NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	22 April 2021
Paper number	Enc G1

Nursing and Midwifery staffing report – February 2021

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

Accountable Director	Paula Gardner Chief Nurse		
Presented by	Paula Gardner Chief Nurse	**Author /s**	Louise Pearson lead for N&M workforce

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	24 March 2021	Noted

Recommendations	Trust Board are asked to note the staffing papers for Nursing and Midwifery (Part A, included here for Nursing and Part B for Midwifery is provided separately. Nursing • The management of the COVID 19 pandemic third wave remains in place and the requirement for ensure the provision of the 'safest' staffing levels to meet the needs of patients on adult and children's wards, within critical care and maternity services has been a trust wide priority. Through workforce management models staffing levels have been met for February 2021. This has been supported through: • There were no patient harms in adult areas reported for February with staffing identified as a causative factor. However, there has been a decrease in incident reporting. • There has been an increase in patient harm reported with staffing for maternity and a robust action plan is in place to support the staff. • Workforce plans have been instigated and remain in place to support the return of staff from deployment to critical care as de-escalation from Covid 19 activity is experienced. • The overall level of assurance has been assessed at 5

Executive summary	This report provides an overview of the staffing safeguards for nursing and midwifery of wards and critical care units (CCU's) during February 2021. Staffing of the adult wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients being cared has been achieved. This has been through:

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- the deployment of staff,
- Introduction of 3rd year student nurses on paid deployment
- The booking of temporary workforce for short notice absences.

Throughout February the trust has maintained the Covid and Non Covid Pathways for patients requiring inpatient care. Critical care capacity has been maintained at 18 beds, requiring the ongoing need for temporary staffing in this area and substantive staff to be deployed to the area.

Sickness levels remain consistent with January data. There has been a decrease in the reason for absence being related to Covid 19 infections and an increase in stress related causes.

We have been acutely aware of the fact that staff absences and high acuity, bed occupancy has resulted in a two-fold impact:

- potential impact on quality of care. There has been no harm reported at this time to patients from staffing incidents.
- potential impact on staff morale, health and wellbeing: a number of actions taken to support health and wellbeing offers and a road map for deployment instigated.
- A level of assurance of 5 is provided as the actions and plans are in place. Consistency in delivery of actions and the need to deployment staff back to their base wards when de-escalation from surge in COVID 19 activity is to reach and return to pre covid levels of patient activity is required to reach level 6 assurance with a predicted time period over the next 4 months.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A	
Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position, increased absence levels from Covid infections and the requirement on the use of temporary staffing.																	

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						

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Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing, Midwifery and Allied Health Professional for February 2021

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

Following the third wave of Covid 19 we have seen a second surge in Covid 19 cases into the Trust from 1st January 2020. The first surge was seen in March 2020. The number one priority has been to ensure patients who require urgent and critical care have been able to get it when they need. The nursing workforce supported the Trust in achieving this by staff being deployed from their base clinical area to the identified ward/department. Deployment occurred for a number of reasons which have including:

- The increase in demand for services where seen a surge in the number of patients
- To support new services to support patient/carer experience from COVID 19.
- To support areas where staff are off sick.
- To support certain areas as elective and routine services return, and to potentially support a back log of work.

The evidence from learning after COVID 19 wave 1 was that the emotional burden for staff will manifest after the experience. The main factors found that negatively influenced an impact on their emotional wellbeing were:

a. Lack of access to effective social support (including colleagues, supervisors, family and friends)
b. Increased pressure felt as they try to recover. Such pressures include direct effects of the traumatic experience (e.g. moral injury, ill-health, bereavement) secondary stressors (e.g. financial difficulties, relationship problems, altered working conditions etc.) RCP (2020).During the 'post' COVID period staff may reflect on what has gone on and develop a narrative that makes sense to them which may in turn reduce the chance they will suffer with moral injuries which have been highlighted as a particular risk during the current crisis (Greenberg et al 2020).

Issues and options

- **The provision of safe care and treatment**

Staff support ongoing

From January 1st a step by step deployment of nursing/ allied health care/health scientist staff has taken place of:

- 1. Nurses who have previous Critical care (CC) experience from wards/departments to critical care.
- 2. Those non CC skilled staff (nurses/ childrens nurses, physios) to supported blended model* of care in CC.
- 3. Registered nurses, health care assistance, AHP/ Allied health scientists from base department wards to date.
- 4.Allied Health Professionals/ shielding staff/ health scientists to support family liaison role, PALS and quality improvement initiatives implemented to support patient and carer experiences

Divisions 'own' and maintain own staffing lists, supported with the implementation of a redeployment hub (clinical and non-clinical) providing a central list and corporate oversight for reporting and recording on a shift by shift basis. The redeployment support team update daily requests, identify suitable people for redeployment and signpost / liaise with the relevant Managers. The E-rostering team update the e-rostering system on a live basis to ensure full visibility of the roster.

The provision of staff support has continued to be been pivotal in providing the safeguard for staffing. It has been essential to continue:

- A shift by shift, 7 days a week senior nursing leadership presence on hospital sites.
- The introduction of the COVID responsive leadership team on each hospital site was reinstated on 6th January 2020.
- Health and well-being support through telephone helplines and various counselling services, particularly for teams reporting ongoing challenges as COVID 19 pandemic continues. This has been revisited as the redeployment of staff through blended models of staffing from AHP /health scientists has required significant support both in terms of training/retraining and listening forums to anxieties and fears of working in a different practice setting.
- Re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements
- Reinstated use of the dynamic trigger tool in safety huddles with weekly auditing care provision.
- Redeployment of staff, use of a blended model of staffing facilitated by buddy system and meet and greet model at start and end of shifts in CC.
- The role out of Lateral flow testing kits have been reported as beneficial for staff and the role out of the Covid 19 vaccine through January has also supported anxieties.

Harms

There were no significant harms reported for February 2021. There were 6 minor and insignificant harms reported. There has been a decrease in incident reporting over this period of time for adult areas. This has been discussed in Nursing & Midwifery Workforce Group and related reasons for staff being extremely busy explored. However, there remains

in place the Site Covid responsive leadership model with Senior Nurse daily oversight for staffing levels and escalation of patient incidents. No escalations have been reported. Where levels have dropped to that rostered redeployment and booking of temporary staffing has been put in place.

Good Governance

The senior Nursing, Midwifery and AHP team continue to meet twice weekly to review issues and take forward recommendations.

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*". The National rates is set >than 95% across day and night RN and HCA.

Current Trust Position			Current level of assurance	What needs to happen to get us to level 6
	Day % fill	Night % fill	**5**	Review establishment for planned hours for all areas and ensure staffing rota is correct. Word based establishment will be facilitated in April 2021.
RN	91%	96%		
HCA	91%	100%		

The continued challenges in maintaining consistent shift fill rates levels without the need for deployment and use of temporary staffing has reported by divisions and relates to:
1.Staff having to re-shield due to the third national lockdown and are unable to return to the clinical activity specifically within maternity services.
2. Levels of vacancies specifically Urgent care and Specialised Medicine.

The trusts Vacancy is 7%

Current Trust Position			Current level of assurance	What needs to happen to get us to level 6
Registered Midwives	4.89%	10	**5**	Increased RN Recruitment to reduce vacancies. International nurse pipeline in place with 12-15 nurses in March Targeted Domestic pipeline recruitment for: Urgent care, surgery, health care assistance in
Registered Nurses	11.09%	213		
HCA's	3.92%	35		

		place.

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

- Inpatient wards have deployed staff and employed use of bank and agency workers.

Bank and Agency Usage

The Trust target is < 7% usage.

Current Trust Position			Current level of assurance	What needs to happen to get us to level 6
Division	Bank	Agency	**5**	Increase Recruitment across all areas for RN and HCAs A review of Agency contracts in line with new HTE framework and support from NHSIE around reduction of off framework and high cost agency usage in place for April 2021.
Speciality Medicine	8.69%	6.6%		
Urgent Care	13.65%	19.52%		
Surgery	10.4%	11.76%		
SCSD	5.88%	6.21%		
Women'sand Children's	6.37%	2.17%		

Recruitment

International nurse (IN) recruitment pipeline

The first 12/100 nurses from the 20/21 business case arrived on the 15th February 2021. There are 7 nurses from the co-hort allocated to the Alexandra hospital and 5 allocated to the Royal site to support the reduction in vacancies.

Further financial support has been allocated to the trust following a successful bid submitted to HEE/NHSI. This will support a further 20 nurses over 21/22 totally 120 IN for 20/21.

Domestic nursing and midwifery pipeline

During the COVID 19 pandemic there have been two directives from Higher Education England to support staffing safeguard during emergency national measure are employed. The Trust has supported both approaches: the Bring Back Scheme and also the deployment of 48 third year students in to paid band 4 for 11 weeks.

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Sickness

The Trust Target for Sickness is <4% - February Trust 4.55%

Trust average for staff absent pre-covid with stress related illness was 23.42%

Current Trust Position			Current level of assurance	What needs to happen to get us to level 6
Division	Monthly	Stress related	**5**	Divisions to ensure Sickness reviews in place staff signposted to Health and wellbeing package of support.
Speciality Medicine	5.04%	28.82%		
Urgent Care	4.26%	15.45%		
Surgery	6.3%	22.27%		
SCSD	4.59%	30.33%		
Women'sand Children's	4.06%	27.38%		

Turnover

Trust target for turnover 11%

Current Trust Position			Current level of assurance	What needs to happen to get us to level 6
Division	RN/RM	HCA	**5**	HR to update retention policy – staff development in house for all staff groups Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff
Speciality Medicine	7.09%	13.11%		
Urgent Care	9.93%	12.83%		
Surgery	8.41%	10.7%		
SCSD	10.77%	11.61%		
Women'sand Children's	7.93	13.13%		

Recommendations

Trust Board are asked to note:

- The management of the COVID 19 pandemic third wave remains in place and the requirement for ensure the provision of the 'safest' staffing levels to meet the needs

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of patients on adult and children's wards, within critical care and maternity services has been a trust wide priority. Through workforce management models staffing levels have been met for February 2021. This has been supported through:

- There were no patient harms in adult areas reported for February with staffing identified as a causative factor. However, there has been a decrease in incident reporting.
- There has been an increase in patient harm reported with staffing for maternity and a robust action plan is in place to support the staff.
- Workforce plans have been instigated and remain in place to support the return of staff from deployment to critical care as de-escalation from Covid 19 activity is experienced.
- The overall level of assurance has been assessed at 5

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Midwifery Safe Staffing Report December 2020 – February 2021

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

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing	**Author /s**	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing

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	March 2021	
TME	24 March 2021	Noted

Recommendations	The Committee is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Executive summary	This report provides a breakdown of the last three months maternity staffing. Going forward 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 tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) Throughout this period it remained challenging to maintain safe staffing levels due to non-Covid and Covid related sickness absence, vacancies and the number of clinically vulnerable staff who are required to shield. There was an increase in incident reporting culture during this period in response to engagement with staff facilitated by the governance team and also following feedback in the CQC report. All staffing incidents were reviewed and no harm was identified. The deployment of staff and the cancelling of study leave and non- clinical working days provided additional staff to maintain safe levels and provided appropriate

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	mitigation. Despite these actions there were some delays in care for women undergoing induction of labour. During periods of escalation a decrease on the reliance on 'out of hours' support from the on call community midwifery teams was noted. The directorate has recently recruited 17 WTE midwives to cover all vacancies, additional posts released to support Covid challenges and planned maternity leave. A continuous recruitment programme remains in place for staffing in both inpatient and community recruitment. The pipeline of recruitment over the next three months will see 5.8 WTE midwives starting in March. There is an additional 6 WTE in April for the inpatient area and 6.8 WTE expected in May for the community service. The level of assurance provided for safe maternity staffing is 5.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5	x	6		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	**3 months**					

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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 tool (4 hourly)
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Daily staff safety huddle
- COVID SitRep (re -introduced during COVID 19 wave 2)

In addition to the above actions a biannual report (published in June and December) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The bi annual report is provided as an appendix. The next complete full Birthrate plus audit will take place in Spring 2021.

