The Trust submitted a plan which delivered the Faster Diagnosis Standard for Cancer and remains on track to deliver this. This is contingent on the continued insourcing for Dermatology referenced above for skin cancer.

The Trust submitted a plan to deliver against a maximum wait of 65-weeks from referral to treatment by the end of March 2024.

The Trust has made progress in delivering reductions in the number of patients who are waiting over 65-weeks and remains committed to delivering this for our patients. The current position and a revised trajectory are included below, which assumes that a level of insourcing will continue to support General Surgery, ENT, Oral and Maxillofacial Surgery (including orthodontics) and Dermatology. The exact levels of insourcing required and associated run rate are under review with the operational teams and assume that any insourcing will at least be self financing through additional ERF funding sources.

Our Response

Deliver a Break Even position

The Trust is reporting a £18.9m deficit as at Month 7 which is £11.3m adverse to plan.

Statement of comprehensive income	Oct-23 Plan	Oct-23 Actual	Oct-23 Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
	£'000	£'000	£'000	£'000	£'000	£'000
INCOME & EXPENDITURE						
Operating income from patient care activities	54,021	54,911	890	367,037	377,205	10,168
Other operating income	2,552	2,595	43	16,849	18,039	1,190
Employee expenses	(32,350)	(34,868)	(2,519)	(230,814)	(241,062)	(10,248)
Operating expenses excluding employee expenses	(20,700)	(22,994)	(2,294)	(146,796)	(159,281)	(12,485)
OPERATING SURPLUS / (DEFICIT)	**3,524**	**(356)**	**(3,880)**	**6,276**	**(5,099)**	**(11,374)**
FINANCE COSTS						
Finance income	40	130	90	580	775	195
Finance expense	(1,280)	(1,278)	2	(8,960)	(8,952)	8
PDC dividends payable/refundable	(803)	(839)	(36)	(5,621)	(5,619)	2
NET FINANCE COSTS	**(2,043)**	**(1,987)**	**56**	**(14,001)**	**(13,797)**	**204**
Other gains/(losses) including disposal of assets	0	0	0	0	(2)	(2)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**1,481**	**(2,343)**	**(3,824)**	**(7,725)**	**(18,897)**	**(11,172)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**1,481**	**(2,343)**	**(3,824)**	**(7,725)**	**(18,897)**	**(11,172)**
Remove capital donations/grants I&E impact	10	11	1	70	38	(32)
Adjusted financial performance surplus/(deficit)	**1,491**	**(2,332)**	**(3,823)**	**(7,655)**	**(18,859)**	**(11,204)**
Less gains on disposal of assets	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**1,491**	**(2,332)**	**(3,823)**	**(7,655)**	**(18,859)**	**(11,204)**

Welcome
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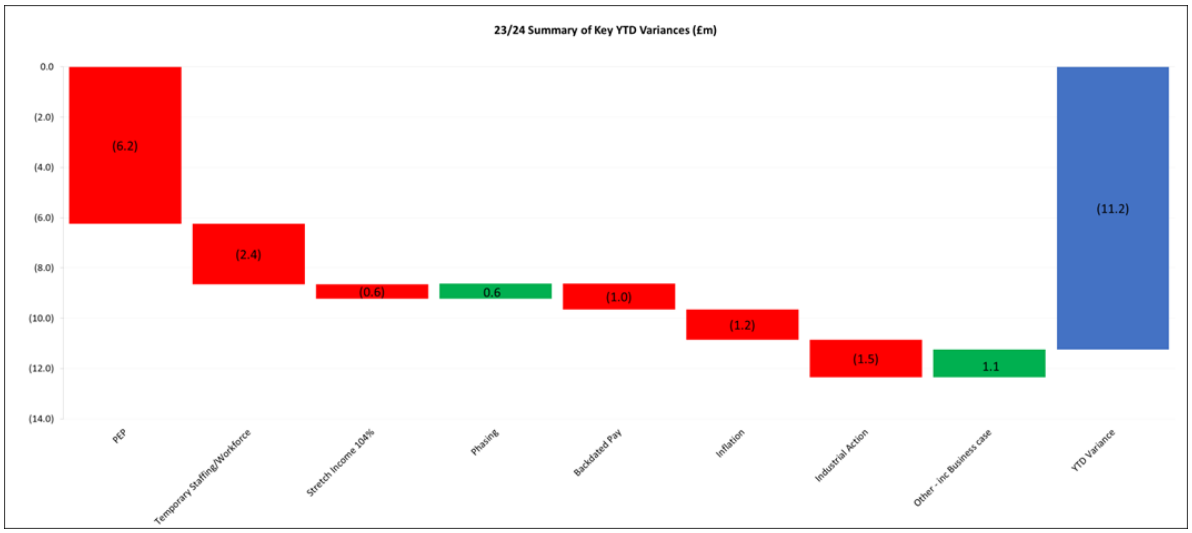
Key drivers of the variance are as follows:



Additional Funding Received since month 7 reported position:

Industrial Action

As detailed above to cover the costs of industrial action to date £800m has been agreed nationally with each system receiving an allocation. The Herefordshire and Worcestershire ICB allocation is £7m shared, Wye Vale Trust £2m and Worcestershire Acute Trust £5m.

Elective Recovery Fund Recalculation

The elective activity target for 2023/24 has been reduced to a national average of 103% of 2019/20 activity (with a floor of 100%), which will now be maintained for the remainder of the financial year. The target had previously been reduced from 107% to 105% to reflect the impact of industrial action up to April 2023. As with the adjustment for April, 2% will be paid as part of fixed payment rather than earnable through activity-based payments. Worcestershire Acute Hospitals target was 103% at the beginning of the year, and has subsequently been reduced to 100% following 2 successive 2% adjustments to the 100% floor. The latest resulting in £2.3m of additional income from a shift of variable to block income over that assumed at month 7.

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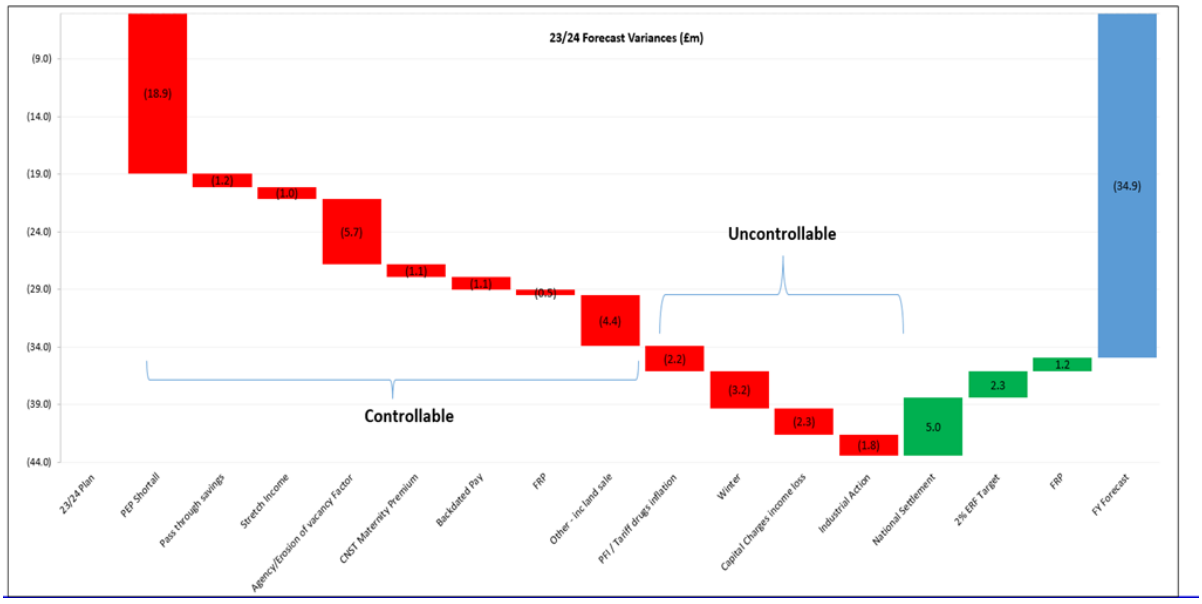
Winter Funding

The winter bids submitted in September has provided additional funding to the Trust of £1.9m of which £1.1m was already included in the plan for the Pathway Discharge Unit (PDU). There is therefore £0.8m of additional funded schemes contributing to delivery of winter capacity in the plan.

