not signed for.

Monitoring the midwife to birth ratio

The ratio in May was 1:21 (in post) and 1:18 (funded) again due to a small in-month reduction in births. The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This huddle is attended by the multi professional team and includes the unit bleep holder, midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Director of Midwifery. No additional huddles were held in May.

Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

Unify Data

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service. Again the rates reported demonstrate an improvement in fill rates for

registered midwives however there is a reduction in maternity support workers fill rates due to sickness, maternity leave and vacancies. MSW & MCA recruitment was successful with 10 WTE posts filled with expected start dates in September. Focused sickness absence management is being supported by the HR team.

	Day RM %	Day MCA/MSW %	Night RM %	Night MCA/MSW %
Continuity of Carer	100%	n/a	100%	n/a
Community Midwifery	79%	n/a	n/a	n/a
Antenatal Ward/Triage	88%	63%	92%	55%
Delivery Suite	93%	56%	97%	97%
Postnatal Ward	96%	62%	91%	68%
Meadow Birth Centre	81%	60%	93%	39%

Maternity SitRep

The maternity SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and her deputies. Maternity staffing is also discussed at the Chief Operating Officers daily meeting.

The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional sitrep was launched in February 2023. A new internal sitrep will be available in May to reflect the regional tool.

COVID SitRep/Huddle (re-introduced during COVID 19 Wave 2)

The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing. The meetings are now held weekly as part of the QRSM agenda. The national COVID SitRep continues to be completed as requested.

Vacancy

There are 20 unfilled clinical midwifery posts and 6 unfilled leaderships, governance and specialist roles – vacancy rate 10%. Active recruitment continues.

The directorate remains in contact with the 21 WTE midwives recruited in March to support them through the recruitment process.

There are 17 MSW/MCA posts with 10 WTE expected over the next quarter. Further recruitment is planned for MCAs.

Further work continues with international recruitment with the aim to employ 6 WTE midwives by Dec 2023, it is noted that only 2 midwives have continued to engage with the

ongoing process which presents a risk in meeting the agreed target. No further update available in month.

Sickness

Sickness absence rates for midwives were reported at 5.6% in month. Over the last 2 months there has been a significant increase in sickness absence within the non-registered group at 17.7%.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Focus review of sickness management in areas with high levels of absence
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Regular walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.
- Health and wellbeing work stream actions

Turnover

The rolling turnover rate is at 9.56% for midwives and at 15.8% for non-registered staff. It is anticipated that the retention midwife will be in post in June to work with the team and introduced a number of initiatives to improve retention. A Practice Development midwife for MSWs will also be in post shortly and will support the development of the MSW role within the service and aid retention of our non-registered staff.

Risk Register –staffing

Risk ID	Narrative	Risk Rating
4208	If maternity safe staffing levels are not maintained this may impact on safety and outcomes for mothers and babies	5

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- Agency staff block booked to support until June 2023.
- Sitrep report completed three times per day
- Maintained focus on managing sickness absence effectively.
- Progressing IR following recruitment.
- Fortnightly ‘drop - in’ sessions led by the DoM continued in month.
- Safety Champion walkabouts

Conclusion

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc I

There was a decrease in the % of time that acuity was met on delivery suite without the need for mitigation. To maintain safety staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. The escalation policy was utilised on 14 occasions to maintain safety.

Agency midwives continue to provided additional support however safe staffing levels were maintained without deployment of non- clinical/specialist midwives. The continuity of carer midwives were not required to support the inpatient team in April.

Red flags were reported via the acuity app; the supernumerary status of the shift leader was maintained and 1:1 care in labour was also achieved. Two no harm medication incidents were reported and no delays in care in month.

Sickness absence rates reported at 5.6% (MWs) and 17.7% (MSWs & MCAs); ongoing actions are in place to support ward managers and matrons to manage sickness effectively and maintain improvements.

The rolling turnover rate is at 9.56% (MWs) and 15.8% (MSWs & MCA's). The vacancy rate remains at 10% for MWs and 29% for MSW/MCA's. There are 21WTE midwives and 10 WTE MSWs/MCAs in the recruitment pipeline.

Any reduction in available staff on duty will impact on the health and wellbeing of the team; support is available from the visible leadership team, PMAs and local line managers.

The suggested level of assurance for May is 6. This level of assurance is recommended because sickness absence, vacancy and turnover rates continue to reduce.

Recommendations

The Board is asked to note the content of this report for information and assurance.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	13 July 2023
Paper number	Enc J

Terms of Reference

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Matthew Hopkins		
Presented by	Committee Chair	**Author /s**	Rebecca O'Connor

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	X	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	21/06/23	Approved

Recommendations	Trust Board is asked approved the updated Terms of Reference of the Trust Management Executive.