Issues and options

Completion of the Birthrate plus acuity tool (4 hourly)

Acuity of women is recorded in the tool every 4 hours (6 times per day) and acuity was reported to be higher than the actual staffing levels in 45% of occasions throughout this period. In 72% of cases a shortfall of 2 midwives was reported in the intrapartum area due to staff sickness and/or a midwife scrubbing in theatre. Staff were redeployed from other clinical areas to mitigate the risk.

A more sophisticated acuity tool is now available and the Division is exploring the purchase of an updated tool and an additional tool that has the ability to record ward based acuity. The new tools will be purchased in March and training will take place in April. This will assist the Trust to monitor safe staffing with a greater degree of precision across the entire inpatient area that will record the acuity in all areas and the impact on acuity when staff are deployed.

Monitoring the midwife to birth ratio

The monthly birth to midwife ratio is recorded on the maternity dashboard. The outcomes are reviewed in Maternity Governance meeting monthly. The ratio in December and January was 1:25, this fell to 1:21 in February. This is within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit (1:29). This was due to lower than expected activity.

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

The Women and Children's Divisional Governance team has worked with the directorates to raise the importance of incident reporting and staff have also received feedback following the recent CQC inspection which identified that there was a culture of low reporting. In response to this there has been n an increase in reported incidents. There were 8 staffing incidents reported in December; 11 in January and 23 in February. All of the reports record less than

expected staffing numbers in triage, the antenatal ward and delivery suite.

It is recognised that whilst staffing levels were safe and no clinical incidents occurred as a result of these incidents reduced staffing numbers has caused additional pressure for our staff and has resulted in delays in care which has reduced women's experience.

Across the three months there were 18 medication incidents. One incident was investigated as a comprehensive investigation as a concern was raised about oxygen delivery during a neonatal resuscitation. The equipment was checked and was working correctly. No harm was identified.

There were delays in the administration of antibiotics in two babies following birth and some errors in administering paracetamol over a 24 hour period to mothers. All other medication errors were 'no harm' events and no themes were identified.

The remaining clinical red flags (as listed in the NICE Safe staffing guidance) can now be reported on Safecare although this has not yet commenced as training is currently being arranged. All red flags will continue to be reported via Datix until all team members have access and are trained to use this reporting system.

Daily staff safety huddle

Daily staffing huddles have been 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 called with the senior team during this time period as the acuity across the month was generally lower than average due to lower activity.

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

The Divisional Management team continue to complete a daily COVID huddle with all directorates to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels. These meetings will continue whilst the Trust remains on *alert level 5*.

Actions taken throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations.
- The delays in Induction of Labour continued in this period but decreased in January and February: each delay was managed through continuous risk assessment with the multi-professional team.
- No adverse clinical incidents were reported which related to staffing or delays in care however it is acknowledged that some women had a poor experience and staff have been under additional pressure. Daily discussions with the Consultant / midwife in charge were undertaken.
- All non-essential training and non - clinical working days were cancelled and all of the matrons, ward managers and specialist midwives were deployed to the clinical areas to

support safer staffing levels as required throughout this period.

- Further recruitment events planned
- Working with HR to improve midwifery workforce data availability to support planning.
- Working with finance to ensure that midwifery staff in post documentation is accurate.
- The roll out of two continuity teams was delayed.
- Scoping work underway with support from HEE to develop the maternity support worker role
- Additional support to the postnatal ward was also provided by neonatal nurses, nursery nurses and nursing staff from the gynaecology service

Many of the actions outlined above have supported the provision of safe staffing levels however until the following actions are completed the Division will not be able to offer a higher level of assurance:

- 17 WTE midwives in post and having completed a period of induction
- Reduction in Covid and non Covid related absence

The above actions are expected to be completed by June 2021.

Conclusion

It remained a challenging time to maintain safe staffing levels. Actions taken did provide appropriate mitigation to maintain safety however delays in care were noted. There was an increase in reporting staffing incidents demonstrating an improved reporting culture in response to local and regulatory feedback.

We saw a decline in the utilisation of the community midwifery team to support the inpatient areas and a positive response to our ongoing recruitment with 17 WTE midwifery posts offered during recent recruitment events.

Recommendations

The Committee is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Appendices

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Safe staffing Report Midwifery July –December 2020

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

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing	**Author /s**	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing

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	19th February 2021	Approved
TME	24 March 2021	Noted

Recommendations	Trust Board is asked to note the information and actions taken within the report.

Executive summary	This report is to provide assurance of an effective system of midwifery workforce planning to meet the required safety standard 5 for the NHSLA Maternity Incentive Scheme for a six month period between July and December 2020. There are six approaches used within the Maternity Directorate to monitor safe midwifery workforce and outcomes: • Completion of the Birthrate plus table top audit (bi-annual) • Completion of the Birthrate plus acuity tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Daily staff safety huddle • Daily staffing SitRep (introduced during COVID 19 wave 1) There is a robust system of monitoring midwifery workforce and activity levels within the Maternity Directorate. In the defined 6 month period July - December 2020 the midwife to birth ratio exceeded the recommended 1:28 in October and following the completion of the Birth Rate plus table top exercise no additional midwifery posts were indicated. Timely information can be provided from the Birth Rate Plus acuity tool for delivery suite and there is a robust method now in place to report all

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	red flags. The maternity service plans to complete the 3 yearly Birthrate Plus Audit in Spring 2021. Following concerns raised by staff about safe staffing levels the Divisional management Team met with the midwifery teams, an action plan was completed and regular briefing were commenced to feedback progress against the action plan.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5	x	6		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	**3 months**					

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Introduction/Background

This paper is to provide assurance of an effective system of midwifery workforce planning to meet the required safety standard 5 for the NHSLA Maternity Incentive Scheme between July and December 2020.

The Maternity Incentive Scheme Safety Standard 5 requires that the number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months is reported to the Trust Board as part of assurance on effective midwifery workforce planning. This should include how they are collected, where/how they are reported and any actions arising.

Issues and options

There are six approaches used within the Maternity Directorate to monitor safe midwifery workforce and outcomes:

- Completion of the Birth Rate plus Table Top exercise (bi-annual)
- Completion of the Birth Rate plus acuity tool (4 hourly)
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 ‘Safe Midwifery
  Staffing for Maternity Settings’
- Daily staff safety huddle/LMNS huddle
- Daily staffing SitRep (introduced during COVID 19 Wave 1)

1. Completion of the national Birth Rate Plus Audit

The full Birth Rate Plus Audit was published in March 2018 and it is expected that this will be repeated in Spring 2021. It is recommended that a ‘table top’ exercise is completed every six months and this was completed in January 2021.

The table top exercise details the recommended clinical establishment based on agreed standards of care and case mix, reflecting the local population. The report includes the WTE required to staff the service. Birth Rate Plus recommendations support care to women and their babies 24 hours a day, 7 days a week inclusive of 22% for annual, sick & study leave allowance and 15% for travel in community.

Table 1 details the establishment recommended in the Birth Rate Plus report. There have been some changes in the required establishment due to a decrease in the number of births in 2019/20 from 5250 to 5,100 births. Given that the full Birth Rate Plus audit is due for completion in Spring 2021 it is not recommended that any further decrease in the midwifery establishment should take place prior to the findings of the audit.

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Calculations based on information collected for the period FY2018/19
Methodology Birthrate Plus (Ball & Washbrook)
Guidance RCM Staffing Standard 2009

Trust name		**Differentiated ratios**	%
		Tertiary	38 to 1
Service Type		DGH > 50% categiores IV & V	42 to 1
		DGH < 50% categiores IV & V	45 to 1
	Community excluding home and stand alone mlu births		98 to 1
	Home and stand alone mlu births		35 to 1
Leave allowance (%)			22.0%
Existing establishemt clinical midwives and clinical element managers/specialists			194.00
Exisiting establishment non clincial managers/specialist elements			18.32
Existing establishment band 3 and above *currently* included in 10% skill mix			1.60
those with appropriate qualifications, skills and competency used currentlyto replace midwifery times, includes nursery nurses, RGN's, MSW's)			

Case Mix Ratio	No. Hospital Births	Home Births & Standa Alone MLU Births	Exports (del only)	Imports (ANI/PN only)	Wbirths
42:1	5100	120	10	300	

Hospital Midwives no of hospital births / differntiated ratio (42))	A	121.43	
Community Care No of hopsital births - exports + imports /98)	B	55.00	
Home Births & Stand Alone MLU births No of births/35)	C	3.43	
Total Clinical Midwives Required A + B + C)	D	179.86	
Assessed Ratio Total births/ clinical midwives required)		29.02	
Additional % required for non clinical element managers/specialists		10%	
Additional number required for non clinical element managers/specialists		17.99	
Theatres		4.00	
Scanning		2.30	
Total Midwives required		204.14	

Table 1 BR+ recommended establishment

2. Completion of the Birth Rate Plus Acuity Tool

The Birth Rate Plus Acuity tool is completed every four hours by the shift co-ordinator on Delivery Suite. For the purpose of this report Tables 2- 4 present six months data to demonstrate how often acuity is higher than the 'actual' not 'planned' staffing and the reasons and actions taken for any shortfalls.