Given the significant challenges that continue to be experienced with the move over to the new UEC a number of further unfunded schemes have been put forward including the cost of recommissioning the 2 moth balled wards (1 on each acute site) to provide an additional 40 beds at a cost of £2.1m. Further initiatives have been put forward by the Operational team to manage patient safety over winter leading to a further £0.5m adverse impact on the run rate. The table below provides the list of schemes for approval. Total investment in winter schemes is £4.2m of which £2.5m is not presently funded and therefore will be adverse to existing run rate.

Forecast

The bridge from the month 7 forecast below shows the resultant impact of the additional income and expenditure on the forecast out turn position.



Fully worked up Efficiency Plans

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The expectation from NHSE is that we will have fully worked up efficiency plans, the submission requires us to provide an updated efficiency delivery forecast. Our original plan included an efficiency target of £28m (4.2%) including a late adjustment of £4m of stretch to be worked on jointly with the ICB that has not come to fruition.

The month 7 forecast includes £9.1m of efficiency savings, a shortfall of £18.9m. Work continues with the Executive Senior Responsible Officers (SROs) to drive forward efficiency plans however some of the opportunity identified by the SCW CSU has fallen away and some is proving harder to extract than anticipated leading to slippage on plans.

A Turnaround Director was appointed on 1st November and is working on a plan for recovery to a progressively lower run rate at year end to commence 2024/25 in a better position. We have also commissioned additional support from the Foundation Group Consultancy arm to support a line by line review of budgets with managers and a review of the PFI contract. Both these initiatives are expected to bear fruit before the end of the financial year. However, we need to be cautious on making a firm commitment on a target level of reduction until a firm assessment of the savings opportunity and ease of extraction has been made given we have been challenged with delivery of the current PEP opportunity.

An elective plan that is refocused on driving productivity from core capacity

We are required to deliver an elective plan that is refocused on driving productivity from core capacity rather than insourcing / outsourcing to deliver the priorities of reducing longest waits, treating urgent elective cases, and maintaining and achieving cancer standards. The Trust has spent over £10m year to date on insourcing and outsourcing contracts and is projecting a further £5m before year end. Some of these contracts have yet to be approved. However, these are in challenged service areas and would therefore impact on performance standards. Work is under way to review all insourcing and outsourcing contracts to improve the run rate.

An assessment of a scenario of further strike action

Industrial Action

We have been asked to model and report the financial risk in a scenario where industrial action continues for the remainder of the year, the assumption is there is no further strike action for November, and for December to March assume both consultants and junior doctors hold strikes 3 days per month, around the middle of the month, and at the same time. Our modelled financial impact of this is £1.3m and this would be a financial risk to our forecast.

Approach to management of the revised trajectory to year end

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Management of the financial run rate and the operational performance standards expected by NHSE for the remainder of the year will be key. The further investment in winter pressures and insourcing to support delivery of long waits and cancer standards must be linked to management of an agreed run rate trajectory.

Work is progressing with Divisions to identify the key performance metrics that we will track daily / weekly to monitor how work is progressing to achieve the overall standards expected above. This work will be finalised once the Trust's submission has been signed off with NHSE and Divisional targets set accordingly and monitored through the Financial Recovery Board with assurance to Board.

Risks

Acceptance by NHSE of the revised projections: We are not compliant with the requirements laid out in the letter from NHSE. There is therefore a risk that we may fall foul of additional external intervention limiting our flexibility to operate independently.

Industrial Action: The operational and financial projections assume, in line with the national ask for this exercise, that there will be no further impact of industrial action over the period to March 2024. In the event that industrial action was to continue, this would be a significant financial risk to the forecast in direct cost and lost activity / ERF.