Executive summary	The Trust is completing its annual review of Committee terms of reference. The following changes are proposed to the terms of reference: **Trust Management Executive:** • The TOR remain substantively the same and with minor housekeeping updates being made

Risk			
Which key red risks does this report address?	*n/a*	**What BAF risk does this report address?**	*N/A however the Committee considers all BAF risk areas*

Assurance Level (x)	0		1		2		3		4		5		6	X	7		N/A	
Financial Risk																			

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Terms of Reference

TRUST MANAGEMENT EXECUTIVE

Version: 1.4

Terms of Reference approved by: Trust Management Executive/trust board

Date approved: April 2019/March 2020/March 2021/2022/June 2023

Author: Director of Corporate Governance

Responsible directorate: CEO

Review date: March 2024

NHS
Worcestershire
Acute Hospitals
NHS Trust

TRUST MANAGEMENT EXECUTIVE

TERMS OF REFERENCE

1 Authority

The Trust Management Executive (TME) is authorised by the Trust Board.

2 Purpose

TME will be the primary executive decision making body for the Trust. It is set up to drive the strategic agenda for the Trust. TME will drive the business objectives for the Trust. It will ensure that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets. TME will ensure that its work upholds the Trust vision of *Putting Patients First*, working in partnership to provide the best healthcare for our communities, leading and supporting our teams to move 4ward.

3 Membership

Chief Executive
Chief Operating Officer
Chief Medical Director
Chief Nursing Officer
Chief Financial Officer
Director of People and Culture
Director of Communications and Engagement
Director of Strategy, Improvement and Planning
Chief Digital Information Officer
Director of Corporate Governance
Divisional Director – Surgery
Divisional Director – Women and Children
Divisional Director – Speciality Medicine
Divisional Director – Urgent Care
Divisional Director – Specialised Clinical Services
Director of Medical Education
Director of Estates and Facilities
Director of Infection Prevention and Control
Director of Continuous Improvement
Deputy Chief Operating Officer
Chief Pharmacist
Deputy CMO
AHP Lead

If Executive Directors are unable to attend, deputies can attend in their absence. If DDs are unable to attend, the Divisional Director of Nursing or the Divisional Operations Director may attend in their absence. It is the responsibility of the Director who cannot attend to fully brief the deputy.

Other staff will be invited as appropriate.

4 Arrangements for the conduct of business

4.1 Chairing the meetings

The CEO shall chair TME and the Deputy CEO will be the deputy chair.

4.2 Quorum
A quorum will be when 50% of members (10) are in attendance, including two divisional directors and two voting members of the Trust Board.

4.3 Frequency of meetings
The Group shall meet at least 12 times a year (once a month).

4.4 Attendance
Members are expected to attend all meetings, with a minimum of at least 10 meetings per year.

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

4.6 Urgent matters arising between meetings
If there is a need for an emergency meeting, the Chair will call one.

4.7 Secretariat support
Secretarial support will be through the CE secretariat.

5 Duties
In discharging the purpose above, the specific duties of TME are as follows:

- Oversee the development of the annual plan for the Trust.
- Manage the delivery of the plan.
- Manage the delivery of the medium term financial plan including the productivity and efficiency plan.
- Contribute to the development of the ICS and system working
- Identification of the risks to the delivery of the strategic objectives and ensuring mitigation of those risks.
- Oversee the divisional working and receive reports relating to the performance of the divisions as they relate to the achievement of the plan.
- Ensure that risks to patients are minimised through the application of a comprehensive risk management system.
- Ensure those areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place.
- Escalate to the Audit and Assurance Committee and/or Trust Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant risks to the operation, resources or reputation of the Trust.
- Approve service delivery change plans or make recommendation to Trust Board for approval.
- Receive and action relevant external and internal reports on Trust activity, regulatory compliance and peer reviews.
- Monitor the actions associated with internal audit reports, by exception.
- Review progress against key quality and people and culture plans.
- Oversee the corporate performance of the Trust and take appropriate action to rectify if required.

- Approve business cases up to the delegated limit and onward to Finance & Performance Committee and Trust Board as appropriate.

6. Relationships and reporting

6.1 TME is accountable to the Trust Board and will report to the Trust Board at alternate meetings.

6.2 TME will receive reports from:

- Clinical Governance Group
- Risk Management Group
- Health and Safety Committee
- Strategic Programme Board
- Strategy and Planning Group
- Performance Review Meetings
- Best People and 4ward Steering Group
- Information Governance Steering Group

TME will set up task and finish groups as appropriate.

7 Review Period

Terms of reference will be reviewed annually or earlier if necessary.