In July - September 2020 it was noted that in 45% of recorded episodes staffing did not meet the required acuity. This was noted to be 49% of recordings in October – December. The reason for this shortfall was due to midwives 'scrubbing' in theatre, unplanned sickness (Covid and non - Covid related) and some vacancies. The directorate continue to work with SCSD to review the current theatre provision however this work has paused due to the 2nd wave of the pandemic.

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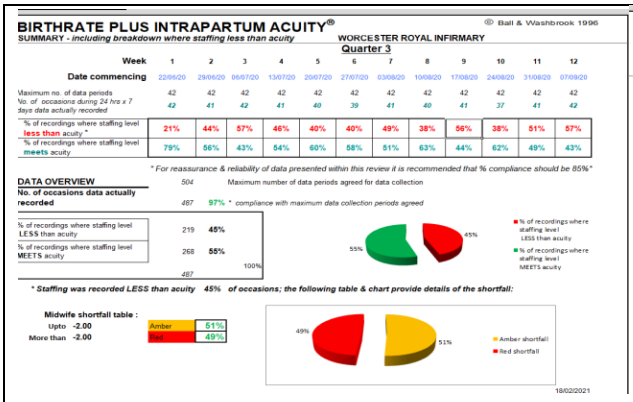

Table 2-Birthrate Plus Intrapartum Acuity

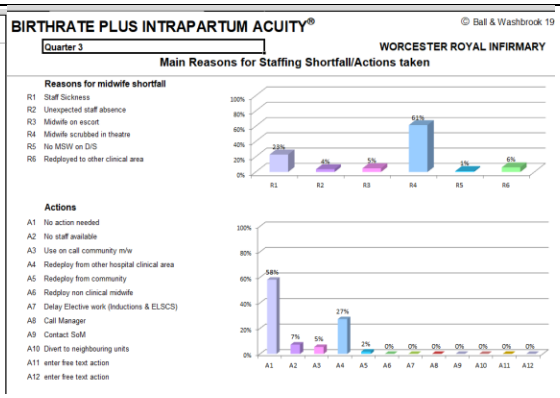

Table 3 Reason for shortfall/action taken

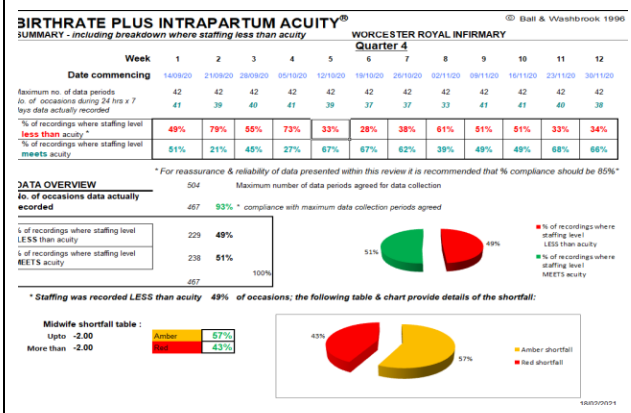

Table 4 –Birth Rate Plus Intrapartum Acuity

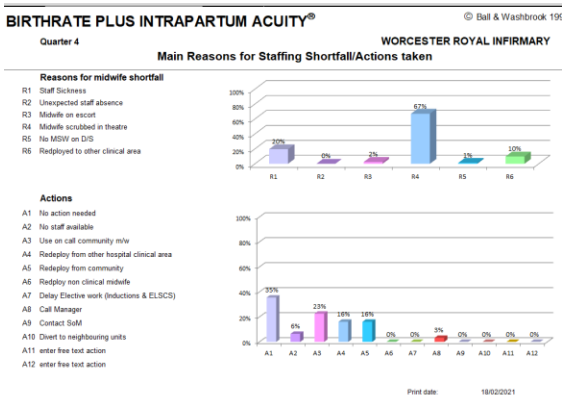

Table 5 - Reason for shortfall/action taken

The actions taken during times of higher acuity are recorded within the diary section of the tool ; staff are redeployed to delivery suite to support the provision of 1:1 care in labour, the supernumerary status of the shift coordinator and ultimately achieve safe staffing levels in this high risk area whilst ensuring levels of staffing in ward areas remain at or above minimal agreed levels.

3. Monitoring the midwife to birth ratio

The Birth Rate Plus recommended midwife to birth ratio is 1:28; any increase in this ratio is considered to be a safety 'red flag'. This information is recorded on the maternity dashboard and monitored at maternity governance meetings. The ratio between July - December 2020 ranged between 1:24 -28. In October the ratio was noted to be 1:29 as the birth rate was high (this is an expected seasonal variation).

4. Daily Safety Huddle/LMNS huddle

The Safety Huddle is a multidisciplinary meeting held once a day, one at 08:30. Members of the Maternity Safety Huddle include:

- Duty Consultant Obstetrician
- Duty Anaesthetist
- Clinical Matrons for each area (or deputy)
- Duty Consultant Anaesthetist
- 223 Maternity Bleep Holder
- Delivery Suite Coordinator
- Midwives from all ward areas
- Neonatal Nurse

5. Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015).

The agreed staffing red flags were approved and ratified in 2016:

- Delay of 30 minutes or more between presentation and triage
- Delay in category 1 caesarean section
- Delay of 2 hours or more between admission for induction and beginning of process Maternity Only)
- Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.
- Delay in suturing of more than 60 minutes due to the lack of a midwife
- Delay in giving IV drugs due to the lack of a midwife

Any issues that would require reporting under the 'staffing red flag' criteria are monitored over a 24 hour period. This is monitored by the unit bleep holder and out of hours by the Delivery Suite Band 7 Coordinator. If any concerns are identified subsequent actions to mitigate highlighted safety issues are recorded on the Birth Rate Acuity Tool and via Datix.

Conclusion

The 2nd wave of the COVID pandemic has created additional challenges to maintain safe staffing. Staff have been regularly redeployed to other areas of the service to maintain safety.

In October staff raised their concerns regarding the levels of staff on each shift.

The Divisional Management Team met with staff to discuss their concerns and to provide assurance as outlined below:

- It was established that whilst acknowledging expected levels of staffing had not been met on certain occasions, minimum safe staffing levels were achieved and patient safety maintained.
- The increased episodes of escalation and the reliance on support from the on-call community midwife were also acknowledged and staff assured that this was a result of COVID related absence. Daily safe staffing huddles continued to monitor and plan mitigations.

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- The delays in Induction of Labour continued in October: each delay was managed through continuous risk assessment with the multi-professional team and some women were transferred within the LMNS supported by Wye Valley Trust.
- No adverse clinical incidents were reported which related to staffing or delays in care however it is acknowledged that some women had a poor experience. Daily discussions with the Consultant / midwife in charge were undertaken and further support offered by the named lead midwife following discharge.
- All non-essential training and non - clinical working days were cancelled and all of the matrons ward managers and specialist midwives were deployed to the clinical areas to support safer staffing levels as required throughout this period.
- To support the directorate to manage the additional COVID challenges, funding for an additional 10wte posts was agreed and recruitment is now underway.
- The roll out of two continuity teams was delayed.
- Additional support to the postnatal ward was also provided by neonatal nurses, nursery nurses and nursing staff from the gynaecology service

The facility to record Red flags on 'Allocate' is now available however training of staff is still to be undertaken. .

The maternity service continues to recruit to all vacancies and regular staff briefings have commenced to provide staff with regular updates about recruitment and the agreed action plan.

Recommendations

Trust Board is asked to note the information and actions taken within the report.

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Freedom to Speak Up

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

Accountable Director	Tina Ricketts Director of People and Culture		
Presented by	Melanie Hurdman FTSU Guardian	**Author /s**	Melanie Hurdman FTSU Guardian

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

Report previously reviewed by		
Committee/Group	Date	Outcome
People & Culture Committee	30th March 2021	Noted

Recommendations	The Board is asked to: • Support the on-going communication of Freedom To Speak Up (FTSU) and the importance of creating a culture that support the safety of our patients and welfare of colleagues • Discuss any improvements that could be made to the FTSU programme • Support the plan to develop an effective learning process from concerns raised

Executive summary	The role of the Freedom to Speak up (FTSU) Guardian is mandatory within all NHS Trusts following the Francis report. It is incumbent that each Trust gives adequate support in order to enable the FTSU Guardian to do their job effectively. Within the Trust this has been embraced and embedded with dedicated hours, administrative support and the resources to establish an online FTSU portal. Cases are logged on a confidential database with themes captured; this data is also reported to the national guardian's office on a quarterly basis. Any highlighted areas of concern are escalated to the appropriate director/ manager and an action plan is formulated and agreed.

Risk									
Key Risks	BAF 10: If we do not deliver a cultural change programme, then we may fail to attract and retain staff with the values and behaviours required for putting patients first, resulting in lower quality care								
Assurance									
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**		
Financial Risk	*None identified*								

Introduction/Background

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Worcestershire Acute Hospitals NHS Trust

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Role of the Guardian
Every Trust has a nominated FTSU Guardian, the current Guardian works 3 days a week in the role. The role of the guardian is to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. This is done by ensuring that workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement.

Role of the Champions
We currently have 45 appointed FTSU champions spread across all three sites and departments who can be the first point of contact for staff who wish to raise or discuss a potential concern. A virtual training programme has been developed which all champions will attend. The role of the champion is to support any member of staff who wishes to raise a concern, take their full details and forward to the Guardian for action. We have champions meetings and these are held on a monthly basis to review progress and propose improvements. The Guardian is in the process of developing a champion criteria/strategy for recruitment and development of FTSU champions in the future.

Issues and options

Policy and Process
The Freedom to Speak up Policy has been reviewed in line with the National Guardian Office's framework and this is currently awaiting approval at the Policy Working Group, this sees the addition of an appendix on detriment, this was scheduled for February meeting but was delayed due to the Trust status with Covid. It is on the agenda for the policy working group on April 6th and then for JNCC approval at the end of April.

Vision and Action plan
The Guardian is currently in the process of developing a vision for speaking up within the Trust and formulation a new action plan in line with the Vision which will be underpinned by the National Guardians five year strategy that is due for publication in June.

Good news
October saw the launch of the FTSU portal on the intranet. This can be accessed via the front page, favourites link and will soon be accessible externally to staff. Since the introduction of the portal the number of concerns raised has increased. We have welcomed Anita Day as the Non Executive Director for FTSU and Anita has joined the Champions in the meetings with an active voice providing them with support and assurance at board level.
The Guardian has also taken on the role of Lead Mentor in the Trust Reciprocal Mentoring programme to allow mentors/mentees a safe person should the need be required.
We have actively recruited more champions and they are very motivated to support staff.

