Putting Patients First 4ward

# QUALITY AND SAFETY IN NUMBERS

## February 2022

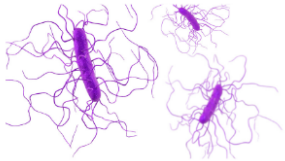
NHS Worcestershire Acute Hospitals NHS Trust

**MRSA**

**0**

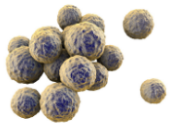
**ECOLI**

**4**



**CDIFF**

**4**



**MSSA**

**1**

**Hand Hygiene**

| | |
|---|---|
| Participation | **90.99** |
| Compliance | **99.69** |


**Sepsis**

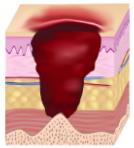
| | |
|---|---|
| Screening Compliance | **82.91** |
| Sepsis 6 bundle compliance | **58.47** |

**ICE reports viewed**

| | |
|---|---|
| Radiology | **92.00** |
| Pathology | **90.85** |


**Falls per 1,000 bed days causing harm**

**0.00**



**Pressure Ulcers**

| | |
|---|---|
| All hospital acquired pressure ulcers | **21** |
| Serious incident pressure ulcers | **0** |

**Response Rate**

| | |
|---|---|
| A&E | **17.97** |
| Inpatients | **29.91** |
| Maternity | **1.94** |
| Outpatients | **10.62** |

**Recommended Rate**

| | |
|---|---|
| A&E | **74.49** |
| Inpatients | **95.78** |
| Maternity | **100** |
| Outpatients | **92.11** |

**HSMR 12 months rolling (June 21)** **95.61**

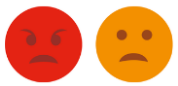
**Mortality Reviews completed </=30 days (Nov-20)** **35.50**

**Risks overdue review** **166**

**Risks with overdue actions** **254**

**Discharged before midday**

**15.12**



**Complaints Responses </=25 days**

**68.57**

**Total Medicine incidents reported** **139**

**Medicine incidents causing harm (%)** **2.88**

Putting Patients First 4ward

# WORKFORCE COMPOSITION IN NUMBERS

NHS Worcestershire Acute Hospitals NHS Trust

February 2022

Employees

**6,796**

BAME employees

**19%**

Part-time workers

**45%**

Female

**82%**

Registered nurses

**1,978 (29%)**

Registered midwives

**253 (4%)**

HCAs, helpers and assistants

**1,298 (19%)**

Doctors

**733(11%)**

Other clinical and scientific staff

**854 (13%)**

>55

Over age 55

**18%**

≤30

30 years and under

**20%**

Staff with less than 2 years service

**27%**

Staff with 20 years service or over

**10%**

# Women & Children's Division
# Maternity & Neonatal Dashboard

Worcestershire Acute Hospitals NHS Trust

**Reporting Period: January 2022 v1**

## ANTENATAL

| Area | Indicator Type | LMS ID | WAHT ID | WVT ID | Indicator Description | Type | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Year to Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Booking | National | ABO1.1 | | | Women booked before 12 + 6 weeks | Integer | 389 | 365 | 374 | 381 | 356 | 318 | 324 | 386 | 338 | 371 | 365 | | 3967 |
| | National | ABO1.2 | MSB1.1 | | % Women booked before 12 + 6 weeks | % | 79.7% | 84.3% | 81.7% | 83.7% | 78.9% | 76.8% | 80.4% | 82.5% | 84.3% | 74.9% | 74.2% | | 80.0% |
| | LMS | ABO2.1 | | | Women booked after 12 + 6 weeks | Integer | 99 | 68 | 84 | 74 | 95 | 96 | 79 | 82 | 63 | 124 | 127 | | 991 |
| | LMS | ABO2.2 | | | % of Women booked after 12 + 6 weeks | % | 20.3% | 15.7% | 18.3% | 16.3% | 21.1% | 23.2% | 19.6% | 17.5% | 15.7% | 25.1% | 25.8% | | 20.0% |
| | Contractual | ABO3.0 | MSB1.2 | | Total bookings | Integer | 488 | 433 | 458 | 455 | 451 | 414 | 403 | 468 | 401 | 495 | 492 | | 4958 |
| | LMS | ABO4.1 | | | Midwife led care at booking | Integer | 222 | 173 | 199 | 212 | 198 | 166 | 202 | 239 | 187 | 245 | 223 | | 2266 |
| | Contractual | ABO4.2 | MOI7.0 | | % Midwife led care at booking | % | 45.5% | 40.0% | 43.4% | 46.6% | 43.9% | 40.1% | 50.1% | 51.1% | 46.6% | 49.5% | 45.3% | | 45.7% |
| Risk Management | LMNS | ARM1.1 | | | Women with BMI of 30 and over at booking | Integer | 140 | 133 | 119 | 127 | 120 | 122 | 101 | 120 | 92 | 128 | 119 | | 1321 |
| | LMNS | ARM1.2 | | | % Women with BMI of 30 and over at booking | % | 29% | 31% | 26% | 28% | 27% | 29% | 25% | 26% | 23% | 26% | 24% | | 26.6% |
| Smoking | LMS | ASM1.1 | | | Smoking at booking | Integer | 55 | 61 | 70 | 59 | 56 | 64 | 49 | 47 | 63 | 53 | 64 | | 641 |
| | LMS | ASM1.2 | | | % Smoking at booking | % | 11.3% | 14.1% | 15.3% | 13.0% | 12.4% | 15.5% | 12.2% | 10.0% | 15.7% | 10.7% | 13.0% | | 12.9% |
| | LMS | ASM2.1 | | | Smokers accepting smoking cessation service referral at booking | Integer | 36 | 36 | 36 | 34 | 36 | 48 | 33 | 31 | 46 | 34 | 31 | | 401 |
| | LMS | ASM2.2 | MSB1.4 | | % Smokers accepting smoking cessation service referral at booking | % | 65.0% | 59.0% | 51.0% | 58.0% | 64.0% | 75.0% | 67.3% | 66.0% | 73.0% | 64.2% | 48.4% | | 8.1% |
| | LMS | ASM3.1 | | | Smokers accepting CO screening at booking | Integer | 47 | 56 | 62 | 53 | 50 | 58 | 49 | 47 | 60 | 48 | 56 | | 587 |
| | Local | ASM3.2 | MSB1.6 | | % Smokers accepting CO screening at booking | % | 85.5% | 91.8% | 88.6% | 89.8% | 89.3% | 90.6% | 100.0% | 100.0% | 95.2% | 92.5% | 87.5% | | 11.8% |
| Carbon Monoxide | LMS | ACM1.1 | | | Women screened for CO at booking | Integer | 356 | 361 | 402 | 406 | 417 | 358 | 342 | 409 | 370 | 443 | 405 | | 4269 |
| | LMS | ACM1.2 | | | % Women screened for CO at booking (of total bookings) | % | 73.0% | 83.4% | 87.8% | 89.2% | 92.5% | 86.5% | 84.9% | 87.4% | 92.3% | 89.5% | 82.3% | | 86.1% |
| | LMS | ACM2.1 | | | Women with CO reading of 4 ppm or more at booking | Integer | 24 | 37 | 39 | 41 | 31 | 33 | 30 | 29 | 39 | 28 | 34 | | 365 |
| | Local | ACM2.2 | | | % Women with CO reading of 4 ppm or more at booking (of total bookings) | % | 4.9% | 8.5% | 8.5% | 9.0% | 6.9% | 8.0% | 7.4% | 6.2% | 9.7% | 5.7% | 6.9% | | 7.4% |