Winter period: There is a risk to managing spend in line with forecast levels, with a risk to elective activity and ERF in the event of significant pressure. We are already experiencing high demand impacting on long waits in A&E and ambulance handover delays.

Efficiency: Historically, management of continued and excessive winter pressures has led to a lack of capacity within Divisional Leadership to focus on efficiency and improvement.

Underlying Position: The majority of the mitigations identified will be non-recurrent in nature and provide very little benefit to the underlying deficit position as we exit the current financial year.

Cash: As reported to, and approved by Board previously, the in-year deficit plan resulted in a requirement to access revenue cash support to meet obligations and cash flow mitigations are being proactively managed. An application for revenue support in December is currently with the national team for decision. The projected adverse variance to plan will result in a further risk to the cash flow position.

Planning for 2024/25 and the medium term: The focus on in year delivery will reduce capacity within the Trust to focus on the 2024/25 operational planning process and medium term planning. However, embedding operational improvements and reducing the £ run rate as low as possible by the end of the year will serve to provide a better baseline on which to plan. Plans for 2024/25 should therefore be focussed on fewer priorities aligned to the 10 point plan.

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Meeting	Public Trust Board
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Recommendation

The Board is asked to endorse the report and note the risks and assumptions made for the two-week exercise, across operational performance metrics and the financial forecast recognising the further work progressing with Divisions to secure delivery of the revised trajectories.

The Board should note that the revised trajectories are not compliant with the requirements of the attached letter from NHSE for the following reasons:

- Break even financial plan - we are reporting a £34.9m variance to plan.
- A&E 4hour standard of 76% - we are projecting recovery to 73%.

A plan for Financial and Operational Recovery will be brought back to the next Board meeting.

Wells Jo
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To:
- ICB and Trust:
  - Chief executives
  - Chief finance officers
  - Chief operating officers

cc.
- ICB and Trust:
  - Chairs
  - Chief Nurses
  - Medical Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

8 November 2023

Dear colleague

Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

We are writing to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

As a result of these pressures, for the remainder of the financial year our agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

In response, we are asking systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year.

Financial pressures in 2023/24

We asked you to set ambitious plans for 2023/24 in the context of NHS funding increasing in real terms between 2019/20 and 2023/24 to over £160bn, recognising the actions you have had to take to deal with a range of significant new pressures.

Plans were set on the basis that there would not be significant ongoing industrial action. Despite 10 months of strikes, the NHS has made progress on the delivery of the UEC, primary care access and elective recovery plans, while also displaying professionalism in planning for and managing periods of action. The strikes have nonetheless had a significant impact on patients and staff.

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The impact of the more than 40 days of industrial action this financial year has created unavoidable financial costs that we estimate to be around £1 billion, with an equivalent loss of elective activity.

National action

To cover the costs of industrial action to date we are taking the following actions which have been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.

- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Discontinuing the application of holdback to the Elective Recovery Fund (ERF) for the rest of the year and formally allocating systems their full ERF funding.

Actions for ICBs and Trusts

We are asking ICBs and providers, by 22 November, to agree the steps required to live within their re-baselined system allocation and reflecting the impact of the reduced elective activity goal. Plans should be based on a scenario where there are no further junior doctor or consultant strikes.

The foundation of this reset should be protecting patient safety, including in maternity and neonatal care, and prioritising UEC so that patients receive the best possible care this winter. Progress on existing commitments on elective and primary care recovery programmes, as well as other goals, should build on that foundation.

Actions to deliver UEC performance should include the agreed investments in capacity – including beds and ambulance services – as well as other components of UEC plans, including admissions avoidance and discharge schemes. Following the additional funding and changes to the ERF threshold, these are expected to be fully implemented without further delay.

The primary focus for elective activity should be on long waits and patients with urgent care and cancer needs, including reducing the cancer backlog. Primary care plans should protect improvements in access.

In showing how you will deliver financial balance you will need to show:

- you have fully worked up efficiency plans, including the reductions in agency staffing set out at the start of the year;

- where you require flexibility on programme funding;

Wells Jo
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- an elective plan that is refocused on driving productivity from core capacity, identifying the insourcing/outsourcing and waiting list initiatives you still consider necessary within a balanced financial plan focused on the longest waits, urgent elective, and cancer care.