Cases

Data on FTSU Concerns to date on 31st March 2021

Month	Cases raised	Open	Closed	Anonymous
April 2020	0	0	0	0
May 2020	2	0	2	0
June 2020	8	3	5	0
July 2020	8	4	4	1
August 2020	5	3	2	0
September 2020	4	4	0	0
October 2020	1	1	0	0
November 2020	6	3	3	1
December 2020	5	4	1	0
January 2021	7	4	3	3
February 2021	8	8	0	4
March 2021	9	9	0	4
Total	63	43	20	13

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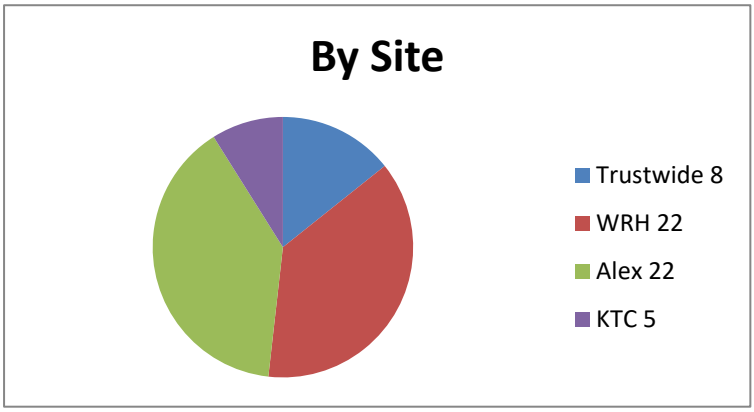

Theme	Number
Bullying and harassment	**21**
Staff Levels	**3**
Attitudes and behaviours	**24**
Policy and Procedures	**13**
Quality and Safety	**11**
Other	**5**

The data highlights that the site spread is even between the Alexandra Hospital and Worcester Royal sites, however since the advent of the portal more concerns have been raised at the Alexandra. The majority of these cases are infection control in relation to personal protective equipment adherence and anxieties around Covid 19 admissions in inappropriate areas, this has already been escalated and dealt with. From April 1st a new category of reporting is being introduced by the National Guardians Office for 'worker safety and well-being' it is hoped that this will capture the concerns around PPE.
The majority of the cases raised cover the themes of inappropriate behaviour and attitudes including bullying and harassment. The advent of the portal has also seen an increase in anonymous concerns, the majority again being around Covid 19 and infection control. It was identified that there was an issue of bullying on one ward at the Alexandra and the Guardian is working with the Matron and the Ward Sister to encourage staff to speak up. A live listening event was arranged and the Guardian is attending the next ward meeting, a walkabout has also been undertaken by the Guardian to increase visibility and provide staff assurance. The concern has also been escalated to the new CNO so as to raise awareness of the need for visibility in that area. In future reports the Guardian will be able to dive deeper into staff groups, divisions and equality data.

Marketing
Marketing continues with the following:

- A slot on the Worcestershire Weekly every Tuesday incorporating the showcasing of a champion
- National training for new champions,
- Working more closely with the forward advocates and quality improvement (Pathway to Platinum), monthly meetings with the forward advocate lead
- The recruitment of a BAME FTSU champion

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- Champions posters developed and printed and distribution across the three sites
- Attendance at divisional/directorate meetings
- Representation at the BAME, LGBT+ and disability network and the education/training work stream within the BAME network ,
- Mandating of the FTSU training on the e-learning platform
- Feedback questionnaires to be generated from portal to gather feedback on the process
- Ordering and distribution of new FTSU champion badges to increase visibility

Governance

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

- The FTSU working Group (Chaired by Director of People & Culture) bi-monthly
- The People and Culture Committee twice yearly
- The Board twice yearly
- The Audit and Assurance committee annually
- The Chief Executive on a quarterly basis

A quarterly report is also submitted to the National Guardians Office.

Conclusion

The portal launch has seen an increase of the cases being raised; further development of the data will provide greater assurance in future.
The champion strategy and further marketing of champions will give staff additional points of contact for support and guidance should they wish to raise a concern. Representation at the staff networks is helping to raise the profile of speaking up and look at the barriers and how we can overcome them.

Recommendations

The Board is asked to:

- Support the on-going communication of Freedom To Speak Up (FTSU) and the importance of creating a culture that support the safety of our patients and welfare of colleagues
- Discuss any improvements that could be made to the FTSU programme
- Support the plan to develop an effective learning process from concerns raised

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Personal Safety

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

Accountable Director	Paul Brennan, Chief Operating Officer for Health & Safety Paula Gardner, Chief Nursing Officer for Safeguarding Tina Ricketts, Director of People & Culture for HR Policies		
Presented by	Tina Ricketts	**Author /s**	Tina Ricketts

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		Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is asked to receive the report for information and assurance.

Executive summary	Between the period 1st April 2020 to 31st March 2021 staff reported 237 incidents of physical assault or verbal abuse in the workplace. During the same period we referred 508 suspected cases of domestic abuse (for both patients and staff) for multi-agency risk assessment. Surprisingly, despite regular awareness raising the number of referrals for suspected domestic abuse did not increase during the Covid-19 pandemic. The 2020 NHS staff survey results show that we score better than acute trust average for the level of physical violence experienced by staff. Additional resource has been put in place to support staff and this includes the external review of each physical assault case and a comprehensive staff health and wellbeing package.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	Not applicable																	

Action						
Is there an action plan in place to deliver the desired	Y	x	N		N/A	

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improvement outcomes?						
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 2021**					

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Date of meeting	22nd April 2021
Paper number	Enc G3

1.0 Introduction/Background

The murder of Sarah Everard in March 2021 has highlighted the importance of personal safety. This report provides and overview of the physical assault and verbal abuse experienced by staff during the last year, the number of domestic abuse/ violence referrals made by the Trust in the same period and the support we have in place to keep people safe.

1.1 Staff Safety Data

From 1st April 2020 to 31st March 2021 there were 237 incidents of physical assault and verbal abuse reported by staff :

Physical assault (intended harm)	63
Physical assault (unintentional)	55
Safeguarding	11
Verbal Assault	97
Inappropriate conduct	11
Total	**237**

Of the reported incidents:

- 152 occurred at the Worcester Royal site
- 76 occurred at Alexandra Hospital site
- 6 occurred at Kidderminster Treatment Centre
- 1 occurred off-site
- 1 occurred at Evesham Community Hospital
- 1 occurred Prince of Wales Community Hospital

Of the 63 physical assaults (intended):

- 4 were by members of the public on members of staff
- 1 was by a member of the public on a patient
- 4 were by patients on a patient
- 54 were by patients on members of staff.

This is a slight reduction on the number of assaults in 2019/20 which totalled 249 (72 intended harm, 94 unintentional and 83 verbal).

Unintentional assaults are recorded as such due to the assailant not being fully aware of their actions due to medication, or not being in a fit state of mind.

In the 2020 NHS staff survey we score better than the acute trust average for staff experiencing physical violence as summarised in the graphs below:

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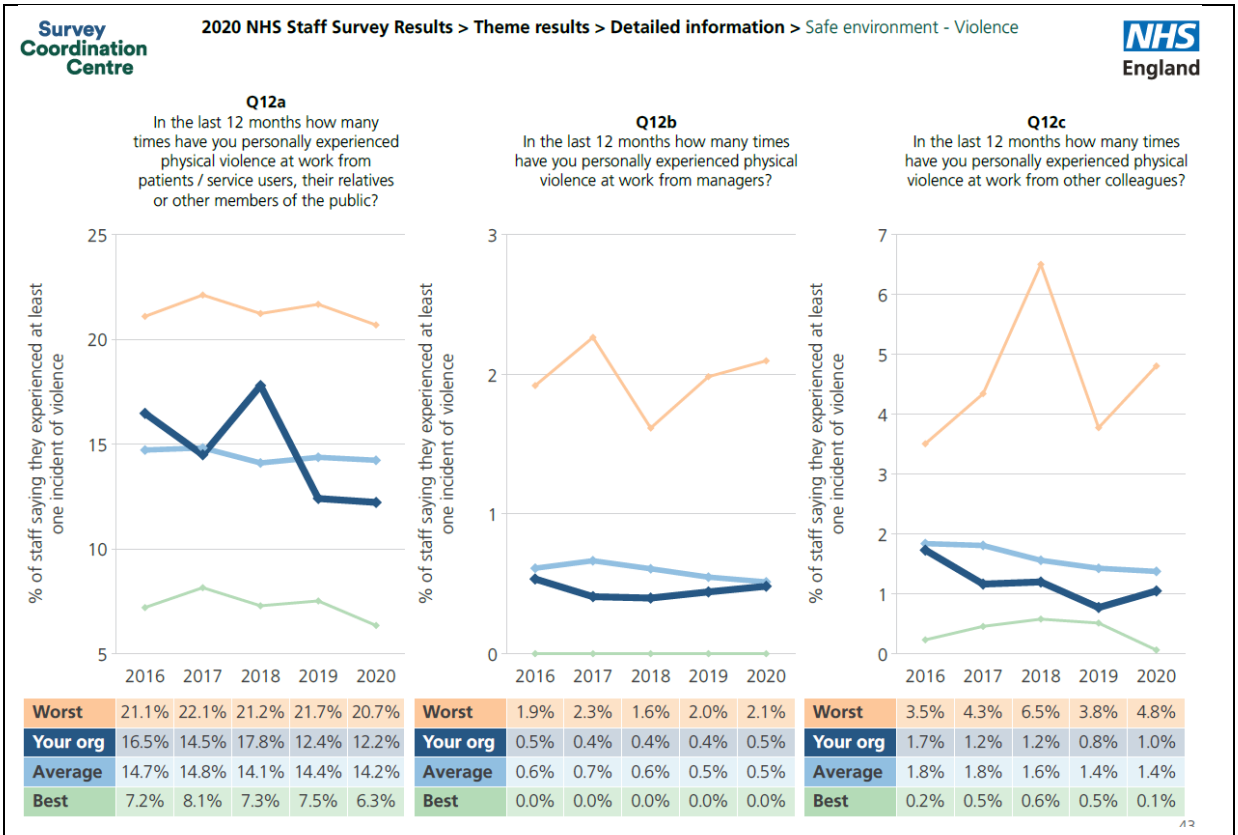

	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your org	16.5%	14.5%	17.8%	12.4%	12.2%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

	2016	2017	2018	2019	2020
Worst	1.9%	2.3%	1.6%	2.0%	2.1%
Your org	0.5%	0.4%	0.4%	0.4%	0.5%
Average	0.6%	0.7%	0.6%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

	2016	2017	2018	2019	2020
Worst	3.5%	4.3%	6.5%	3.8%	4.8%
Your org	1.7%	1.2%	1.2%	0.8%	1.0%
Average	1.8%	1.8%	1.6%	1.4%	1.4%
Best	0.2%	0.5%	0.6%	0.5%	0.1%

1.2 Domestic Violence/ Abuse Data

The number of suspected domestic violence/ abuse referrals made for a multi-agency risk assessment conference (MARAC) from 1st April 2020 to 31st March 2021 was 498 with 290 police logs. This compares to 509 referrals and 276 police logs for the same period in 2019/20.