## INTRAPARTUM

| Area | Indicator Type | LMS ID | WAHT ID | WVT ID | Indicator Description | Type | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Year to Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deliveries | Contractual | IDE1.0 | MDEL1.0 | | Total Deliveries | Integer | 412 | 407 | 401 | 411 | 451 | 452 | 450 | 385 | 406 | 404 | 364 | | 4543 |
| Delivery Method | Contractual | IDM1.0 | | | Vaginal deliveries | Integer | 230 | 242 | 222 | 240 | 259 | 268 | 243 | 214 | 207 | 243 | 210 | | 2578 |
| | LMS | IDM1.1 | MNVD1.0 | | % Vaginal deliveries | % | 55.8% | 59.5% | 55.4% | 58.4% | 57.4% | 59.3% | 54.0% | 55.6% | 51.0% | 60.1% | 57.7% | | 56.7% |
| | LMS | IDM2.1 | | | Ventouse & forceps deliveries | Integer | 45 | 36 | 35 | 43 | 51 | 40 | 55 | 45 | 50 | 50 | 31 | | 481 |
| | Contractual | IDM2.2 | MIVD1.0 | | % Ventouse & forceps deliveries | % | 10.9% | 8.8% | 8.7% | 10.5% | 11.3% | 8.8% | 12.2% | 11.7% | 12.3% | 12.4% | 8.5% | | 10.6% |
| C-Section Deliveries | Contractual | ICS4.1 | | | Elective (category 4) caesarean deliveries | Integer | 67 | 56 | 73 | 56 | 65 | 75 | 62 | 63 | 78 | 50 | 60 | | 705 |
| | LMS | ICS4.2 | MCS1.1 | | % Elective (category 4) caesarean deliveries | % | 16.3% | 13.8% | 18.2% | 13.6% | 14.4% | 16.6% | 13.8% | 16.4% | 19.2% | 12.4% | 16.5% | | 15.5% |
| | Trust | ICS3.1 | | | *Emergency (category 3) caesarean deliveries* | *Integer* | 14 | 17 | 17 | 13 | 25 | 18 | 15 | 17 | 23 | 22 | 14 | | 195 |
| | Trust | ICS3.2 | | | *% Emergency (category 3) caesarean deliveries* | % | 3.4% | 4.2% | 4.2% | 3.2% | 5.5% | 4.0% | 3.3% | 4.4% | 5.7% | 5.4% | 3.8% | | 4.3% |
| | Trust | ICS2.1 | | | *Emergency (category 2) caesarean deliveries* | *Integer* | 37 | 38 | 38 | 40 | 26 | 35 | 55 | 31 | 30 | 22 | 32 | | 384 |
| | Trust | ICS2.2 | | | *% Emergency (category 2) caesarean deliveries* | % | 9.0% | 9.3% | 9.5% | 9.7% | 5.8% | 7.7% | 12.2% | 8.1% | 7.4% | 5.4% | 8.8% | | 8.5% |
| | Trust | ICS1.1 | | | *Emergency (category 1) caesarean deliveries* | *Integer* | 19 | 18 | 15 | 17 | 24 | 16 | 20 | 14 | 16 | 16 | 17 | | 192 |
| | Trust | ICS1.2 | | | *% Emergency (category 1) caesarean deliveries* | % | 4.6% | 4.4% | 3.7% | 4.1% | 5.3% | 3.5% | 4.4% | 3.6% | 3.9% | 4.0% | 4.7% | | 4.2% |
| | Contractual | ICS5.1 | | | Emergency (category 1-3 inclusive) caesarean deliveries | Integer | 70 | 73 | 71 | 72 | 76 | 69 | 90 | 63 | 71 | 60 | 63 | | 778 |
| | LMS | ICS5.2 | MCS1.2 | | % Emergency (category 1-3 inclusive) caesarean deliveries | % | 17.0% | 17.9% | 17.7% | 17.5% | 16.9% | 15.3% | 20.0% | 16.4% | 17.5% | 14.9% | 17.3% | | 17.1% |
| | LMS | ICS6.1 | | | Total deliveries as caesarean | Integer | 137 | 129 | 144 | 128 | 141 | 144 | 152 | 126 | 149 | 110 | 123 | | 1483 |
| | Contractual | ICS6.2 | MCS1.0 | | % Total deliveries as caesarean | % | 33.3% | 31.7% | 35.9% | 31.1% | 31.3% | 31.9% | 33.8% | 32.7% | 36.7% | 27.2% | 33.8% | | 32.6% |
| Midwife Led Care | Contractual | IML1.1 | W-IL.M1.1 | H-IML1.1 | Midwife led care deliveries | Integer | | | | | | | | | | | | | 0 |
| | LMS | IML1.2 | MOI3.0 | | % Midwife led care deliveries | % | | | | | | | | | | | | | 0.0% |
| | LMS | IML2.1 | | | Home deliveries | Integer | 17 | 19 | 17 | 15 | 11 | 14 | 8 | 9 | 9 | 5 | 3 | | 127 |
| | LMS | IML2.2 | | | % Home deliveries | % | 4.1% | 4.7% | 4.2% | 3.6% | 2.4% | 3.1% | 1.8% | 2.3% | 2.2% | 1.2% | 0.8% | | 2.8% |
| Births | Contractual | IBI1.0 | MBIR1.0 | | Total Births | Integer | 417 | 413 | 408 | 416 | 458 | 455 | 457 | 389 | 414 | 409 | 372 | | 4608 |
| | LMS | IBI2.1 | | | Full term births (babies born at 37wks gestation or over) | Integer | 394 | 373 | 375 | 392 | 419 | 427 | 428 | 357 | 371 | 363 | 343 | | 4242 |
| | LMS | IBI2.2 | | | % Full term births (babies born at 37wks gestation or over) | % | 94.5% | 90.3% | 91.9% | 94.2% | 91.5% | 93.8% | 93.7% | 91.8% | 89.6% | 88.8% | 92.2% | | 286.0% |
| | LMS | IBI3.1 | W-IBI3.1 | H-IBI3.1 | Pre-term births (babies born under 37wks gestation) | Integer | 23 | 40 | 33 | 24 | 39 | 28 | 29 | 32 | 43 | 46 | 29 | | 366 |
| | LMS | IBI3.2 | W-IBI3.2 | H-IBI3.2 | % Pre term births (babies born under 37wks gestation) | % | 5.5% | 9.7% | 8.1% | 5.8% | 8.5% | 6.2% | 6.3% | 8.2% | 10.4% | 11.2% | 7.8% | | 24.7% |
| | LMS | IBI4.1 | W-IBI4.1 | H-IBI4.1 | Stillbirths | Integer | 2 | 2 | 4 | 1 | 0 | 2 | 1 | 0 | 1 | 3 | 1 | | 17 |
| | LMS | IBI4.2 | W-IBI4.2 | H-IBI4.2 | % Total births stillbirth | % | 0.5% | 0.5% | 1.0% | 0.2% | 0.0% | 0.4% | 0.2% | 0.0% | 0.2% | 0.7% | 0.3% | | 1.1% |
| Risk Management | Contractual | IRM1.1 | | | Low birth weight where IUGR detected antenatally | Integer | | | | | | | | | | | | | |
| | Contractual | IRM1.2 | MOI4.0 | | % Low birth weight where IUGR detected antenatally | % | | | | | | | | | | | | | |
| Breastfeeding | National | IBR1.1 | | | Breast feeding initiation rate | Integer | 216 | 299 | 290 | 290 | 321 | 308 | 306 | 255 | 283 | 275 | 241 | | 3084 |
| | National | IBR1.2 | MOI1.0 | | % Breast feeding initiation rate | % | 52.4% | 73.5% | 72.3% | 70.6% | 71.2% | 68.1% | 68.0% | 66.2% | 69.7% | 68.1% | 66.2% | | 67.9% |
| Smoking | National | ISM1.1 | W-ISM1.1 | H-ISM1.1 | Women smoking at delivery | Integer | 43 | 41 | 42 | 40 | 48 | 51 | 37 | 50 | 47 | 46 | 31 | | 476 |
| | National | ISM1.2 | MOI2.0 | H-ISM1.2 | % Women smoking at delivery | % | 10.4% | 10.1% | 10.5% | 9.7% | 10.6% | 11.3% | 8.2% | 13.0% | 11.6% | 11.4% | 8.5% | | 10.5% |

## NEONATAL

| Area | Indicator Type | LMS ID | WAHT ID | WVT ID | Indicator Description | Type | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Year to Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | Local | NAD1.0 | MOI6.0 | | Total admissions to neonatal care | Integer | 45 | 51 | 60 | 60 | 77 | 47 | 58 | 67 | 63 | 66 | 71 | | 665 |
| | National | NAD2.1 | MOI6.1 | | Unexpected admissions of full-term babies to neonatal care | Integer | 16 | 14 | 12 | 13 | 8 | 11 | 7 | 15 | 6 | 11 | 17 | | 130 |
| | LMS | NAD2.2 | MOI6.2 | | % Unexpected admissions of full-term babies to neonatal care (of all live term births) | % | 3.8% | 3.4% | 2.9% | 3.1% | 1.7% | 2.4% | 1.5% | 3.9% | 1.4% | 2.7% | 4.6% | | 3.1% |
| Risk Management | LMS | NRM1.1 | W-NRM1.1 | H-NRM1.1 | Neonatal deaths | Integer | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 2 | | 6 |
| | LMS | NRM1.2 | | | % Neonatal deaths (of total neonatal admissions) | % | 0.0% | 0.0% | 0.0% | 1.7% | 0.0% | 2.1% | 0.0% | 1.5% | 1.6% | 0.0% | 2.8% | | 0.9% |
| | LMS | NRM2.1 | | | Neonatal brain injuries | Integer | | | | | | | | | | | | | |
| | LMS | NRM2.2 | | | % neonatal brain injuries (of total neonatal admissions) | % | | | | | | | | | | | | | |
| | LMS | NRM3.1 | | | Referrals to NHS Resolution | Integer | | | | | | | | | | | | | |
| | LMS | NRM3.2 | | | % referrals to NHS Resolution (of total births) | % | | | | | | | | | | | | | |
| | LMS | NRM4.1 | | | Neonatal transfers for therapeutic cooling | Integer | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | | 4 |
| | LMS | NRM4.2 | | | % Neonatal transfers for therapeutic cooling (of total neonatal admissions) | % | 2.2% | 0.0% | 0.0% | 0.0% | 1.3% | 2.1% | 0.0% | 0.0% | 0.0% | 1.5% | 0.0% | | 0.6% |
| | LMS | NRM5.1 | | | Administration of antenatal steroids (to mothers of babies born between 23 and 33wks gestation) | Integer | 8 | 11 | 3 | 6 | 13 | 8 | 7 | 10 | 10 | 4 | 2 | | 82 |
| | LMS | NRM5.2 | | | Mothers eligible for antenatal steroids (of babies born between 23 and 33wks gestation) | Integer | 8 | 14 | 6 | 8 | 17 | 12 | 11 | 10 | 13 | 4 | 3 | | 106 |
| | LMS | NRM5.3 | | | % Administration of antenatal steroids (of babies born between 23 and 33wks gestation) | % | 100.0% | 78.6% | 50.0% | 75.0% | 76.5% | 66.7% | 63.6% | 100.0% | 76.9% | 100.0% | 66.7% | | 77.4% |
| | LMS | NRM6.1 | | | Administration of magnesium sulphate (to mothers of babies born under 30wks gestation) | Integer | 1 | 0 | 1 | 3 | 0 | 2 | 3 | 0 | 2 | 0 | 0 | | 12 |
| | LMS | NRM6.2 | | | Mothers eligible for magnesium sulphate (of babies born under 30wks gestation) | Integer | 1 | 0 | 1 | 3 | 0 | 2 | 3 | 0 | 2 | 0 | 0 | | 12 |
| | LMS | NRM6.3 | | | % Administration of magnesium sulphate (to mothers of babies born under 30wks gestation) | % | 100.0% | - | 100.0% | 100.0% | - | 100.0% | 100.0% | - | 100.0% | - | - | | 100.0% |

## POSTNATAL

| Area | Indicator Type | LMS ID | WAHT ID | WVT ID | Indicator Description | Type | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Year to Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Management | Local | PRM1.1 | MMM2.0 | | ITU admissions in obstetrics | Integer | 1 | 2 | 0 | 2 | 2 | 2 | 1 | 1 | 0 | 0 | 0 | | 11 |
| | Local | PRM1.2 | | | % ITU admissions in obstetrics (of all deliveries) | % | 0.2% | 0.5% | 0.0% | 0.5% | 0.4% | 0.4% | 0.2% | 0.3% | 0.0% | 0.0% | 0.0% | | 0.2% |
| | LMS | PRM2.1 | MMM4.0 | | Maternal deaths | Integer | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 1 |
| | National | PRM2.2 | | | % Maternal deaths (of all deliveries) | % | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | | 0.0% |

# Committee Assurance Reports

Trust Board

7th April 2022

# Finance & Performance Committee Assurance Report - 30 March 2022

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| Richard Oosterom<br>Associate Non-Executive Director | Richard Oosterom<br>Associate Non-Executive Director | Rebecca O'Connor<br>Company Secretary |

| | | | |
|---|---|---|---|
| **Assurance:** Does this report provide assurance in respect of the Board Assurance Framework strategic risks? | Y | **BAF number(s)** | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 |

**Executive Summary**

**The Committee met virtually on 30 March and the following key points were raised - Escalations to Board:**

| Item | Rationale for escalation | Action required by Trust Board |
|---|---|---|
| 22/23 Plan | The current position with regards to the plan was and Trust Board requested agree a delegation to Committee ahead of final submission | Note the current position and approve a delegation for final approval ahead of submission |
| Net Zero Carbon Strategy and Green Plan 2022-25 | The position in development of the strategy and approach in further developing the same was noted and Trust Board asked to approve the plan | Approval |

**The following levels of assurance were approved:**

| Item | Level of Assurance | Change | BAF Risk |
|---|---|---|---|
| 22/23 Plan | Level 2 | Maintained | 7, 8, 9, 11, 14, 18, 19 |
| Net Zero Carbon Strategy and Green Plan 2022-25 | Level 3 | N/A | 8, 14 |
| International Nurses | Level 3 | - | 7 |
| Integrated Performance Report | Level 4 | Maintained | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 |
| Finance Report: Income and Expenditure | Level 3 | Maintained | 7 and 8 |
| Finance Report: Capital | Level 4 | Maintained | 7 and 8 |
| Finance Report: Cash | Level 6 | Maintained | 7 and 8 |