2.0 Issues and options

2.1 Support for Staff Safety

In November 2020 we engaged with CW Audit to assist and provide additional local security management support and work in conjunction with the Health & Safety Team to monitor all physical assault incidents. The support includes:

- A review of the effectiveness of current health and safety policies
- Independent review of all security/violence related incidents and support to the person(s) affected if required
- Meetings between ISS (a contractor providing support staff to the Worcester Royal site), Health & Safety Manager and appointed person to discuss security/violence incidents reported by ISS with weekly reporting and monthly reviews being put in place

In addition, the themes and trends of these incidents are regularly monitored and reviewed by the Trust's Health & Safety Committee.

We have improved the robustness of our alert system in regards to patients managed by the special allocation scheme (SAS). These patients are registered with a specific GP practice

because of known violence or aggression and have been removed from mainstream GP practice lists. We have an alert which provides staff with key information in the event the individual attends our Trust. We start and cease these alerts based upon a list provided by the Clinical Commissioning Group every 6 months.

We work with the MOSVO (Managing sexual offenders and violent offenders) assigned to offenders and again these are flagged on our alert system in order to keep our staff and patients safe.

We support colleagues who have experienced violence or abuse through our wellbeing hub of resources on the staff intranet and via our refreshed health & wellbeing hub which is accessible here:

http://nww.worcsacute.nhs.uk/departments-a-to-z/human-resources/health-and-wellbeing/

2.2 Support for Domestic Violence/ Abuse

We have a Hospital Independent Domestic Violence Advisor (HIDVA) service which provides advice, support and signposting service to patients and staff that may be at risk of, or experiencing domestic abuse /violence.

For staff this service provides information and advice about domestic abuse including awareness raising and training so that colleagues feel confident to ask about domestic abuse. The service also provides a point of contact to discuss any concerns or issues that colleagues may have. A bespoke package of support is offered to staff suffering from domestic abuse.

In addition to the above all of our safeguarding adult and children mandatory training packages cover domestic violence/ abuse. During the Covid-19 pandemic, awareness raising days have been held within the Trust which has included reference to staff support, examples of how this may present in the workplace and staff are encouraged to 'ask the question' where there are suspicions of domestic abuse/violence or a person is known to be experiencing this. Surprisingly we have not seen a big increase in domestic abuse/ violence referrals during the pandemic despite this awareness raising. However, we would not necessarily know if people have assessed any of the services following our awareness initiatives as this information is confidential.

A professionals pack is available on the safeguarding training pages of the Trust intranet containing a wealth of information.

Covert items have been purchased (supported by charitable funds) for key areas within the Trust such as tampon vouchers, lip balms, tissues which contain the contact details of West Mercia Women's Aid – a service that is available to both males and females.

Staff who come to the attention of the safeguarding team either via the multi-agency risk assessment conference process (MARAC) for high risk domestic abuse, or via Police logs (medium risk domestic abuse) are contacted where required and the HIDVA service offered.

Supervision and support for staff experiencing domestic violence/abuse has also been provided by the Named Professionals within the Integrated Safeguarding team providing a

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safe space for them to disclose/ be supported.

Although previously available, support around domestic violence was re-launched by the Health & Wellbeing group on 3rd March 2021 as part of our “Wellbeing Wednesday” and in partnership with the 4Ward Advocates and Staff Side.

Support and resources from our wellbeing hub includes:

- Via Occupational Health, staff have 24/7 access to counselling and where appropriate, are signposted to the Police and men and women’s refuges

- An infographic signposts staff "In a crisis" to the Samaritans Domestic Violence Hotline 0808 2000 247

3.0 Conclusion

Personal safety is a priority for the Trust and is regularly monitored through the Health and Safety Committee and by the Hospital Independent Domestic Violence Advisor (HIDVA) service.

4.0 Recommendation

The Board is asked to receive the report for information and assurance.

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Paper number	Enc G4

Audit and Assurance Committee Report

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

Accountable Director	Anita Day, Audit and Assurance Committee Chair		
Presented by	Anita Day, Committee Chair	**Author /s**	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is requested to: 1. Note the report for assurance

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 9 March 2021 The following key points are escalated to the Board's attention: **1. Value for Money** There is a technical issue regarding potential qualification of accounts, as a result of stocktake issues last year impacting on opening balances. As a principle, Committee felt given a proper stocktake showing a true and fair value in the accounts, the accounts should not be qualified this year, regarding an issue which occurred last year. The technical issues around opening balances may be unavoidable, however the wording will be key and draft wording will be shared with Committee. **2. Away Day** Committee held a successful Away Day to develop the internal audit plan for 2021/22. The draft plan will be received by Committee in May. **3. Fraud Standard Operating Protocol** Committee agreed the development of a Standard Operating Protocol, liaising with both finance and HR teams, as part of a broader piece of work regarding the expectations of the Trust in managing fraud cases. This alongside changes to the standard reporting template, would enable Committee to understand the strategy used by the Trust to prioritise those frauds requiring greatest scrutiny

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4. Alignment of pharmacy update and losses
The work plan will be adjusted to enable consideration of these interlinked items together to enable a strategic and holistic debate by Committee of the relevant risks, issues and assurances.

5. Extraordinary meeting
To facilitate the business required for the year end period an additional Committee meeting will be held on 20 April

Risk													
Which key red risks does this report address?		**What BAF risk does this report address?**	*N/A – the Committee reviews all strategic risks*										
Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this report*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
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						

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Meeting	Trust Board
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Paper number	Enc G5

Annual Review of Terms of Reference

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

Accountable Director	Rebecca O'Connor, Company Secretary		
Presented by	Rebecca O'Connor, Company Secretary	**Author /s**	Martin Wood, Deputy Company Secretary

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
All Committees	January/February/March 2021	Approved

Recommendations	The Trust Board is requested to approve the updated attached Terms of Reference for the Board Committees.

Executive summary	This is the annual review of the Terms of Reference of Board Committees, each Committee having approved their revised Terms of Reference: 1. Finance and Performance 2. Quality Governance Committee 3. Audit and Assurance 4. People and Culture 5. Charitable Funds 6. Remuneration 7. Trust Management Executive

Risk			
Which key red risks does this report address?	*N/A*	**What BAF risk does this report address?**	*N/A*

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
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

FINANCE AND PERFORMANCE COMMITTEE

Version: **3.2**

Terms of Reference approved by: **Trust Board**

Date approved: March 2019/March 2020/March 2021

Author: **Company Secretary**

Responsible directorate: **Finance**

Review date: March 2022

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Introduction

The purpose of the Finance and Performance Committee (F&P) is to act as a sub-committee of the Trust Board to give the Board assurance on the management of the financial and operational performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee will review business cases with a significant financial impact and oversee developments in financial systems and reporting, e.g. SLR/PLICS. The Committee will provide oversight of the IT/Digital agenda.

The Committee will also review the performance strategy of the Trust and hold the Trust to account on national and local targets.

2. Membership

- Three non-executive directors
- Chief Executive
- Chief Operating Officer
- Chief Finance Officer
- Chief Nursing Officer and/or Chief Medical Officer (or their nominated Deputy)
- Director of Strategy and Planning
- Director of People & Culture
- Chief Digital Officer

In attendance:

- Deputy/Assistant Directors of Finance/Performance/Procurement (as necessary)
- Company Secretary or Deputy Company Secretary
- Divisional Management Teams will attend on a rotational basis
- Other staff as appropriate

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

3 Arrangements for the conduct of business

3.1 Chairing the meetings

A non-executive director will chair the meetings. In the absence of the Chair, another non-executive director will chair the meeting.

3.2 Quorum

The Committee will be quorate when two non-executive directors and two executive directors (or nominated deputies) are present.

3.3 Frequency of meetings
The Committee will meet monthly.

3.4 Frequency of attendance by members
Members are expected to attend each meeting, unless there are exceptional circumstances.

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

3.6 Urgent matters arising between meetings
If there is a need for an emergency meeting, the Chair will call one in liaison with the Chief Finance Officer and Chief Operating Officer.

3.7 Secretariat support
Secretarial support will be through the Company Secretary.

4 Authority
The Committee is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose
To act as a sub-committee of the Trust Board to:

- Give the Board assurance on the management of the financial and operational performance of the Trust
- To review and monitor those strategic risks in the BAF (finance and operational risks) allocated to the Committee and Finance Risk Register
- To develop the Trust's financial strategy for approval by the Trust Board
- To oversee business planning for the Trust
- Monitor and support the financial planning and budget setting process
- Review business cases with a significant financial impact.
- Oversee developments in financial systems and reporting, e.g. SLR/PLICS
- To conduct post implementation reviews of all major business cases approved by the Committee
- To review Procurement Strategy Development
- Monitor the working capital position of the Trust including availability and management of, the capital investment programme and cash flow.
- To oversee the implementation of major digital and IT systems
- Oversight of cyber security and IT
- The following sub-groups will report to the Finance & Performance Committee on a frequency determined by their business cycle:

- Capital Prioritisation Group
- Strategy and Planning Group

5.2 Duties

In discharging the purpose above, the specific duties of the F&P Committee are as follows:

5.2.1 Financial Management

To provide key assurances on the financial governance of the Trust through a programme of review work incorporating the following:

- To oversee and evaluate the development of the Trust's medium term financial plan to deliver its integrated business plan.
- To regularly review the financial standing of the Trust
- Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval.
- Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur.
- Review expenditure against the agreed capital plan.
- To be responsible for overseeing identification, evaluation, response to and monitoring of financial risk
- To review financial aspects of key policy areas
- To review and monitor the continued development and implementation of the Trust's Productivity and Efficiency Programme. To review the financial impact on quality of the medium term financial plan
- To receive reports relating to any financial recovery plan
- To commission work as needed to enhance the work of the Committee

5.2.2 Performance Management

To provide key assurances on the Trust's performance management framework through a programme of review work incorporating the following:

- To oversee and evaluate the development of the Trust's performance strategy to performance manage against strategy and against plan.
- Review the performance report and dashboards against local/national targets
- Review performance against the CQUIN targets
- Review areas of underperformance and agree corrective actions
- Horizon scan regarding new targets
- Develop performance dashboards for reporting to the Board

5.2.3 Digital

- To approve the business cases required for the implementation of the Digital Strategy
- To oversee the implementation of the Digital Strategy

5.2.4 Other Duties

- To scrutinise the financial aspects of business cases/investment proposals as necessary.
- Receive updates on the contract management and negotiations giving direction as necessary.

- Periodically review financial policies and procedures including the SFIs, scheme of delegation, etc. to ensure that they are still relevant and appropriate.
- Review the outputs of benchmarking exercises and consider appropriate actions.
- To identify any training needs for Committee members and to ensure that all members are competent in ensuring they can undertake their duties as members of the Committee.

6. Relationships and reporting

6.1 The F&P Committee is accountable to the Trust Board and will report monthly to the Board.

6.2 Through the linkage of common NED membership, the F&P Committee will retain a close relationship with the Quality Governance Committee, People & Culture Committee and the Audit and Assurance Committee. This will include referring matters to those committees and receiving referrals from those committees.

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2022 or earlier if deemed appropriate by the Chair particularly in the light of changes in the system working arrangements.

Martin Wood
Deputy Company Secretary
March 2021

Worcestershire Acute Hospitals NHS Trust

Terms of Reference

Quality Governance Committee (QGC)

Version: 4.2

Terms of Reference approved by: QGC/Trust Board

Date approved: September 2017/October 2018/November 2018/March 2020/March 2021

Author: **Company Secretary**

Responsible directorate: CNO/CMO

Review date: March 2022

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Quality Governance Committee

Terms of Reference

1. Introduction/Authority

The Quality Governance Committee (QGC) is constituted as a standing committee of the Trust board. Its constitution and terms of reference are set out below, subject to amendment at future Trust board meetings.

The QGC is authorised by the Board to act within its terms of reference. All members of Trust staff are directed to co-operate with any request made by the QGC.

The QGC is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

The QGC is authorised to obtain such internal information as is necessary and expedient to fulfil its functions.

2. Membership

Non-Executive Director (Chair)
Two Non-Executive Directors
Chief Executive
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer
Patient Forum Representative
Chief Digital Officer

In attendance:
Company Secretary
Deputy CNO (quality)
CCG representative
Assistant Director – Information and Performance
Trainee representative
HealthWatch
Divisional governance leads

As required:
Other personnel as invited by the Chair

2.1 The Chair of the Committee is appointed by the Trust Board and shall be a Non Executive Director.

2.2 Trust employees who serve as members of the QGC do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

3 Arrangements for the conduct of business

3.1 Chairing the meetings

The Non-Executive Director will chair the meetings. In the absence of the Non-Executive Director, the Chair will be another Non-Executive Director.

3.2 Quorum

The QGC will be quorate when one third of the members are present including at least two non-executive directors and one clinician, including the Chief Nurse or the Chief Medical Officer or their deputies.

3.3 Frequency of meetings

The QGC will meet monthly.

3.4 Frequency of attendance by members

Members are expected to attend all meetings each year, unless there are exceptional circumstances. The Chair must be informed of expected absences; members should arrange for an appropriate officer with full delegated authority to deputise for them on such occasions.

3.5 Declaration of interests

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

3.6 Urgent matters arising between meetings

If there is a need for an emergency meeting, the Chair will call one in liaison with the CNO/CMO.

3.7 Secretariat support

Secretarial support will be provided by the Company Secretary and a report will be presented to the Trust board.

4 Authority

The QGC is authorised by the Trust Board.

5 Aims and Objectives

5.1 Aims

- The Quality Governance Committee provides the Trust Board with assurance that:-
  - Care to patients is being delivered to the highest possible standards and that there are appropriate policies, processes and governance in place to continuously improve the quality and safety of care, and to identify gaps and manage them accordingly.
  - the care quality and patient safety risks on the corporate risk register associated with the Trust's provision of safe, effective, evidence based, compassionate care are identified managed and mitigated appropriately. In doing so, the Quality Governance Committee may consider any quality and or safety issue it deems appropriate to ensure that this can be achieved.
  - the strategic priorities for quality and safety assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes for patients and service users;
  - the independent annual Clinical Audit Programme provides a suitable level of coverage for assurance purposes, and receiving reports as appropriate;

- the organisation is compliant with regulatory standards and statutory requirements, for example those of the NHS Constitution, Duty of Candour, the CQC, NHSR and the NHS Performance Framework are reviewed.
- the quality risks on the Board Assurance Framework together with any other risks allocated to the Committee on the Board Assurance Framework are reviewed and the Committee is satisfied as to the adequacy of assurances on the operation of the key controls and the adequacy of mitigations and action plans to address weaknesses in controls and assurances;
- the Annual Quality Report is reviewed ahead of its submission to the Board for approval.

- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee and how well any recommended actions have been implemented.
- The Committee may also initiate such reviews based on its own tracking and analysis of quality and safety trends flagged up through the regular performance reporting to the Board.

5.2 Objectives

5.2.1 The Committee provides oversight of the Quality Improvement Strategy and the workstreams that support implementation of the strategy which at the time of writing are:

- **The SAFETY of treatment and care provided to patients** – safety is of paramount importance to patients and is the bottom line when it comes to what services must be delivering
- **EFFECTIVENESS of the treatment and care provided to patients** – measured by both clinical outcomes and patient-related outcomes
- **The EXPERIENCE patients have of the treatment and care they receive** – how positive an experience people have on their journey through the organisation can be even more important to the individual than how clinically effective care has been.

5.2.2 The Committee's objectives are:

- To approve and oversee the implementation of the Quality Improvement Strategy (QIS) and receive monthly updates through the report from the Clinical Governance Group.
- To approve the three Plans supporting the QIS
- To oversee the implementation of any CQC 'must' and 'should' do's identified at inspection
- To approve the Trust's annual quality account before submission to the Board;
- To monitor and review the Trust Quality and Safety Performance Dashboard
- To review the Trust's performance against the annual CQUINs
- To consider matters referred to the Committee by the Trust Board, other Committees or other sources;
- To have oversight of the Infection Prevention and Control Plan and receive regular updates on the action plan
- To receive the Annual Report for Infection Control prior to it being presented to the Trust Board
- To monitor the Trust's compliance with the national standards of quality and safety of the Care Quality Commission, and NHS Improvement's licence conditions that are relevant to the Quality Governance Committee's area of responsibility, in order to provide relevant assurance to the Board so that the

Board may approve the Trust's annual declaration of compliance and corporate governance statement

5.2.3 In relation to **SAFETY**

- To scrutinise serious incidents and never events, analyse patterns and monitor trends and to ensure appropriate follow up within the Trust
- To provide the Board with assurance regarding Adult and Child Safeguarding requirements and processes
- To promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern and monitoring the implementation of that policy
- To ensure that where practice is of high quality, that practice is recognised and propagated across the Trust
- To monitor the impact on the Trust's quality of care of cost improvement programmes and any other significant reorganisations
- To monitor the quality impact of the implementation of the Digital Care Record.

5.2.4 In relation to **EFFECTIVENESS**

- To have oversight and monitor progress of the annual clinical audit programme
- To make recommendations to the Audit & Assurance Committee concerning the clinical audit programme;
- To approve relevant policies and including but not limited to:
    - Risk Management Policy
- To have oversight of Trust-wide compliance with clinical regulations and Central Alert System requirements;
- Ensure the review of patient safety incidents (including near-misses, complaints and Rule 43 coroner reports) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;
- To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.
- To have oversight of the Trust's Mortality and Morbidity Surveillance Group, and to monitor Trust performance in these areas;

5.2.5 In relation to **EXPERIENCE**:

- To monitor the Trust's Friends and Family Test response rates
- To provide the Board with assurance that complaints are handled both effectively and timely
- To scrutinise patterns and trends in patient survey results, Friends and Family results, complaints and PALs data, and ensure appropriate actions are put into place and lessons are learnt
- To oversee the Trust's progress on Patient Experience.

6. Relationships and reporting

6.1 The Committee is accountable to the Trust Board. The Quality Governance Committee will report to the Trust Board at each of its meetings in public and where appropriate in private.

6.2 The following sub groups report to the Quality Governance Committee

- Clinical Governance Group (CGG)
- Infection Prevention and Control Committee

The following groups are accountable to the CGG:

- Patient and Carer Experience

- Research and Development
- Safeguarding
- Blood Transfusion
- Harm Reduction
- Divisional Governance
- Medical Devices
- Resuscitation and deteriorating patient
- Medicine Optimisation
- Serious Incident Review
- Mortality Review

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2022 or earlier if there are changes to working arrangements.

MW/TOR (corp gov TOR)
January 2021

NHS
Worcestershire
Acute Hospitals
NHS Trust

Terms of Reference

AUDIT AND ASSURANCE COMMITTEE

Version: 3.3

Terms of Reference approved by: A&A Committee, Trust Board

Date approved: September 2017/September 2018/March 2020/January 2021

Author: **Company Secretary**

Responsible directorate: Finance

Review date: March 2022

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 Purpose

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

2 Constitution

The Committee is established by the Trust Board and is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

3 Membership

Three non-executive directors, one of which shall be appointed chair by the Trust board.

The Chair of the Trust shall not be a member of the Committee.

4 Attendance

The following shall be in attendance at each meeting:

- The Chief Financial Officer
- Deputy Director of Finance or representative
- The Head of Internal Audit or representative
- External Audit engagement lead or representative
- Head of Counter Fraud
- Company Secretary

The Chief Executive and other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

In addition, the Chief Executive should be invited to attend, at least annually, to discuss with the Audit and Assurance Committee the process for assurance that supports the Annual Governance Statement.

5 Administrative support

The administrative support shall be through the Company Secretary.

6 Attendance

Except in exceptional circumstances, members are required to attend all of the meetings per year.

7 Quoracy

A quorum shall be two members.

8 Frequency of meetings

There should be a minimum of 5 meetings per year, scheduled on a bi-monthly basis.

The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The holding of such a meeting shall be at the discretion of the Chair of the Audit and Assurance Committee.

The Committee may meet the internal/external auditors privately as required.

9 Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

10 Duties

The duties of the Committee can be categorised as follows:

10.1 Integrated Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

1. The Assurance Framework as the key source of evidence that links strategic objectives to risks, controls and assurances and the main tool that the Trust Board uses in discharging its overall responsibility for internal control. Thus, the Committee should review whether;

    - The format of the Assurance Framework is appropriate for the organisation
    - The processes around the Framework are robust and relevant
    - The controls in place are sound and complete
    - The assurances are reliable and of good quality
    - The data the assurances are based on is reliable

2. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

3. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

4. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

5. The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work, and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example Quality Governance Committee) so that it understands processes and linkages. However these other committees must not usurp the Committee's role.