# Finance & Performance Committee Assurance Report - 30 March 2022

## Executive Summary

**The Committee met virtually on 30 March and the following key points were raised :**

| Item | Discussion |
|---|---|
| **22/23 Plan** | Committee had a comprehensive discussion as to the current position. The activity position was now compliant with all standards. Maturity levels of PEPs are still under review given the challenged operational position and major incident. It was confirmed the Trust are not part of the convergence adjustments this year due to additional £8m Financial Improvement Target already included. Challenges remain in some cancer diagnosis targets and this is a risk. Activity targets are adjusted as a result of changes to the baseline as a result of the long standing First to Follow up SUS rule correction required, however this change is subject to agreement. Review of opportunity to go further, should funding be available, are being considered. The workforce implications were noted and impacts were discussed along with the cross cutting themes The waterfall of the finance position was discussed in detail. It was noted that CAU is not in the current position and is under discussion; this is a risk, but is a system issue. It was noted there continued to be more risks than opportunities with PEPs development and maturity insufficient to meet the £15.7m requirement . It was agreed a further committee would be held following the Trust Board but ahead of submission. |
| **Net Zero Carbon Strategy and Green Plan 2022-25** | Outline of the plan was described and the cross links with digital and best people programme were noted. This is consistent approach with local Trusts and a pragmatic approach is taken to implementation and learning with both H&CT and SWFT group. Deliverables and the action plan were noted and a programme board approach will be reinstated. It was proposed sustainability be a future board development session. Benchmark information was included but slightly dated and this would be updated. A clear plan with specific outputs and KPIS will be reported back including financial implications and benefits following the appointment of the Director of Estates. |
| **International Nurses** | Comprehensive pastoral support was outlined and Committee noted this was well received and staff retention was positive. The source and application of funding was described and set out in the paper. There was a £1.9m benefit in swap out with bank and agency, or costs avoidance if not a swap out. The Committee supported a solid business case with good execution. Support in gaining onwards access to accommodation would be followed up noting this had not been an issue raised with the team supporting the International nurses. |
| **Integrated Performance Report** | Executive summary headlines were noted. The key issues were Emergency and Urgent Care and associatted Patient Flow and Capacity; recovery and restoration of the elective programme including diagnostics and outpatients, cancer and stroke. The internal process regarding flow were discussed and good progress made at ALX were outlined. Challenges remain at WRH with a reduction in the number of patients discharged before midday. Regarding LOS 21/14/17 the Trust performs highly. Teams are meeting to discuss the learning from the ALX and implement criteria led discharge. This will be a key focus of focus at the next committee. **Assurance level 4 overall was agreed** |
| **Finance Report – Month 11** | Variance of -£1.6m at month 11, key point will be focus on the variance on the PEP plans as we move into the new year. CAU position is still to be determined. There is an adverse variance against nursing and SCSD. Costs due to workload activity and sickness/absence. However a number of rebates have been received and CNST premium is within the position. Asset register adjustments have also improved the positon. Not all capital funds have be drawn down and vesting arrangements are being considered. The position on cash was good. **Assurance levels were approved at levels 3 I&E, 4 capital and 6 cash** |
| **Other** | N/A |

# Quality Governance Committee Assurance Report – 31 March 2022

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| Dame Julie Moore – Non-Executive Director | Dame Julie Moore – Non-Executive Director | Rebecca O'Connor<br>Company Secretary |

| | | | |
|---|---|---|---|
| **Assurance:** Does this report provide assurance in respect of the Board Assurance Framework strategic risks? | Y | **BAF number(s)** | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 |

## Executive Summary

**The Committee met virtually on 30 March and the following were agreed as escalations to Board:**

| Item | Rationale for escalation | Action required by Trust Board |
|---|---|---|
| Research and Innovation Strategy | Recommended for approval by the Trust Board | Approval |
| Ockenden Compliance Report | To note compliance against the recommendations | To receive for assurance |
| Whitespace | MAU and Chestnut Ward to be escalated | To receive an update on the current position |
| Major Incident Debrief | To update the Board following the major incident | To receive an update on the current position |

**The following levels of assurance were approved:**

| Item | Level of Assurance | Change | BAF Risk |
|---|---|---|---|
| ICS Quality Forum | N/A | - | 4, 21 |
| Infection Prevention & Control | Level 4 | Maintained. | 3 |
| Integrated Performance Report | Level 4 | Maintained | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 |
| Research and Innovation Strategy | Level 5 | - | 3, 4, 9, 11, 21 |
| CQC Strategy | Level 4 | - | 4 |
| Maternity Services Safety Report | Level 5 | Maintained. | 2, 4, 9, 10 |
| Ockenden One Year On | Level 6 | - | 2, 4, 9, 10 |
| Picker Report | Level 4 | - | 2, 4, 11 |
| Clinical Governance Group | N/A | | 4 |

# Quality Governance Committee Assurance Report – 31 March 2022

## Executive Summary

**The Committee met virtually on 31 March and the following key points were raised:**

| Item | Discussion |
|---|---|
| **ICS Quality Forum** | Feedback from the ICS quality forum was shared with common themes including discharge delays and staffing challenges. Healthcare support workers were noted as difficult to recruit to across the system, suggestions regarding training of support workers was discussed. |
| **Escalations** | Received an update as to the major incident, its impact and ongoing resilience at WRH. The letter from NHSE following the IPC visit was discussed. Good progress has been made but green was not met. This is expected to be upgraded in May. |
| **Infection Prevention & Control** | The quarterly report was reviewed. An unusual c-diff ribotype was noted and deep cleans had taken place as appropriate. MSSA position maintained, e-coli target breached locally but well inside national target. Major challenges with Covid outbreaks and the Covid BAF was noted. Risk assessments and changes through gold command to manage risk were noted and this is managed on a daily basis. NOF performance was discussed, noting trauma theatre capacity at weekends and recruitment challenges. **Level 4 assurance was approved.** |
| **Integrated Performance Report** | Executive summary headlines were noted. Q&S indicators included Covid (128 inpatients today), challenges in ambulances handovers were noted. Despite UEC pressures, the Trust has provided above plan activity for restoration and recovery, focussed on those waiting the longest and highest clinical priority. Sepsis report now includes benchmarked information on mortality and length of stay. Discharges are challenging, but good progress is being made at ALX. A criteria led discharge event is being planned. **Level 4 assurance was approved.** |
| **Research and Innovation Strategy** | Committee received a comprehensive presentation on the strategy which was welcomed. The research opportunities and funding were discussed. The strategy aims and aspirations were supported and it was recommended for approval by the Trust Board. |
| **CQC Strategy** | Committee noted the overarching themes and ambitions of the CQC's approach. A number of engagement events have been positive. UEC remains the key issue for the Trust. The key is the relationships between the executive and the local CQC team. |
| **Maternity Service Safety Report** | Committee discussed the confidential (due to small numbers and patient confidentiality) update, noting the position and assurances. Issues with 12 week booking are isolated to one team. Perinatal mortality rates are aligned to the national rates with no concerns. Neonatal deaths have reviewed. Mandatory training has restarted in March. Sickness and turnover were down, but supernumerary shift lead red flags had been noted. Consultant and middle grades have been recruited. Picker report actions are being addressed. CQC action plan embedded with only five actions to complete and a plan in place. **Level 5 assurance was approved.** |
| **Ockenden Report** | 92% compliant against recommendations. Others are partially compliant, none are not compliant. £20k from LMNS to support the website work. Insight visit on 31 May to review evidence. Ockenden Two is published and have circa 60 recommendations, an action plan will be developed to address issues. The impact on staff team working was discussed. **Level 6 assurance was approved.** |
| **Whitespace/MAU** | Work is ongoing with the water system and this space is intended to be open from w/c 18 April. A SOP is in development regarding the use of this space and how this can support ambulance handover delays. Revenue implications remain under discussion |

# Quality Governance Committee Assurance Report – 31 March 2022

## Executive Summary

**The Committee met virtually on 31 March and the following key points were raised:**

| Item | Discussion |
|---|---|
| **Picker Report** | Committee noted the governance and use of the Picker Survey and key themes were noted. Positive feedback was noted for the ED department and children's teams. Plans are in place at divisional level and this will be triangulated against PALs/complaints and assured via CGG/TME/QGC. Committee sought assurance regarding the impact of live data and how this could be used in future and a digitised platform is being considered **Level 4 assurance approved** |
| **CGG Escalations** | The CGG escalation were noted. |
| **Other** | Thanks were expressed to all staff who had responded to the major incident and all were commended. Thanks to Tracey Cooper for the work as DIPC and best wished for her retirement. |

# People & Culture Committee Assurance Report - 29 March 2022

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| Dame Julie Moore – Non-Executive Director | Dame Julie Moore – Non-Executive Director | Rebecca O'Connor<br>Company Secretary |

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

## Executive Summary

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

| Item | Rationale for escalation | Action required by Trust Board |
|---|---|---|
| **People & Culture Strategy 2022-25** | To recommend approval of the strategy | Approval |
| **Freedom to Speak Up (F2SU) Guardian** | To note the issues raised and ensure a direct line from the F2SU Guardian and the Trust Board | To receive the report of the F2SU Guardian |
| **Staff Story** | To recommend Trust Board receive the staff story | To receive the staff story at a future meeting |
| **Terms of Reference** | To recommend approval of the updates | Approval |

**The following levels of assurance were approved:**

| Item | Level of Assurance | Change | BAF Risk |
|---|---|---|---|
| People & Culture Strategy 22-25 | **Level 4** | N/A | 9, 10, 14, 15 |
| Workforce Plan | **Level 4** | N/A | 9 |
| Staff Health & Wellbeing Plan | **Level 4** | N/A | 14 |
| Flexible Working Plan | **Level 5** | N/A | 9 |
| Guardian for Safer Working | **Not reported** | | Not reported |
| Freedom to Speak Up | **Level 6** | N/A | 10 |
| Nurse Staffing | **Level 5** | Maintained | 9 |
| Midwifery Staffing | **Level 4** | Maintained | 9 |
| Terms of Reference | **Level 6** | N/A | N/A |

# People & Culture Committee Assurance Report - 29 March 2022

## Executive Summary

**The Committee met virtually on 29 March and the following key points were raised:**

| Item | Discussion |
|---|---|
| **Staff Story** | Outline of the story was shared regarding international nurses and pastoral support; this will be received at Trust Board. |
| **People & Culture Strategy 22- 25** | The simplified strategy pillars were discussed at length. They had been tested at TME and were linked to the NHS People Promise and BAF risks. Staff will be engaged on the staff offer, 4ward phase two and signature behaviours. Leadership will have a clear framework, linked back to job descriptions, with a package of support including 360 feedback, career development conversations and training in 4ward improvement system. Management structure and accountability framework was discussed. Gaps around band 6 workforce and career progression will be considered alongside the impact on clinical governance. Work is underway in improving staff experience by addressing unfair treatment, implementing guidance for managers and behavioural charter. The collective approach to improving the Trust's culture change journey was discussed. The annual staff survey results showed common with other Trusts, a slight decline. The Trust improvement trajectory aims were outlined and feedback from the quarterly pulse check survey was positive. The lived experience of staff and the importance of recognition and saying thank you was critical in improving culture, retention and wellbeing. |
| **Workforce Plan** | Committee noted the paper which set out the case for change in shifting the reliance on temporary workforce, setting the right sized workforce organised in the right way. The plan moves the Trust from operational workforce management to strategic workforce transformation over a three year plan. Establishment growth was considered in detail; the key strands were endorsed and the paper commended. The approach for managing bank at both Trust and system levels were noted. |
| **Health & Wellbeing Framework** | Committee noted the pin wheel interventions and progress made in addressing the health and wellbeing priorities. Some targets have not been achieved due to Covid, but it was considered the staff wellbeing offer has contributed to the Trust's lower sickness levels. The new framework will focus on seven elements and these collectively create a culture of wellbeing but more progress was required. |
| **Flexible Working Action Plan** | Committee had previously approved the framework and noted progress against plan. The Trust had been awarded Timewise accreditation. The Flexible Working Steering Group is aiming towards level 4/5 maturity, where flexible working is encouraged and supported. Reasons for flexible working outside of childcare and actions to overcome barriers were noted. The importance of meeting patient needs was reiterated and it was confirmed this is part of the framework. |
| **Guardian for Safer Working** | Committee noted the report. Issues regarding some foundation year doctor's self development time were noted, including a lack of national funding for backfill for self development time. Options are under consideration to encourage time away from clinical areas for self development. |
| **Nursing & Midwifery Staffing** | Nursing staff position was noted with assurance level 5. Safe staffing achieved but high acuity was noted and winter incentive utilised. HSW schemes are in progress. Midwifery position of level 4 assurance; absence still above target. Staff deployed to meet acuity. Some issues re red flags but not seen in February. Turnover reduced and fill rates increased. No harm incidents related to the staffing position. |
| **Freedom to Speak Up** | Noted the importance of communicating action taken in respect of poor behaviour as a way of addressing it. The breakdown of the diversity of the F2SU guardians to be shorted with committee. . |
| **Terms of Reference** | Changes were approved and reflected the strategy |

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Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc G1 |

# Nurse staffing report – February 2022

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Paula Gardner, Chief Nursing Officer | | |
| **Presented by** | Jackie Edwards, Deputy 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 | 23 March 2022 | Noted |
| People & Culture | 29 March 2022 | Noted |

| | |
|---|---|
| **Recommendations** | Trust Board are asked to note:<br>• Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout February 2022 has been achieved.<br>• The winter staffing plan which was implemented in November has provided the structure to deploying permanent staff where identified in real time and the incentive measures for the temporary workforce and support of the temporary Clinical Assessment Unit at Worcestershire Royal Hospital.<br>• February has seen a rise in patient acuity and dependency. This has impacted upon the needs for temporary staffing in the areas of urgent care, paediatrics and Covid positive wards.<br>• There were 24 insignificant or minor incidents reported which is a increase from last month.<br>• The key area for targeted recruitment is the urgent care division. Targeted International nurse recruitment will support the urgent care position. |

| | |
|---|---|
| **Executive summary** | This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during February 2022. Maternity staffing is provided as a separate report.<br><br>Staffing of the wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients was achieved through February 2022. However, to note that February has seen a rise in patient acuity and dependency. This has impacted upon the needs for temporary staffing in areas such as urgent care, paediatrics and Covid positive wards. This coupled with 1. COVID and winter related virus affecting staffing absences, |

| | |
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| Meeting | Trust Board |
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| | |
|---|---|
| | 2. long term sickness has impacted upon the health and wellbeing for staff with reports of staff feeling an increased tiredness. |

| **Risk** | | | |
|---|---|---|---|
| **Which key red risks does this report address?** | | **What BAF risk does this report address?** | *BAF risk 9 -If we do not have a sustainable fit for purpose and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.* |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 and short term sickness. | | | | | | | | | | | | | | | | | |

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

## Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for February 2022

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

## Issues and options

**The provision of safe care and treatment**
**Staff support ongoing**

A priority for the trust remains the health and wellbeing of staff as the continued management of the COVID 19 pandemic and experiences of winter 21/22 is in place. Across the Nursing, Midwifery, Health Care Scientists and Allied health professional, all line managers have been made aware of staff support available both internally through HR and occupational health and externally to the trust. There is nursing representation on the Health and wellbeing group. A campaign to raise awareness of the Health and wellness pin wheel for staff to access support has been promoted.

The provision of staff support continues to be a high priority for the teams. There is a Trust wide weekly meeting in place to assess progress with the winter staffing plan and to gain a professional update on health and wellbeing issues at ward/clinical level, led by the CNO/Deputy Chief Nurse. Twice daily trust staffing huddles are in place to ensure safest staffing across the trust.
Roll out of the Professional Nurse Advocate (PNA) training programme and PNA network is in place and restorative supervision offered for staff as required.

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| | |
|---|---|
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**Harms**

There were 24 minor and insignificant patient harms reported for February 2022 over a variety of ward areas.

**Good Governance**

There are twice daily staffing escalation calls to cover last minute sickness and the divisions work together to cover the staffing gaps with last resort escalation to off framework agencies. Demand for short term sickness absence has increased in month. There remains an assurance weekend staffing meeting held each week with the CNO and the monthly NWAG meeting. Also a Weekly winter staffing meeting is held with regards to recruitment and retention and the e-roster capabilities.
A review of Vacancy sickness and maternity will need to be completed in month to review against bank and agency usage.

**Safe Staffing**

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

| Current Trust Position | | | What needs to happen to get us there | Current level of assurance |
|---|---|---|---|---|
| | Day % fill | Night % fill | The current domestic and international pipeline to be reviewed. The increase in RN fill is significant across the COVID areas and the need for additional staffing on these areas.<br>The HCA fill rate on days has increased slightly this month a trust wide advert is in place to fill all the HCA vacancies and support winter planning. | **4** |
| RN | 89% | 97% | | |
| HCA | 86% | 99% | | |

**DATA from Here is for January 2022**

Vacancy trust target is 7% December position for RN 5.28% and HCA 15.11%

| Current Trust Position WTE | What needs to happen to get us there | Current level of assurance |
|---|---|---|

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
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| Division | RN/RM WTE | HCA WTE | | |
|---|---|---|---|---|
| Speciality Medicine | 11 | 14 | Increased RN and RM recruitment to reduce vacancies. Rolling adverts for specialities have been ongoing. Targeted international nurse recruitment is in process for Urgent Care with ED sisters interviewing. HCA recruitment continues following the recruitment drive with HEE and a centralised trust wide advert being launched in October to support winter planning. International nurse recruitment recommenced in August with cohorts of 12 nurses per month. | 5 |
| Urgent Care | 50 | 13 | | |
| Surgery | 15 | 0 | | |
| SCSD | 4 | -21 | | |
| Women's and Children's | 11 RN 13 RM | 30 | | |

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

- Inpatient wards have deployed staff and employed use of bank and agency workers.
- Vacancies numbers has led to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
- Urgent Care is currently carrying the majority of the RN vacancies.

**Recruitment International nurse (IN) recruitment pipeline**

The financial year 2021-2923 has seen the arrival of 132 International nurses into the trust with the last 12 due to arrive in March. The next round of recruitment has already commenced with arrivals planned through from April 2022 to December 2022.

**Domestic nursing and midwifery pipeline**

With the commencement of the grow our own campaign through the Best people programme, September will hopefully see new cohorts of Registered Nurse associates and Registered nurse degree apprentices.

**Bank and Agency Usage**

Trust target is 7%- current usage is Bank 8.63% Agency 7.82%

| Current Trust Position WTE | | | What needs to happen to get us there | Current level of assurance |
|---|---|---|---|---|
| Division WTE | Bank and agency RN | Bank and Agency HCA | In month we have seen a decrease in agency usage and an increase in bank fill. There is also a significant rise in bank usage for RM which has increased significantly since last month | **4** |
| Speciality Medicine | 67 | 61 | | |
| Urgent Care | 86 | 28 | | |
| Surgery | 51 | 45 | | |
| SCSD | 59 | 27 | | |
| Women's and Children's | 15 RN 23 RM | 15 | | |

**Sickness –**

The Trust Target for Sickness is 4%, January position 6.18% stress related 1.47%

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| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
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| Current Trust Position | What needs to happen to get us there | Current Level of Assurance |
|---|---|---|
| <table><tr><th></th><th>Monthly</th><th>Stress related</th></tr><tr><td>Spec Med</td><td>5.51%</td><td>0.95%</td></tr><tr><td>Urgent care</td><td>4.71%</td><td>0.65%</td></tr><tr><td>Surgery</td><td>5.73%</td><td>1.75%</td></tr><tr><td>SCSD</td><td>6.58%</td><td>1.79%</td></tr><tr><td>W & C's</td><td>6.14%</td><td>2.13%</td></tr></table> | Sickness has increased in Divisions in month with an increase in stress related reports. Revisit Communications of support services available. Deep dive required for sickness the main theme is the increase month on month for stress related sickness | **4** |

**Turnover**

Trust target for turnover 11%. January is RN 10.23% RM 14.32%  HCA 15.91%

| Current Trust Position | What needs to happen to get us to there | Current level of Assurance |
|---|---|---|
| <table><tr><th>Division</th><th>RN/RM</th><th>HCA</th></tr><tr><td>Speciality Medicine</td><td>8.3%</td><td>19.34%</td></tr><tr><td>Urgent Care</td><td>11.44%</td><td>16.81%</td></tr><tr><td>Surgery</td><td>10.58%</td><td>11.71%</td></tr><tr><td>SCSD</td><td>10.64%</td><td>14.2%</td></tr><tr><td>Women's and Children's</td><td>RN 10.5% RM 14.32%</td><td>13.8%</td></tr></table> HCA turnover is higher than trust target across all divisions | Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3 – level 7 are available through the apprenticeship Levy. Work being undertaken with NHSEI to develop a recruitment and retention action plan to support HCA recruitment. To have a pool of ready to start HCAs as vacancies arise. | **3** |

## Recommendations

Trust Board are asked to note:

- Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout February 2022 has been achieved.
- The winter staffing plan which was implemented in November has provided the structure to deploying permanent staff where identified in real time and the incentive measures for the temporary workforce and support of the temporary Clinical Assessment Unit at Worcestershire Royal Hospital.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc G1 |

- February has seen a rise in patient acuity and dependency. This has impacted upon the needs for temporary staffing in the areas of urgent care, paediatrics and Covid positive wards.
- There were 24 insignificant or minor incidents reported which is a increase from last month.
  The key area for targeted recruitment is the urgent care division. Targeted International nurse recruitment will support the urgent care position.

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NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc G2 |

# Midwifery Safe Staffing Report February 2022

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Paula Gardner, Chief Nursing Officer | | |
| **Presented by** | Justine Jeffery, Director of Midwifery | **Author /s** | Justine Jeffery, Director of Midwifery |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| Maternity Governance | 18th February 2022 | |
| TME | 23 March 2022 | Noted |
| People & Culture | 29 March 2022 | Noted |

| | |
|---|---|
| **Recommendations** | The Trust Board is asked to note how safe midwifery staffing is monitored and actions taken to mitigate any shortfalls. |

| | |
|---|---|
| **Executive summary** | This report provides a breakdown of the monitoring of maternity staffing in February 2022. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance.<br><br>Safe midwifery staffing is monitored monthly by the following actions:<br><br>• Completion of the Birthrate plus acuity tools<br>• Monitoring the midwife to birth ratio<br>• Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'<br>• Unify data<br>• Daily staff safety huddle<br>• SitRep report & bed meetings<br>• COVID SitRep (re - introduced during COVID 19 wave 2)<br>• Sickness absence and turnover rates<br>• Recruitment/Vacancy Rate<br>• Monthly report to Board<br><br>The birth rate in February was reduced and is reflected in the acuity tool results.<br><br>The escalation policy was enacted to reallocate staff internally as required however the community and continuity teams were not required to support in February. |

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc G2 |

There were ten medication incidents reported resulting in no harm. There were seven no harm staffing incidents reported on Datix which is a noticeable reduction and likely due to the ability to report red flags on the acuity app. The supernummary status of the shift leader was not maintained in February.

There is further support required to embed the acuity app into the ward areas.

Sickness absence rates decreased in February and continue to be higher than the Trusts target at 9.73% across all areas. The directorate continue to work with the HR team to manage sickness absence timely. The rolling turnover rate was noted at 13.93%. Further recruitment events are planned. The vacancy rate is 12%.

The suggested level of assurance for February remains at 4. This is in response to the current sickness and turnover rate. The supernummary status of the shift leader has not been maintained for the duration of February however 1:1 care in labour was achieved. A few delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience.

A return to a higher level of assurance will be offered when the COVID related absence, sickness and turnover rates reduce to previous achieved levels and a reduction in red flag reporting.