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards 2017 (or latest update) and provides appropriate independent assurance to the Audit and Assurance Committee, Chief Executive and Trust Board. This will be achieved by:-

1. Consideration of the provision of the Internal Audit Service, including the cost of the audit.
2. Review and approval of the Internal Audit plan and strategy, and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
3. Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
4. Ensuring that the Internal Audit function is adequately resourced, suitably qualified and has appropriate standing and access within the organisation.
5. Annual review of the effectiveness of internal audit, including consideration of the Internal Audit Annual Report.

10.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:-

1. Consideration of the appointment and performance of the External Auditor.
2. Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the

External Audit Annual Plan, and ensure coordination, as appropriate, with other Internal Audit and External Auditors in the local health economy.

3. Discussion with the External Auditor of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee**.**
4. Review all External Audit reports, including agreement of the annual audit report before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
5. Ensure that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

10.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care (DHSC) arm's length bodies or regulators/inspectors for example the Care Quality Commission, NHS Resolution and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies).

The Committee shall also ensure that the Trust appoints external auditors in compliance with the requirements of the Local Accountability and Audit Act 2014 and The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (or latest applicable regulations).

In addition, the Committee will through an agreed annual work plan, review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. When reviewing the work of the QGC and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee shall report to the Board in relation to the robustness of the processes behind the quality accounts. The Committee shall also provide assurance to the Board in relation to the management of cyber security arrangements.

10.5 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counterfraud, bribery and corruption that meet NHS CFA standards and shall review the outcomes of work in these areas.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS CFA.

10.6 Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions or major change programmes within the organisation as appropriate.

10.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the Trust Board

The Committee shall review and approve the Annual Report and financial statements before submission to the Board, focusing particularly on:-

- The wording in the Annual Governance Statement, and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgments in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of Representation
- Explanations for significant variances

10.8 Whistleblowing

The Governance Institute's *Guidance note – terms of reference for the audit committee* states that 'the committee shall review the adequacy and security of the company's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action'.

To that end, the Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any concerns are investigated proportionately and independently.

11 Reporting Structure

The Minutes of Committee meetings shall be formally recorded and a report of each meeting submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work

- in support of the Annual Governance Statement,
- specifically commenting on the fitness for purpose of the Assurance Framework,
- the completeness and embedding of risk management in the organisation,
- the integration of governance arrangements

- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts.

The Committee's annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

12 Record of Business

Minutes of Committee meetings shall be produced and circulated to members of the Committee no later than five working days following each meeting.

Agendas and associated papers shall be sent out no later than five working days before the meeting.

13 Review Period

The Committee's membership and terms of reference will be reviewed annually by 31st March. reviewed annually by 31 March or earlier in the light of changes in the system working arrangements"

January 2021

Worcestershire Acute Hospitals NHS Trust

Terms of Reference

PEOPLE AND CULTURE COMMITTEE

Version: 1.8

Terms of Reference approved by: P&C Committee/Trust Board

Date approved: /March 2021

Author: **Company Secretary**

Responsible Executive: Director of People & Culture

Review date: March 2022

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Terms of Reference
People and Culture Committee

1. Introduction

This Committee will act as a Committee of the Trust Board and is set up to ensure that the Trust has an effective people & culture strategy that attracts and retains a high performing workforce capable of delivering the Trust strategic objectives. The Committee is also responsible for the identification and monitoring of people and culture strategic risks through the regular review of the Board Assurance Framework.

The People and Culture Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

The Committee is authorised to obtain such internal information as is necessary and expedient to fulfil its functions.

2. Purpose

The purpose of the Committee is:

- To assure the people and culture implications of the Trust's strategic objectives, national,regional and integrated care system people and culture strategies, employment legislation, and local initiatives
- To oversee the development and implementation of the Trust's People and Culture Strategy and associated plans.
- To monitor the effectiveness of the strategy and report on progress against plan.
- To provide assurance to the Board on the operation of effective and robust people and culture practices and governance frameworks.

3 Membership

- Three Non-Executive Directors/Associate Non-Executive Directors
- Chief Executive
- Chief Finance Officer (or nominated deputy)
- Director of People and Culture
- Director of Communications and Engagement
- Chief Operating Officer (or nominated deputy)
- Chief Nursing Officer (or nominated deputy)
- Chief Medical Officer (or nominated deputy)
- Deputy Director of People & Culture
- Academy Director
- Chairs of the sub committees (if not listed above)

In attendance:

- Company Secretary or Deputy Company Secretary
- Freedom to Speak Up Guardian
- Assistant Director HR Corporate Services
- Guardian for Safer Working for set agenda items
- 4ward lead advocate
- Divisional representatives and other staff as appropriate

3.1 Chair of the Committee is appointed by the Trust Board.

4 Arrangements for the conduct of business

4.1 Chairing the meetings

The Non-Executive Director Chair will chair the meeting. In the absence of the Chair, another Non-Executive (or Associate) Director will Chair the meeting.

4.2 Quorum

The Committee will be quorate when one third of the members are present including one Non-Executive Director and two Executive Directors.

4.3 Frequency of meetings

The Committee will meet every two months.

4.4 Frequency of attendance by members

Members are expected to attend each meeting, unless there are exceptional circumstances.

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 in liaison with the Director of People and Culture.

4.7 Secretariat support

Secretarial support will be through the CE secretariat and a report will be presented to the Trust Board.

5 Purpose and Functions

5.1 Purpose

To act as a Committee of the Trust Board to:-

- Enable the Board to obtain assurance on the Trust's people and culture agenda.

5.2 Duties

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

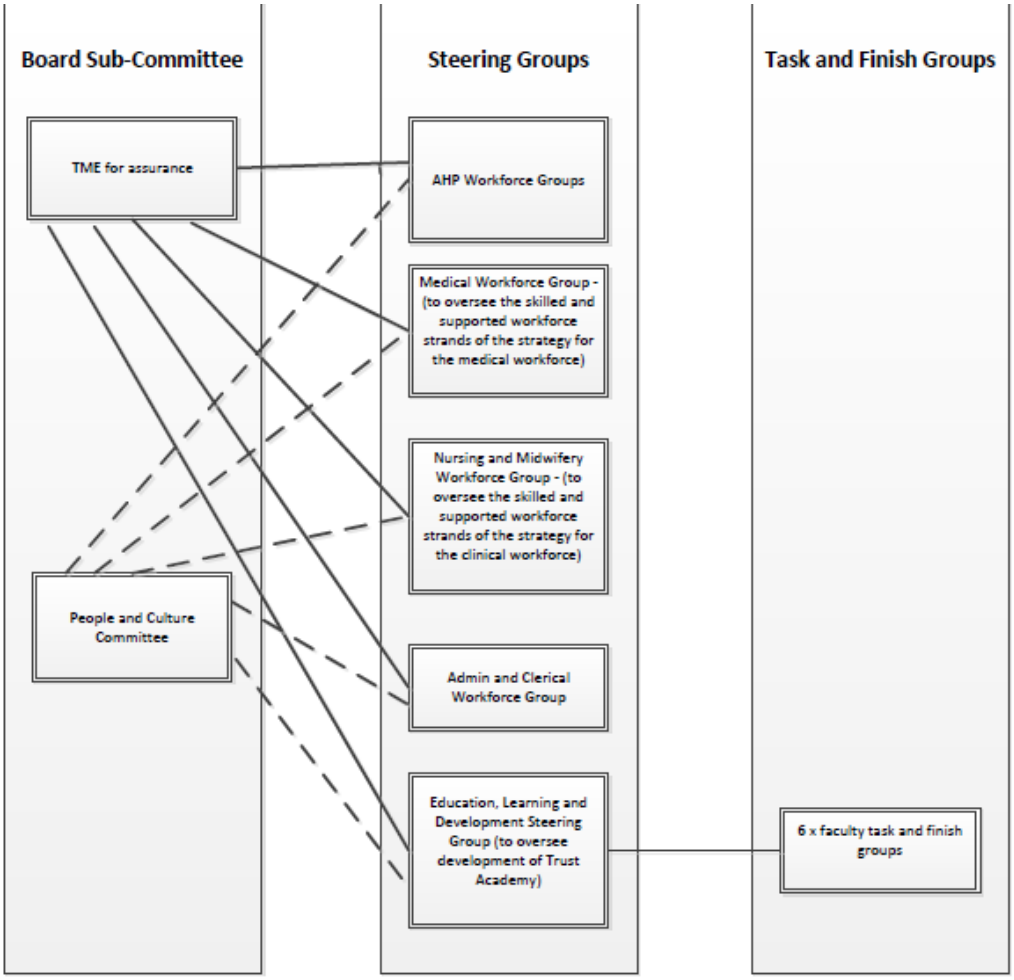
- To develop and oversee the implementation of the People and Culture Strategy and associated plans including
  - The implementation of trustwide cultural change programmes. To regularly review the effectiveness of these programmes with particular focus on their impact on equality, diversity and inclusion
  - the effectiveness of the Trust's Leadership Plan
  - the effectiveness of the Trust's workforce equality and diversity plan
  - the development and implementation of a strategic workforce plan to ensure sustainability and affordability of workforce supply and demand on a short, medium and long term basis
  - the implementation of the Trust's recruitment and retention plans to ensure the Trust has the right number of staff to deliver high quality safe services
  - the development and implementation of a workforce education and development plan to ensure the knowledge and skills of the workforce enable continuous improvement in the delivery of services
  - the effectiveness of the Trust's employee health and wellbeing plan that minimises sickness absence rates across the Trust
  - the effectiveness of the Trust's staff offer to improve our standing as an employer of choice

- Review staff survey results and monitor implementation of the action plan and effectiveness of arrangements to engage colleagues
- Identify risks associated with people and culture issues ensuring ownership with mitigating actions, escalating to Trust Board as required.
- To assure the Board on all matters relating to the Health & Safety of the workforce
- Assure the Board on the progress of the people and culture related Board Assurance Framework risks and relevant corporate risk register risks
- To assure the Board that plans and controls are in place to reduce reliance on the temporary workforce (all areas) and therefore reduce premium staffing costs.
- To ensure that all Trust polices relevant to HR / OD / Education / Training/Equality and Diversity and Occupational Health are maintained and updated in accordance with best practice, operational service activities, relevant legislation as well as taking into account the requirements of NHS regulatory bodies

6. Relationships and reporting

6.1 The Committee is accountable to the Trust Board and will report after each of its meetings to the Trust Board in public and where appropriate in private.

6.2 The following governance structure has been established to oversee the effectiveness of the strategy and to ensure that associated plans are implemented within agreed timescales.



7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2022 or earlier if deemed appropriate by the Chair.