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

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

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc G2 |

## Introduction/Background

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

Safe staffing is monitored monthly by the following actions:

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

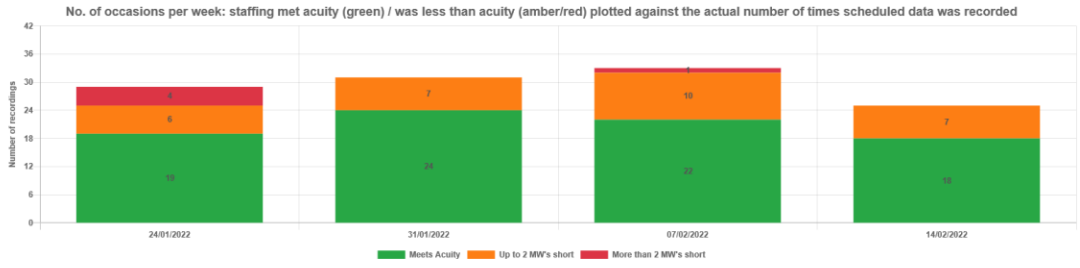
In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The next complete full Birthrate plus audit is currently being undertaken. A review of the draft reported is planned for March 17th 2022.

## Issues and options

***Completion of the Birthrate plus acuity app***

***Delivery Suite***

The acuity app data was completed in 70.2% of the expected intervals and is below the recommended rate and therefore caution should be taken when interpreting the summary of the acuity presented below. The diagram below demonstrates when staffing was met or did not meet the acuity. This indicator is recorded prior to any actions taken.




**Overall during the data period for weeks commencing 24/01/2022**

| | |
|---|---|
| % of recordings where staffing level more than 2 MW's short | 3% |
| % of recordings where staffing level is up to 2 MW's short | 17.9% |
| % of recordings where staffing level meets acuity | 49.4% |
| Data collected for the period covered by this summary provides | 70.2% compliance |

The quality of data has improved following some additional training which had previously

identified over classification of some groups of women. The completion rate has remained static and an improvement is expected in next month's report.

From the information available the acuity was met in 49% (increase 10% from prev month) of the time and recorded at 21% when the acuity was not met prior to any actions taken. The mitigations taken are presented in the diagram below and demonstrate the frequency of when staff are reallocated from other areas of the inpatient service (66%) to mitigate the risk and when staff are unable to take their allocated breaks (23%). The data demonstrates an increase in the frequency of staff deployment to meet acuity and also those unable to take allocated breaks within the delivery suite. The data does also demonstrate a sustained reduction in those staff working beyond their shift and a reduction in the need for on call midwives and/or the continuity teams to support the inpatient services.

**Number & % of Management Actions Taken**
From 31/01/2022 to 28/02/2022

| | | | |
|---|---|---|---|
| MA1 | Redeploy staff internally | 31 | 66% |
| MA2 | Redeploy staff from community | 3 | 6% |
| MA3 | Redeploy staff from training | 0 | 0% |
| MA4 | Staff unable to take allocated breaks | 11 | 23% |
| MA5 | Staff stayed beyond rostered hours | 0 | 0% |
| MA6 | Specialist midwife working clinically | 0 | 0% |
| MA7 | Manager/Matron working clinically | 0 | 0% |
| MA8 | Staff sourced from bank/agency | 0 | 0% |
| MA9 | Utilise on call midwife | 0 | 0% |
| MA10 | Escalate to Manager on call | 2 | 4% |
| MA11 | Maternity Unit on Divert | 0 | 0% |

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

All of the NICE recommended red flags can be reported within the new acuity app. In February the following red flags have been reported:

**Number & % of Red Flags Recorded**
From 31/01/2022 to 28/02/2022

| | | | |
|---|---|---|---|
| RF1 | Delayed or cancelled time critical activity | 2 | 13% |
| RF2 | Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) | 2 | 13% |
| RF3 | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0% |
| RF4 | Delay in providing pain relief | 0 | 0% |
| RF5 | Delay between presentation and triage | 0 | 0% |
| RF6 | Full clinical examination not carried out when presenting in labour | 0 | 0% |
| RF7 | Delay between admission for induction and beginning of process | 5 | 31% |
| RF8 | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) | 0 | 0% |
| RF9 | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0% |
| RF10 | Delivery Suite Co-ordinator is not supernumerary | 7 | 44% |

The labour ward coordinator was not supernummary 100% of the time; it was reported that there were 7 events across the month when this was not maintained. The reporting of this red flag has decreased in month as previously reported on 22 occasions in January. There were no reports that women did not receive 1:1 care in labour which is a sustained improvement for the last two months.

Delays in the IOL pathway continued during February however there was a 50% reduction in reported delays. There was a small increase in the number of other delayed clinical activity.

***Antenatal & Postnatal Wards***

Following feedback from the Birthrate team further support was provided to the inpatient ward teams. Despite this support the data remains incomplete for the antenatal ward (completion rate 33%) and although improved reporting from the postnatal ward the current completion rate is 52%. Based on this rate of completion the data is not reliable and therefore cannot be included in the report.

There was only 1 red flag reported (delay in commencing IOL following admission) on the antenatal ward during February and further delays recorded for those women who were continuing on the induction pathway (14 occasions). No red flags or delays in clinical care were reported on the postnatal ward.

Further support and training will be provided for staff in the ward areas to improve reporting.

***Staffing incidents***

There were seven staffing incidents reported in February via Datix and no harm was recorded. The themes reported this month are

- Cancellation of patient on theatre list due to staffing (1)
- Below expected staffing (5)
- Delay in care (1) – near miss event – concise investigation completed

In February the service reported many fewer absences due to COVID. No harm was reported in this period. Role specific training was supported.

It continues to be acknowledged that any reduction in available staff results in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and concern about staffing levels, burnout and staff health and well – being.

Staff support drop in events have continued throughout February to offer support to staff and to update staff on the current challenges in maternity services due to the ongoing pandemic challenges and seasonal increase sickness rates.

***Medication Incidents***

There were ten medication incidents and no harm was reported.
These incidents were due to:

- Allergy not noted and medication given(1)

- Medication not signed at time of administration (2)
- Clexane not prescribed as clinical assessment incorrectly completed (1)
- Clexane TTOs omitted (2)
- FP10 missing (2)
- Incorrect medication administered (1)
- Repeat vaccination administered (1)

***Unify Data***

The fill rates (actual) presented in the table below reflect the position of all inpatient ward areas. The Birth Centre was reopened in February. The rates reported demonstrate an increase in fill rates for registered midwives and maternity support workers in 3 of the 4 clinical areas – delivery suite saw a reduction in registered staff fill rates.

| | Day RM | Day HCA | Night RM | Night HCA |
|---|---|---|---|---|
| Antenatal Ward | 86 | 77 | 90 | 95 |
| Delivery Suite | 80 | 61 | 77 | 86 |
| Postnatal Ward | 85 | 86 | 91 | 93 |
| Meadow Birth Centre | 79 | 70 | 88 | 71 |

***Monitoring the midwife to birth ratio***

The monthly birth to midwife ratio is recorded on the maternity dashboard. The outcomes are reviewed at the Maternity Governance monthly meeting. The ratio in February was 1:22 (in post) and 1:19 (funded). This is within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit (1:28).

***Daily staff safety huddle***

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

The maternity Unit Bleep Holder and the on call manger continue to join the Trust site meeting twice per day. This has facilitated escalation of any concerns and a greater understanding of the pressures within maternity services. The maternity team have also gained an insight into the challenges currently faced across our hospital services.

***Maternity SitRep***

The maternity team SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and her deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. Further work on the Sitrep is ongoing and the pilot of the regional Sitrep continues.

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

The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing. The frequency of these meetings was increased to three times per week in December due to the challenges experienced and has continued throughout February. This enabled the Divisional team to offer support and timely updates to all of the directorates and enabled timely escalation of concerns. The national COVID SitRep continues to be completed each fortnight and there are no 'red flags' to report from this submission.

***Vacancy***

There are currently 28 unfilled midwifery posts – this equates to a vacancy rate of 12%. Following recent interviews 7 WTE posts have been offered and further interviews are planned in early March.

***Sickness***

Sickness absence rates were reported at 9.73% in February. This is a decrease of 1% in absence and the top two reasons continue to be recorded as viral illness (non COVID) and stress and anxiety.

The following actions remain in place:

- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- A Trust psychologist is working with the team.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Daily walk arounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.
- Launch of the health and wellbeing work stream
- Drop in support sessions available with DoM

***Turnover***

The rolling turnover remains below the Trust target at 13.93%; this is a decrease on last month. The expected 9 WTE midwives joined the Trust in February. Further posts have been offered to student midwives. Further recruitment events for community/continuity posts are planned for March with 8 experienced candidates shortlisted.

***Actions throughout this period:***

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed meeting twice per day
- Non - clinical staff redeployed to clinical rota
- Sitrep report completed three times per day
- Maintained focus on managing sickness absence effectively.

- Agency midwives will continue to end March 2022.
- Ongoing training for the acuity app for wards arranged.
- Further recruitment event planned for March for midwives and maternity care assistants.
- Weekly 'drop- in' sessions led by the DoM continued in month.

## Conclusion

The activity was reduced in February (364 births) and there was an increase in the % of time that acuity was met on delivery suite. To maintain safety staff were reallocated to ensure 1:1 care in labour was maintained.

Agency midwives and non-clinical midwives have provided additional support to all areas of the service.

There were reported delays in care but the number of reports was reduced from previous months. It was also noted that there were occasions when the shift leader was not supernumerary.

There were seven staffing incidents and ten medication errors recorded in February. Deployment of all non-clinical staff was requested to maintain safe staffing however the requirement to request support from community midwifery teams or continuity teams was reduced.

Sickness absence rates have been reported at 9.73% which is a 1% decrease on previous months and is recorded as viral illness (non COVID) and stress and anxiety. It is noted this remains above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively.

Turnover is at 13.93%; a reduction on the previous month. As expected 9 WTE midwives commence in February. The midwifery vacancy rate is 12% and a further 7 posts have been offered.

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

The suggested level of assurance for February remains at 4. This is in response to the current sickness and turnover rate. The supernumerary status of the shift leader has not been maintained for the duration of February however 1:1 care in labour was achieved. A few delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience.

A return to a higher level of assurance will be offered when the COVID related absence, sickness and turnover rates reduce to previous achieved levels and a reduction in red flag reporting.

## Recommendations

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

## Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc H |

# Ockenden Compliance Report February 2022

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Paula Gardner, Chief Nursing Officer | | |
| **Presented by** | Justine Jeffery, Director of Midwifery | **Author /s** | Justine Jeffery, Director of Midwifery |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| Maternity Governance | March 2022 | |
| TME | 23 March 2022 | Noted |
| QGC | 31 March 2022 | Noted |

| | |
|---|---|
| **Recommendations** | To note the current Trust position against the 49 Ockenden recommendations and the actions required to meet full compliance. |

| | |
|---|---|
| **Executive summary** | In December 2020 the Ockenden report was published and the Trust was asked to provide evidence against seven immediate actions – a gap analysis was completed (Appendix 1) and a report submitted to Trust Management Executive.<br><br>In February 2021 the Trust provided further evidence to NHSEI (sharing in excess of 200 documents) and at this time the compliance was noted at 48% (Appendix 2). An action plan was completed (Appendix 3).<br><br>In February 2022 a request was made to all Trusts to submit a further 'deep dive' into the seven immediate actions (Appendix 4) and in addition to this a further request to review all of the 49 recommendations from the Ockenden report and submit a return by 15th April 2022. The Trust is able to demonstrate compliance in 45 of the 49 recommendations (92%) (Appendix 5).<br><br>In 2016 an investigation report into Maternity Services at Morecombe Bay Hospital was published by Bill Kirkup; a request was also made to review a selection of the 'Kirkup' recommendations (Appendix 4). The Trust is able to demonstrate compliance in 17 of the 21 selected recommendations (81%) (Appendix 5). An action plan has been agreed to meet the outstanding recommendations. |

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| | |
|---|---|
| | An external visit by NHSEI, supported by the LMNS to review all of the evidence is expected in May 2022.<br><br>An assurance level of 6 is proposed due to the high level of compliance achieved. A higher level of assurance will be suggested once the service can demonstrate 100% compliance with all of the published recommendations.<br>. |

| **Risk** | | | |
|---|---|---|---|
| **Which key red risks does this report address?** | | **What BAF risk does this report address?** | *2, 4, 9, 10* |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Assurance Level (x)** | 0 | | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | x | 7 | | N/A | | |

| | |
|---|---|
| **Financial Risk** | *State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.* |

| **Action** | | | | | | |
|---|---|---|---|---|---|---|
| **Is there an action plan in place to deliver the desired improvement outcomes?** | Y | x | N | | N/A | |
| **Are the actions identified starting to or are delivering the desired outcomes?** | Y | x | N | | | |
| **If no has the action plan been revised/ enhanced** | Y | | N | | | |
| **Timescales to achieve next level of assurance** | As further investment is required a time cannot be currently agreed. | | | | | |

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| | |
|---|---|
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## Introduction/Background

In December 2020 the Ockenden report was published and the Trust was asked to provide evidence against seven immediate actions – a gap analysis was completed (Appendix 1). In February 2021 the Trust provided further evidence to NHSEI (sharing in excess of 200 documents) and the compliance was noted at 48% (Appendix 2), an action plan (Appendix 3) was agreed and further work has been undertaken over the last six months to improve compliance.

In February 2022 a request was made to all Trusts to submit a further review of the seven immediate actions (Appendix 4) and in addition to this a further request to review all of the 49 recommendations from the Ockenden report and provide a current assessment of the available evidence. In 2016 Bill Kirkup published the findings of a report into maternity services at Morecombe Bay Hospital – a further request to review a selection of recommendations from the Kirkup report has been also been completed (Appendix 5) as part of the request.

## Issues and options

**Ockenden recommendations:**

The service is currently able to provide evidence for 45 of the 49 recommendations (92%).There are four areas where the service has met partial compliance. These are:

1. Sharing maternity training plan funding documents with the LMNS
2. Upgrade the current maternity website and complete an action plan with the MVP to ensure that the website meets the needs of our users
3. Develop an action plan to meet the current RCM Leadership manifesto
4. Publish a local process for the completion, ratification, sharing and implementation of local guidelines

**Kirkup recommendations:**

The service is currently able to provide evidence for 17 of the 21 recommendations (81%).There are four areas where the service has met partial compliance. These are:

1. Review the current induction programme for band 6 midwives
2. Provide specific training opportunities in postnatal care
3. Rotation of all staff to maintain competence in all clinical areas
4. Develop a recruitment & retention strategy

An action plan has been agreed to address the outstanding areas of non-compliance and will be monitored by the directorate via the monthly Maternity Governance meeting.

## Conclusion

The Trust is able to provide evidence to demonstrate compliance in the majority of the Ockenden and selected Kirkup recommendations.

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An action plan has been agreed with the directorate to meet the majority of the recommendations however full compliance with the actions to meet the RCM Leadership manifesto will require further investment in a number of specialist and leadership roles.

An 'insight visit' will be undertaken by NHSEI/LMNS in May to validate the evidence and agree the level of compliance against the current recommendations.

## Recommendations

To note the current Trust position against the 49 Ockenden recommendations and the actions required to meet full compliance.

## Appendices

1. Ockenden report Gap Analysis Decemb
2. Results of evidence Worcestershire_1310
3. Assessment and assurance tool Febru
4. Maternity Deep Dive - Slides for regions to
5. Copy of Ockenden Kirkup Return Templa

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|---|---|
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| Paper number | Enc I |

# Net zero Carbon strategy and Green Development Management Plan 2022-5

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Jo Newton | | |
| **Presented by** | Jo Newton | **Author /s** | **Benjamin Agbasi / Ray Cochrane** |

| **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 |
| CETM | 23/3/22 | |
| TME | 23/3/22 | Recognised statement of intent<br>Recommended explore invest to save<br>Bring back detailed KPIs |
| F&P | 30/3/22 | Noted |

| | |
|---|---|
| **Recommendations** | Board is asked to:<br>1) Note the NHSEI requirement to refresh Trust Green Plans to comply with updated NHS policy and guidance<br>2) Note that the Trust is an outlier in submitting an approved plan (slippage from January due to operational pressures)<br>3) Approve the proposed Green Development Management Plan approach recognising that further detailed work on confirming outputs and KPIs is required<br>4) Recommend that a detailed action Plan is submitted to F&P committee by June 2022 |

| | |
|---|---|
| **Executive summary** | In October 2020, NHS England published a development strategy ("Delivering a 'Net Zero National Health Service") which set two key targets:<br><br>• For the emissions under NHS control directly (the NHS Carbon Footprint), to reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;<br>• For the emissions that NHS can influence (our NHS Carbon Footprint Plus), to reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.<br><br>Consistent with this pledge and in line with other NHSEI trusts have been mandated to submit a refreshed Green Management Development Plan (GDMP) to set out the milestones for the first 3 years of this strategy. |

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Whilst good progress as a Trust has been made, it is acknowledged that operational pressures due to the pandemic and unforeseen capital investment opportunities have hampered development and refresh of our Green Management Development plan. Further development will take place as we reset trust business following the pandemic, including prioritisation of the resource required as part of the 3YP and leadership from the new Director of Estates & Facilities once in post.

Whilst the Plan aligns with the strategic objective 'Best Use of Resources' as part of our 3YP 2022-25, it should be noted that the NHS definition of sustainability is a broad one, encompassing elements of staff wellbeing, for example, which we capture as part of the Best People Programme. The GDMP Steering group will be responsible for ensuring that activities are streamlined and not duplicated. Consistent with the ICS Green Strategy, our GDMP has been developed with a focus on maintaining our core values together with continuing delivery of high quality sustainable patient care services now and into the future.

Board approval of the GDMP will provide a public declaration of our commitment and greater visibility of the work within the Trust. The proposed governance framework will provide oversight and assurance of delivery with the GDMP Steering group reporting into TME and Finance & Performance committee going forward.

Funding for developments represents both a risk and opportunity if the ambition of the plan is to be delivered. Opportunities to bid for national sources of funding are available and we need to position ourselves to bid when these occur. As part of the ICS Green strategy group, we will continue to share ideas and best practice to optimise resource available.

The GDMPn outlines our approach to achieving the objectives, work done to date and proposed deliverable three year themes. This work has been constrained in scope and participation largely by those with personal interest given capacity pressures and the lack of an agreed plan. Outputs and KPIs will need to be updated as part of a detailed action plan to be submitted by June 2022.

Irrespective it is recognised that interest and the opportunity for staff involvement in green issues is high with ecological, social and economic benefits for the patients and communities that we serve.

| **Risk** | | | |
|---|---|---|---|
| **Which key red risks does this report address?** | *2,3,7,9,11, 16,17* | **What BAF risk does this report address?** | *8,14* |

| **Assurance Level (x)** | 0 | 1 | 2 | 3 | x | 4 | 5 | 6 | 7 | N/A |
|---|---|---|---|---|---|---|---|---|---|---|

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| | |
|---|---|
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| | |
|---|---|
| **Financial Risk** | There is potential need for significant financial investment over the life of this plan. No immediate financial investment is required and any such investment will be the subject of separate business cases from internal and external funding sources. No budget currently exists |

| **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** | **June 2022** | | | | | |

## Introduction/Background

This report outlines the Trusts' intended three year approach to commence delivering the Net Zero target as out lined in "Delivering a 'Net Zero National Health Service" strategy report published by NHS England in October 2020.This report sets out clear plan with milestones for the NHS organisations in England to achieving 'the net zero' carbon emissions covering both care delivery (the NHS Carbon footprint) by 2040 and the entire scope of NHS emissions (the NHS Carbon Footprint Plus) by 2045.

Under this report NHS organisations in England are required to update and submit a Trust Board approved Green Management Development plan (GDMP) by January 2022 to the local ICS group for integration into a wider regional Green plan, with a nominated executive level sustainability lead responsible for leading on 'net zero' development actions and the broader greener NHS agenda. The remainder of this report provides an outline summary of our proposed GDMP and seeks that it be approved for submission.

**Why the Green Plan**

The Climate Change Act 2008 placed an obligation on organisations to take actions toward reducing their $CO_2e$ (carbon dioxide equivalent) emissions by 80% by 2050. Following the United Nations Framework Convention on Climate Change (UNFCC) in 2015 Paris Agreement, UK Government revised the target to net zero emissions by 2030 to help address the reported deficit on global emissions reduction targets for managing global temperature rise. NHS England responded by setting the Net Zero targets for NHS organisations and introduces the mandate for NHS organisation to work towards this target.

The importance of sustainable healthcare is reflected within national legislative drivers and mandated sustainability reporting within the public sector. For the NHS this is detailed through the NHS Long Term plan, the NHS Standard contract and aligns with HM Treasury Sustainability Reporting Framework and the NHS Estates Return Information Collection. The Carter Report (2016) highlighted the inefficient use of energy and natural resources as a major concern requiring attention.

The GDMP will supersede our previous sustainable development management strategy and the associated implementation plan from 2014/15. The full benefits realisation of this

agenda is dependent on the uptake and adoption of the principles and approach outlined in the plan and objectives. The full Green Management Development Plan can be found in Appendix 1.

Our overall Green development strategy is underpinned by a four phase development process as outlined in the table below. The focus of interest at this stage is in the first development phase (Preparation phase), to deliver a three-year Trust board level approved GDMP outlining progress made to date and development actions proposals and approach for delivering the emissions reduction targets.

**Our Green Development Implementation Plan Time Line**

| Development Phase | Period | Activity |
|---|---|---|
| **Preparation Phase** | **2022 to 2025** | **Establishing leadership commitment**, and priorities, Learning, understandir scoping, auditing, planning, quick win actions, budgeting, **establishing base line performance and schedule improvement/mitigation actions**. |
| **Transformation Phase** | **2025 to 2032** | Taking transitional actions driven by data from preparation phase based on sound science represent a period of change, **implementation of physical an psychological measures** for emission reduction, efficiency and quality improvement actions producing cost savings. |
| **Innovation Phase** | **2032-2040/45** | **Workforce taking innovative actions** to mitigate hard to deliver emission reduction actions. May involve emission offsetting and significant capital expenditures together with attitude and habitual behavioral transformation |
| **Sustainability Phase** | **Beyond 2045** | Ongoing **monitoring, reporting, control and development measures** to maintain emission reduction, efficiency gains and cost savings delivered to lock in the net zero and sustainable development operating conditions. |

## Issues and options

As the major healthcare services provider and employer in our area, we are a significant consumer of material resource and energy, pollutions emitter and significant contributor to the issue of climate change; our position as a non-renewable natural resource consumer has been exacerbated by the COVID-19 pandemic response. As we reset to business as usual the potential to make meaningful emissions reductions through practicing sustainable development improvement actions supporting nationally set $tCO_2e$ emissions reduction targets can be realised.

**The scale of our organisation**

Our Trust is responsible for providing acute healthcare services for the people of Worcestershire and neighbouring communities. We employ over 6000 staff members with 800 volunteers approximately at any one time. We have a total capacity of approximately

1000 hospital beds serving a community of over 580,000 people with an annual budget of £400 million approximately.