MW/ToR People and Culture
February 2021

Worcestershire Acute Hospitals NHS Trust

Terms of Reference

Charitable Funds Committee

Version: 3.3

Terms of Reference approved by: Charitable Funds Committee/Trust Board

Date approved: September 2017/December 2018/March 2020/March 2021

Author: **Company Secretary**

Responsible directorate: Chief Executive

Review date: by March 2022

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1 Authority

1.1 The Charitable Funds Committee (the Committee) is constituted as a Standing Committee of the Trust Board as the Corporate Trustee. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee

1.3 The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee must act in accordance with any statutory/legal requirements or best practice required by the Charity Commission.

2 Purpose

2.1 The Charitable Funds Committee has been established to manage funds held in trust either as charitable funds or non-charitable funds. The Committee reports to the Trust Board as Corporate Trustee.

3 Terms of Reference

The Trustee is responsible for the overall management of the Charitable Funds. It is required:-

- To ensure that best practice is followed in terms of guidance from the Charity Commission, Chartered Institute of Fundraising, Fundraising Regulator, National Audit Office, Department of Health and other relevant organisations.
- To work within the Charity Governance Code as a tool to support continuous improvement and will regularly revisit and reflect on the Code's principles.
- To ensure that the appropriate policies and procedures are in place to support the Charitable Funds Investment Strategy.
- To advise Fund Ambassadors on income and expenditure and that this is reviewed at regular intervals.
- To ensure all income and expenditure is as per the Fund Ambassadors' manual
- To develop, review and support the Worcestershire Acute Hospitals Charity Strategy 2019 – 2024 ensuring adherence to the strategic direction of the charitable funds.
- To monitor all significant transactions within charitable funds.
- To monitor the charitable funds of the Trust to ensure that any specific conditions are met.
- To adhere to the Trust Standing Financial Instructions and Scheme of Delegation for charitable funds.

- On an annual basis, to review and approve summary level income and expenditure plans for the charity and from Fund Ambassadors, ensuring that they complement the strategy.
- To approve expenditure in alignment with the Scheme of Delegation
- To review the number of funds on an annual basis and undertake a programme of rationalisation, where appropriate.
- To approve any request to set up new funds and cost centres including research monies ensuring that they meet the criteria for charitable status as specified by the Charity Commission.
- To decide the bases of apportionment for investment income and administration costs, respectively.
- To periodically review and approve an annual risk assessment.
- To approve the annual financial accounts and annual report, prior to their submission to the Charity Commission.
- To ensure gifted income is used in accordance with Standing Financial Instructions and the purpose stated by the donor.
- To review the internal control arrangements within the Trust, in relation to donated funds held, in conjunction with Internal Audit, External Audit and individual staff.

4 Membership

All Board Directors are Trustees of the Trust's Charitable Funds. The Committee shall be appointed by the Board from amongst the Board and shall consist of three Non-Executive Directors and three Executive Directors.

One of the non-executives shall be the Chair of the Committee.

Members

Three non-executive directors
Chief Financial Officer
Chief Nurse **or** Chief Medical Officer
Director of Communications & Engagement

In attendance: Company Secretary or Deputy Company Secretary

The Deputy Director of Finance, Payables and Charitable Funds Manager, Head of Fundraising and Community Development and the Head of Financial Planning and Financial Services shall normally be expected to attend meetings and report to the Committee on the use of and accounting for funds held on trust. The Committee will request the attendance of others as necessary.

The Trust's Investment Advisors will be required to attend at least one meeting per annum.

Substitutes/Deputies - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum. Any Executive Director may act as nominated substitute / deputy in the absence of any Executive Director and this attendance will count towards the quorum.

5 Quorum

A quorum shall consist of three members, of which one shall be the Chair or Vice-Chair of the Charitable Funds Committee.

6 Frequency

Meetings shall be held six times a year. Members are expected to attend at least 50% of the meetings. Additional meetings may be held in consultation with the Chair.

7 Record of Business

Minutes of the Committee meetings shall be produced and circulated to the members of the Committee no later than 5 working days following each meeting. The Minutes of Committee meetings shall be formally recorded and a report of each meeting submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

Agendas and associated papers will be sent out no later than five working days before the next meeting.

9 Committee Secretary

The Company Secretary is responsible for ensuring the Committee's business is recorded appropriately.

10 Review Period

The Committee membership and Terms of Reference are to be reviewed annually by 31st March or earlier if necessary.

March 2021

Worcestershire Acute Hospitals NHS Trust

Terms of Reference

REMUNERATION COMMITTEE

Version: 2.3

Terms of Reference approved by: Remuneration Committee/Trust board

Date approved: September 2017/November 2017/September 2018/November 2018/March 2020/April 2021

Author: Company Secretary

Responsible directorate: Chair/CEO

Review date: March 2022

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 Authority

The remuneration committee (the committee) is constituted as a standing committee of Trust board. Its constitution and terms of reference shall be as set out below, subject to amendment at future board meetings.

The committee is authorised by the board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

The committee is authorised by the board to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2 Purpose

To be responsible for overseeing and ratifying the appointment of candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

When appointing the chief executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other executive directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

3 Terms of Reference

3.1 Appointments role

The committee will:

- Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, with regard to any changes.
- Give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.
- Keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.
- Be responsible for overseeing and ratifying the appointment of candidates to fill posts within its remit as and when they arise.
- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

- Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

3.2 Remuneration role

The committee will:

- Establish and keep under review a remuneration policy in respect of executive board directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay.
- Consult the chief executive about proposals relating to the remuneration of the other executive directors.
- In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay, including:
    - Salary, including any performance-related pay or bonus;
    - Annual salary increase
    - Provisions for other benefits, including pensions and cars;
    - Allowances;
    - Payable expenses;
    - Compensation payments.
- In adhering to all relevant laws, regulations and trust policies:
    - establish levels of remuneration which are sufficient to attract, retain and motivate all staff covered by these terms of reference with the quality, skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;
    - use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;
    - be sensitive to pay and employment conditions elsewhere in the trust.
- Ensure the annual performance of Board Directors is undertaken and evaluate on an exceptional basis the performance of Board Directors on the advice of the Chief Executive/Chair. This will include consideration of this output when reviewing changes to remuneration levels.
- Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.
- Receive and approve an annual report on Clinical Excellent Awards.

4 Membership

The membership of the committee shall consist of:

- *the trust chair;*
- *two other non-executive directors;*

  and in addition, when appointing executive directors other than the chief executive

- the chief executive

The trust chair shall chair the committee.
The Director of People and Culture will be in attendance when required.

5 Quorum

Two core members must be present, of which at least one must be the Chair and one must be a substantive Non-Executive Director.

5 Frequency of meetings

Meetings shall be called as required, but at least once in each financial year.

6 Attendance

Committee members are expected to attend all meetings,.

7 Record of Business

Formal minutes shall be taken of all committee meetings.

The committee will report to the board after each meeting.

The committee shall receive and agree a description of the work of the committee, its policies and all executive director emoluments in order that these are accurately reported in the required format in the trust's annual report and accounts.

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

8 Performance evaluation

As part of the board's annual performance review process, the committee shall review its collective performance

9 Review Period

Terms of reference will be reviewed annually.

KS/ToR RemCo v2.3
February 2021

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

Author: Company Secretary

Responsible directorate: CEO

Review date: March 2022

NHS
Worcestershire
Acute Hospitals
NHS Trust

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
Deputy 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 and Planning
Chief Digital Officer
Company Secretary
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
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 Group
- Strategy and Planning Group
- Performance Review Meetings
- Cancer Improvement Group
- Information Governance Steering Group
- Emergency Planning Group
- Digital Steering Group

TME will set up task and finish groups as appropriate.

7 Review Period

Terms of reference will be reviewed by March 2022 or earlier if necessary.

MW/ToR TME
February 2021

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	22 April 2021
Paper number	Enc G6

Register of Seals

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

Accountable Director	Rebecca O'Connor, Company Secretary		
Presented by	Rebecca O'Connor Company Secretary	**Author /s**	Martin Wood, Deputy Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is invited to receive this report.

Executive summary	The Trust's Standing Orders require that a report of all sealing shall be made to the Trust Board. The details of the sealing since the last report in September 2019 are set out. Contract which the Trust is entering into are now executed under seal giving the Trust greater protection should any issues arise with the contract.

Risk			
Which key red risks does this report address?	*N/A*	**What BAF risk does this report address?**	*N/A*

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
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						

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	22 April 2021
Paper number	Enc G6

Introduction/Background

The Trust's Standing Orders require that a report of all sealing shall be made to the Trust Board. The report shall contain details of the seal number, the description of the document and date of sealing.

Issues and options

The details of the sealing since the last report in September 2019 is set out below:-

Seal Number	Description	Date of Sealing
194	Hard Services Relating to Worcestershire Royal Hospital Medical Assessment Unit Portakabin Works	4 November 2019
195	Licence to Underlet RVS Shop and Cafe	11 February 2020
196	Licence to Underlet RVS Shop	11 February 2020
197	Lease – Malvern View Residencies (5 copies)	18 March 2020
198	Malvern View – Licence to Assign	25 March 2020
199	PFI Hospital Project Confirmed Variation Instruction No 44 (2 copies)	15 April 2020
200	Updated Supplementary Agreement to the Concession Agreement between the Trust and Worcestershire Hospitals SPC PLC (2 copies)	15 September 2020
201	Supplementary Agreement to the Equipment Services Direct Agreement between the Trust, Worcestershire Hospitals SPC PLC and Siemens PLC (3 copies)	15 September 2020
202	Computacentre Contract Extension (2 documents and 2 copies of each)	4 November 2020
203	PFI Hospital Project Confirmed Variation Instruction No 46 (2 copies)	21 December 2020
204	PFI Hospital Project Confirmed Variation Instruction No 47 (2 copies)	21 December 2020
205	Contract for Aconbury Boiler Replacement	1 February 2021
206	Contract for Kidderminster Oncology Refurbishment	1 February 2021
207	Contract for Extension to Breast Screening Unit	19 February 2021
208	Lease Relating to Land at Spetchley Estate, Worcester	19 February 2021
209	Contract for Diagnostic Equipment Replacement at the Alexandra Hospital	11 March 2021
210	Supplemental MES Agreement between the Trust and Worcestershire SPC PLC (2 copies)	18 March 2021
211	Contract for Extension to Form a Breast Screening Facility at the Alexandra Hospital (2 copies)	31 March2021
212	Contract for Window Replacement at the Alexandra Hospital	31 March 2021

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	22 April 2021
Paper number	Enc G6

Conclusion
Recommendations
The Trust Board is invited to receive this report.
Appendices - None