We operate from three main hospital sites:

- namely Worcester Royal Hospital in Worcester City (GIA 46075 m2),
- Alexandra Hospital in Redditch (GIA 36,330 m2) and
- Kidderminster Treatment Centre in Kidderminster (Total GIA 30,193 m2).

The Trust also

- operates from a total gross internal floor area of 2,463 $m^2$ of rented floor space from building assets owned by the Worcestershire Health and Care Trust at Princess of Wales Community Hospital, Bromsgrove; Evesham Community Hospital; Malvern Community Hospital.
- leases a total of 2956 $m^2$ of floor area from building assets owned by Worcestershire City Council at Kings Court Worcester for administrative functions.
- provides floor spaces in its buildings on lease to Worcestershire Health and Care Trust at each of the main hospital sites and work closely in partnership in areas where there is common interest and there is value in the economy of scale.

**The challenge and our achievements to date**

**Use of energy and waste**

- We generate 2,319.50 tonnes of waste annually
- We recycle 187.16 tonnes of our waste
- We recycle all confidential wastepaper and have reduced significantly our waste destined to landfill
- Our waste management group focus group meets regularly to discuss waste management issues and opportunities for developing the service.
- We convert 1,058.50 tonnes of our waste to energy for heating our hospital at Redditch
- We consume 247,485 m3 of water annually
- We use 78,833,030 KWh of energy annually
- Our energy is procured through managed energy contracts by our PFI partner.
- We have a photo voltaic installation on our oncology building
- **Our pharmacy Department** has a focus group working to address sustainability issues relating to package and waste from pharmaceutical produces and will be supporting the trust emissions reduction targets
- **Our medical services Department** are engaged on **actions to reduce waste from the** use of anaesthetic gases, single use medical equipment and personal protection equipment together with reliance on plastic products.
- Some work is also in progress with reduction of single use plastic inhalers

**Travel**

- Our facilities are fully accessible by public transport services, pedestrians and cyclists.
- Each site has good bicycle storage facilities with showering facility for staff using bicycles for work.
- We promote sustainable travel through links with public transports services such as park and ride, and purchasing of low emission vehicles.

- T**he predominant mode of transport to and from our healthcare facilities is by single occupant petrol and diesel vehicles**.
- **Electric vehicle charging points** are very limited on our sites but proposals exist with financial support to address these issues as the technology matures.
- Currently our electricity supply infrastructures are not fully equipped to handle the expected scale of electric vehicle charging points demand without putting our infrastructure at risk.

**Procurement**

**Our procurement department** are working with the NHSEI Sustainable Procurement Team on embedding social value and net zero conditions in procurement terms and contract conditions with services providers and contractors.

**Capital project requirements**

- all new projects are designed and built to achieve BREAM Excellent rating
- all refurbishment building projects to deliver BREAM Very Good rating.
- emphasis on integration of renewable energy technologies and offsetting of emissions from the operational energy requirement where onsite renewable energy resources are insufficient to satisfy operational energy demand.
- Greater emphasis on choice of construction materials and utilisation of sustainable energy technologies for better thermal general power demand performance for net zero operations post construction.
- Use of an environmental impact assessment to consider life cycle cost, embodied carbon emissions, ethical issues, in use carbon emissions in addition to end of life disposal methodology and costs.

**The Impact of the Coronavirus Pandemic**

The pandemic has fundamentally changed the way the NHS operates. The Trust is looking to learn from the experience of the last two years and continue to build on and develop the positive changes in service delivery initiated during the pandemic. An example of this is that some of our outpatient services are now being provided virtually, reducing the risk of cross-infection but also reducing the environmental impact of patients travelling to and from face-to-face consultations.

Trust staff are working from home in much greater numbers and are using Digital technology for meetings and virtual clinical care. This significant change in how we work will reduce the subsequent carbon and particulate matter emissions associated with travel and in some cases estate. It will have impact on the plan for sustainability for years to come and future discussions in relation to the Trust achieving its sustainability goals will include how the benefits of these changes can be maximised.

**Our vision**

We recognise that sustainable development is a critical factor in our organisation being able to deliver high quality healthcare, both now and in the future. We are therefore dedicated to enabling the creation and embedding of sustainable models of care throughout our operations and to making sure that our operations, and our estates, are as efficient, sustainable and resilient as they possibly can be.

We aim:

1. To **deliver high quality care without exhausting resources** or causing environmental damage to **preserve resources for future generations.**

2. To **embed sustainability into the heart of our organisation** and lead on driving working practice towards using resources, like energy and water, more efficiently to reduce wastage. We believe that investing in infrastructure to improve energy and water efficiency will bring about positive environmental impacts and cost savings.

3. To **engage and inspire our colleagues, patients and our population** to take actions that will collectively make a big impact. Reducing energy and water wastage, generating less waste, and travelling actively and sustainably will benefit the environment and improve physical and mental wellbeing.

4. To be an **anchor institution, leading and influencing key partners in sustainable development**. This includes partnering to create master plans for regeneration of the local area and optimisation of sustainability plans through the scale achieved in partnership working.

**GDMP deliverables and benefits**

In line with the requirements of the Climate Change Act and related legal requirements outlined in NHSEI guidance, our GDMP will achieve:

- **Reduction in our environmental impact:** compliance with net zero emissions targets by 2040/45 and legal obligation on pollution emissions and controls from our business activities.
- **Preparedness for climate Change impacts:** prepare our workforce, business partners, patients and other stakeholders for the impacts of climate change with plans in place to deal with events such as heatwaves, flooding and cold snaps.
- **Progress reporting and accountability:** sets the foundation for progress reporting and highlighting at senior management reports on adaptation under the Adaptation Reporting against climate change as set out in the National Adaptation Programme published July 2013 with the latest guides. This is in addition to progress reporting on social value in the context of procurement and service contracts for their notable additional added value contents and greenhouse gas emissions reporting from the supply chains travel and transport together with Trust own services emissions.
- **Work in partnership with local community leadership and ICS:** to develop strong and proactive acute healthcare services strategies within new and existing services that integrate the principles of sustainable development to achieve public health and sustainable development outcomes that will receive reviews and updates to remain relevant in partnership with our local ICS group, business partners and other stakeholders.

- **Embedding sustainability:** advocates decision making processes take account of sustainability in purchasing, investment, operational and strategic decisions, influencing the behaviour of those both inside and outside of our healthcare system.
- **Improved health outcomes:** measurable progress will be made with the implementation of our green development goals and visions against national NHS, Public Health and Social Care Outcomes Frameworks.
- **Reputation and replication:** leading improvements at community levels; great potential exists to truly benefit as an organisation from the changes proposed, and will have the opportunity to carry the experience into other areas.

**Sustainable Development Actions 2022-5**
As detailed on slides 10-19 of the GDMP attached in Appendix 1, areas of focus have been identified to simplify tracking and reporting progress. Each section details our overall commitment, what we have achieved so far and future objectives under the headings of:

- Corporate strategic planning
- Assets Management and utilities
- Travel and logistics
- Adaption
- Capital projects
- Green space and biodiversity
- Sustainable Care Model (including Digital transformation)
- Our People
- Suitable use of resources (including procurement)
- Carbon/ GHG's (Green House Gases)

**Governance**
Development and implementation of the GDMP will be overseen by the GDMP Steering group with a remit to:

- **Develop, deliver and maintain a Board approved GDMP:** including carbon reduction, adaptation plans and actions across the sustainability agenda.
- **Measure, monitor and report progress towards delivering our green actions objectives:** Generate periodic statement of progress and actions on performance with recognisable core standard figures yearly.
- **Evaluation development actions and performance to identify improvement opportunities:** Evaluation, for instance with the Sustainable Development Assessment Self-assessment Tool (SDAT), to ascertain areas of strengths and opportunities for development.
- **Engage staff, service users and the public to participate in tackling improvement actions:** Engagement with public, patients, clients and staff to help understand and support the development of a more sustainable and resilient Trust healthcare services and systems by encouraging Green champions.

Appendix 2 details a draft action tracker which will be reviewed and updated by June 22

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc I |

**Risks**

| Risks | Mitigations |
|---|---|
| Failure to comply with legislation will lead to potential statutory breach and possible enforcement notices by Environmental Agency and /or NHS England | Board approval of GDMP with oversight and assurance from Finance & Performance Committee |
| Failure to implement action plan leads to loss of business continuity due to climate change | Work closely with system partners to mitigate potential impact; regular review of actions; impact assessments |
| Failure to implement action plan leads to increasing economic inefficiency and loss of productivity | Ensure actions embedded into Annual and Divisional plans as business as usual; Adoption benefits realisation approach |
| Failure to implement plan leads to reputational damage with system partners | Regular assurance reporting to ICS and Trust board level support for plan |
| Failure to implement plan undermines staff wellbeing and reputation as a good employer | Develop and implement engagement plan, harness Green champions; pulse survey of staff |
| Lack of capacity and capability resource to realise benefits from plan | Recommend resource requirement and develop business case to support implementation. Seek support from system, regional and national funding |

## Conclusion

As we reset to business as usual the Trust needs to approve and implement a plan to deliver our NHSEI required actions on climate change. Further work will be undertaken to refresh the KPIs and outcomes overseen by the GDMP Steering group. Awareness of the trust's response and engagement with staff and patients will be critical to embedding principles and ways of working if outcomes are to be achieved.

## Recommendations

Board is asked to:

1) Note the NHSEI requirement for refreshed GDMP approval to comply with updated NHS policy
2) Note that the Trust is an outlier in submitting an approved plan (slippage from January due to operational pressures)
3) Endorse the proposed GDMP approach recognising that further detailed work on confirming KPIs is required

## Appendices

Appendix 1 – Green Development Management plan 2022-25 (powerpoint)
Appendix 2 – Draft Green Action Tracker

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc J |

# Terms of Reference

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Robert D Toole | | |
| **Presented by** | Rebecca O'Connor, Company Secretary | **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 | X | Best use of resources | x | Best people | x |

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| TME | 23 March 2022 | Noted |
| Audit & Assurance | 8 March 2022 | Approved |
| People & Culture | 29 March 2022 | Approved |

| | |
|---|---|
| **Recommendations** | Trust Board is asked to approve the updated draft Terms of Reference for Audit & Assurance and People & Culture Committees. |

| | |
|---|---|
| **Executive summary** | The Trust is completing its annual review of Committee terms of reference. This is the first batch of terms of reference for approval. This year's review is also taking into account publications of the appended guidance:<br><br>*Enhancing board oversight: A new approach to non-executive director champion roles*<br><br>A full stocktake of the guidance is underway and this will inform a new schedule of lead NED role responsibilities.<br><br>Meanwhile, as terms of reference are updated, they will each take into account the specific roles referenced in the attached.<br><br>**Audit & Assurance Committee**<br>The following changes are proposed to the terms of reference:<br>• The TOR remain substantively the same and cross reference the Audit Committee Handbook template<br>• References to counter fraud in the new guidance are currently reflected within section 10.5<br>• An additional reference has been made at section 10.4 in relation to oversight of the efficacy of emergency planning, resilience and response arrangements (EPRR)<br>• A new work plan item has been added to reflect this new responsibility |

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
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|---|---|
| | **People & Culture Committee**<br>The following changes are proposed to the duties section of the terms of reference:<br>• The effectiveness of the Trust's OD plan to include leadership, culture, staff offer and engagement.<br>• The implementation and development of the Trust's workforce plan.<br>• The Development and implementation of a workforce education, learning and development plan.<br>• The development and implementation of the Trust's employee health and wellbeing plan.<br>• Establishment of support groups.<br><br>A mapping of the revised lead NED role responsibilities will come to a future Trust Board meeting. |

| **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 | X | 7 | | N/A | | |
| **Financial Risk** | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| **Action** | | | | | | | | | | | | | | | | | | | |
| **Is there an action plan in place to deliver the desired improvement outcomes?** | | | | | | | | | | | | Y | | N | | N/A | | | |
| **Are the actions identified starting to or are delivering the desired outcomes?** | | | | | | | | | | | | Y | | N | | | | | |
| **If no has the action plan been revised/ enhanced** | | | | | | | | | | | | Y | | N | | | | | |
| **Timescales to achieve next level of assurance** | | | | | | | | | | | | | | | | | | | |

Appendices

1. Terms of Reference
2. *Enhancing board oversight: A new approach to non-executive director champion roles*

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 2023~~2~~

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 and the efficacy of emergency planning/EPRR 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~~March 2022

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 2023~~2~~

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
- Head of HR Business Partnership
- 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 Organisational Development (OD) plan to include leadership, culture, staff offer and engagement,
  - ~~the effectiveness of the Trust's Leadership Plan~~
  - the implementation and development ~~effectiveness~~ of the Trust's workforce equality, ~~and~~ diversity and inclusion 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, learning and development plan to ensure the knowledge and skills of the workforce enable continuous improvement in the delivery of services
  - the development and implementation ~~effectiveness~~ of the Trust's employee health and wellbeing plan that minimises sickness absence rates and ensures our colleagues are supported 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 structures~~sub groups ha~~v~~s~~e~~ been established to oversee the effectiveness of the strategy and to ensure that associated plans are implemented within agreed timescales.

a) Inclusion, Diversity, Equality Committee
b) 4ward Steering Group
c) Health and Safety Committee
d) Best People Programme Board
e) Academy Steering Group

6.3 Decision making is escalated to Trust Management Executive with assurance via People & Culture Committee.

## 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 202~~1~~2~~1~~

Worcestershire Acute Hospitals NHS Trust

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc K |

# 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:<br>1. Note the report for assurance |

| | |
|---|---|
| **Executive summary** | This report summarises the business of the Audit and Assurance Committee at its meeting held on 8 March 2022. The following key points are escalated to the Board's attention:<br><br>**1. External Audit and Value for Money (VFM)**<br>Committee received a progress report from the external auditors and an update with regards to progress made regarding the VFM recommendations. It was noted that as last year, a Section 30 report was likely. Regarding VFM, the potential for Section 24 statutory recommendations were discussed and this will be directly linked to the evidence put forward by the Trust. The Section 30 and Section 24 reports are separate. The risk assessment informing the audit was considered and no adverse effect was noted.<br><br>**2. Internal Audit**<br>Committee received a progress update against delivery of the internal audit plan. Audit reports with findings of significant assurance were made with regards to data quality, financial systems and level A assurance for the BAF. Progress and tracking against recommendations was discussed.<br><br>**3. Counter Fraud**<br>Committee received a progress update and reviewed the National Fraud Initiative position. There have been two new low level referrals made and these are being reviewed. |

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|---|---|
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**4. Going Concern**
Committee endorsed the Chief Finance Officer's statement, for approval by the Trust Board, that the Trust is a viable entity and the accounts will be prepared on a going concern basis.

**5. Losses and special payments**
Committee reviewed and scrutinised losses and special payments. The levels of losses are consistent and not of concern. The policy regarding patient losses is to be reviewed by TME in March.

**6. Board Assurance Framework**
Committee received an update on the BAF; the escalating risk in respect of cyber security was noted.

**7. Declarations of Interest**
The revised approach was noted and a full update as to compliance would be reported to the next Committee.

**8. Terms of Reference**
The Terms of Reference were reviewed and endorsed for approval by the Trust Board.

**9. Committee Effectiveness Reviews**
Committee received a presentation from Mr Hopkins to review the effectiveness of the Trust Management Executive and Mr Horwath regarding the Charitable Funds Committee.

The Committee also met as an Auditor Panel and received an update in relation to the recent tender.

| **Risk** | | | |
|---|---|---|---|
| **Which key red risks does this report address?** | | **What BAF risk does this report address?** | *All – Committee's work cross cuts all underpinning BAF 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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Assurance levels Nov 2020

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 7 April 2022 |
| Paper number | Enc L |

# Report of the Trust Management Executive

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Matthew Hopkins<br>Chief Executive | | |
| **Presented by** | Matthew Hopkins<br>Chief Executive | **Author /s** | Rebecca O'Connor,<br>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 |
| | | |

| | |
|---|---|
| **Recommendations** | The Trust Board is requested to receive this report for assurance. |

| | |
|---|---|
| **Executive summary** | This report gives a summary of the items discussed at the Trust Management Executives (TME) held in February and March 2022. Members will see that there is a clear line of sight between the Board, Committees and TME. |

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

# Trust Management Executive Assurance Report – 16 February 2022

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| N/A - Executive | Matthew Hopkins, Chief Executive | Rebecca O'Connor, Company Secretary |

**The Trust Management Executive met virtually on 16 February 2022. The following escalations were made to Board :**

| Item | Rationale for escalation | Action required by Trust Board |
|---|---|---|
| Contract Award: Resmed Non Invasive and Sleep Therapy | For decision | To approve the contract award |
| Going Concern | For decision | To confirm the Trust is a Going Concern |
| Business Cases x3 (Robot, Raystation and ICU DCR Careview) | For review by Finance and Performance Committee and onwards to Trust Board | To consider any recommended business cases for approval |
| Board Assurance Framework | To consider the strategic risks facing the Trust | To review and approve |

**The following levels of assurance were approved:**

| Item | Level of Assurance | Change | BAF Risk | Decision |
|---|---|---|---|---|
| Covid safety in the Workplace | Level 5 | N/A | 14 | Approved for implementation |
| Three Year Plan and 22/23 Planning | Not reported | N/A | 3, 7, 8, 11,17 | Actions to address the position agreed |
| Integrated Performance Report | Level 4 | Maintained | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 | Noted and progressed to QGC, F&P and P&C |
| VRE Screening | Not reported | N/A | 3 | Approved |
| CAU SOP | Level 5 | N/A | 20, 17, 19 | Approved subject to incorporation of learning from pilot |
| Nurse Staffing | Level 5 | Maintained. | 4 | Noted and progressed to P&C |
| Midwifery Staffing | Level 4 | Maintained | 4 | Noted and progressed to P&C |
| Finance Report | Level 3, 4 & 6 | Maintained | 7 and 8 | Noted and progressed to F&P |
| Maternity Services Safety Report | Level 5 | Maintained | 4 | Noted and progressed to QGC |
| Concessionary Parking Policy | Not reported | N/A | 11 | Approved |
| Family Leave Policy & Business Case | Level 6 | N/A | 10 | Approved – to note in F&P reading room |
| Terms of Reference | Level 7 | N/A | All | Approved for Committee review |

# Trust Management Executive Assurance Report – 16 February 2022

**The following assurance items were received via the Reading Room. These proceeded on the basis of executive approval:**

| Item | Level of Assurance | Change | BAF Risk | Decision |
|---|---|---|---|---|
| Updates to benefits realisation of the UTF bid | N/A | Enhanced description of non cash releasing benefits | 16 | Noted |
| Internal Audit: Interim Review of BAF | Level A | N/A internal audit findings | All | To be received by Audit & Assurance Committee |
| Internal Audit Findings: Financial Systems and Payroll | Significant | N/A internal audit findings | 7 | To be received by Audit & Assurance Committee |
| Internal Audit Findings: Data Quality Cancer Waits | Significant | N/A internal audit findings | 16 | To be received by Audit & Assurance Committee |
| Risk Management Group | Level 5 | Maintained | All | Noted |

# Trust Management Executive Assurance Report – 23 March 2022

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| N/A - Executive | Matthew Hopkins, Chief Executive | Rebecca O'Connor, Company Secretary |

**The Trust Management Executive met virtually on 23 March 2022. The following escalations were made to Board :**

| Item | Rationale for escalation | Action required by Trust Board |
|---|---|---|
| 22/23 Planning | To note progress made and escalation to Finance and Performance (F&P) Committee | To note progress in developing the plan and next steps |
| Research and Innovation Strategy | For review by Quality Governance Committee (QGC) and onwards to Trust Board | To consider the recommendation for approval |
| Ockenden Compliance Report | To note compliance with Ockenden recommendations following consideration by QGC | To publically note the level of compliance and assurances provided |

**The following levels of assurance were approved:**

| Item | Level of Assurance | Change | BAF Risk | Decision |
|---|---|---|---|---|
| 22/23 Planning | Level 2 | Maintained | 3, 7, 8, 11,17 | Actions to address the position agreed |
| Green Plan | Level 3 | N/A | 7, 8, 14, 21 | Noted and progressed to F&P |
| Research and Innovation Strategy | Level 5 | N/A | 3, 11, 9, 4, 21 | Noted and progressed to QGC |
| Quality Strategy and Priorities | Level 5 | N/A | 4, 15 | To come back to next TME |
| CQC Strategy | Level 4 | N/A | 4 | Noted and progressed to QGC |
| Integrated Performance Report | Level 4 | Maintained | 2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20 | Noted and progressed to QGC, F&P and P&C |
| Nurse Staffing | Level 5 | Maintained. | 4 | Noted and progressed to P&C |
| Midwifery Staffing | Level 4 | Maintained | 4 | Noted and progressed to P&C |
| Finance Report | Level 3, 4 & 6 | Maintained | 7 and 8 | Noted and progressed to F&P |
| Maternity Services Safety Report | Level 5 | Maintained | 4 | Noted and progressed to QGC |
| Ockenden Compliance Report | Level 6 | N/A | 4 | Noted and progressed to QGC |
| Picker Report | Level 4 | N/A | 2, 4, 11 | Noted and progressed to QGC |
| Policy: Personal Belongings; Transgender, Counter Fraud, Sanctions & Redress | N/A | N/A | 4, 11, 7 | Approved |

# Trust Management Executive Assurance Report – 23 March 2022

**Cont**

| Item | Level of Assurance | Change | BAF Risk | Decision |
|---|---|---|---|---|
| Location by Vocation | Level 4 | Maintained | 9, 14 | Noted progress and extended pilot |
| People and Culture Strategy | Level 4 | N/A | 9, 10, 14, 15 | Escalated to P&C; back to May TME |
| Workforce Report | Level 4 | N/A | 9 | Escalated to P&C |
| Staff Health & Wellbeing Plan | Level 4 | N/A | 14 | Escalated to P&C |
| Flexible Working Plan | Level 5 | N/A | 9 | Escalated to P&C |
| Guardian for safer working | Not reported | N/A | 14, 17 | Escalated to P&C |
| Freedom to Speak Up Report | Level 6 | Maintained | 10 | Escalated to P&C |
| Internal Audit Plan | N/A | N/A | All BAF areas | Escalated to A&A |
| Escalation from CGG | Not reported | N/A | 4 | Noted; Escalated to QGC |
| Terms of Reference | Level 6 | N/A | N/A | Approved for Committee review |

**The following assurance items were received via the Reading Room. These proceeded on the basis of executive approval:**

| Item | Level of Assurance | Change | BAF Risk | Decision |
|---|---|---|---|---|
| Gold Decision Log and Covid Inquiry | Level 6 | N/A | 4, 12 | Noted |
| PAS upgrade position statement | Not Reported | N/A | 16 | Noted |
| RCA for Digital Incidents | Not Reported | N/A | 16, 13 | Noted and escalated to F&P |
| Q3 IPC Report and Covid BAF | Level 4 | Maintained | 4 | Noted and escalated to QGC |
| Cyber Security Update | Not Reported | N/A | 16, 13 | Noted and escalated to A&A |