Returns should identify the total activity you forecast to do and the implications of any changes on the trajectory to the March 2024 65ww target, including how maintaining existing patient choice, tiering and the GIRFT programme can all support delivery (including on inpatient length of stay, day case rates and capped theatre utilisation).

The current pause in strike action is a positive step. However, it will be important to understand the alternative, and so your plans should also include an assessment of a scenario where the junior doctor and consultant strikes continue in a pattern consistent with the last four months and how those costs can be minimised as far as possible. In this scenario the focus should be on what steps you would take to minimise additional costs.

Next steps

Following yesterday's webinar with ICB and provider CEOs and Directors of Finance, we are holding a further session this afternoon with Directors of Finance.

We will schedule sessions for each individual ICB Executive and their provider colleagues from 27 November to agree proposed actions.

We know how hard you have been working to maintain progress on implementing the recovery plans for elective care, urgent and emergency care, and primary care – as well as wider Covid recovery and priority transformation programmes – in the face of extraordinary pressures from prolonged industrial action.

We hope that this letter provides the clarity you have been seeking to now enact, along with system partners, those actions necessary to balance these financial challenges with your wider responsibilities.

Yours sincerely,




Julian Kelly
Chief Financial Officer
NHS England

Dame Emily Lawson, DBE
Interim Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer, England

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Worcestershire Acute Hospitals NHS Trust

Acute -RWP
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

NHS England

The trust board confirms its commitment to:	Confirmation (Y/N)	If not confirmed, provide a brief explanation including the basis for a revised proposed plan	Actuals		Plans				
			Period	Value	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Headline objectives									
The 4 hour system A&E performance as described in the winter plan	N	The Trust has been challenged in its delivery aga	Sep-23	64.4%	72.4%	71.3%	70.8%	71.0%	76.2%
The March 2024 cancer 62 day backlog position set out in the 2023/24 operational plan	Y		Sep-23	321					190
The March 2024 cancer Faster Diagnosis Standard performance set out in the 2023/24 operational plan	Y		Aug-23	72.8%					75.6%
Key enablers									
Core G&A bed capacity growth committed to within the winter plan	Y		Sep-23	793	765	765	765	765	765
Escalation capacity committed to within the winter plan	Y	A further 40 G&A beds will be opened			0	0	0	0	0
An ambulance handover average delay trajectory, that is consistent with the overall system-level trajectory, has been agreed by the trust Board	Y								
Discharge									
A discharge ready date metric was published for the Trust in November, and the trust Board is regularly reviewing this metric as part of a performance dashboard to drive improvement	N	The discharge ready date metric was published in 9 November 2023. The Trust is currently reviewing the Integrated Performance Report which goes to the Trust board. The Discharge Ready Date metric will be included from December							
OR									
A discharge ready date metric was not published for the Trust in November, and the trust Board has confirmed the date of expected publication (this should be pre-March 2024)	N/A								

Sign off	
The return must be signed off by the trust Chair and CEO on behalf of the trust board. In signing off the return the trust Chair and CEO are providing assurance that the trust Board has considered the quality impact assessment of plans and assured itself of appropriate clinical involvement in decision making.	
Approved by the trust Chair	
Name:	
Date:	
Approved by the trust CEO	
Name:	
Date:	

Wells Jo
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NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Patient safety Incident Response Plan 2023/2024

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

Accountable Director	Sarah Shingler: Chief Nursing Officer		
Presented by	Allan Bailey	**Author /s**	Allan Bailey Associate Director Clinical Governance, Safety & Risk.

Alignment to the Trust's strategic objectives							
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
Trust Board	21.12.2023	
Quality Governance Committee	26.10.2023	Approved with recommendation to Trust Board
Trust Management Executive	18.10.2023	Approved
Clinical Governance Group	05.09.2023	Agreed for submission to TME & QGC and onward to Board for sign off.
PSIRF Implementation Committee	31.08.2023	Agreed for submission to CGG

Recommendations	The Chief Nursing Officer requests that the Board of Directors: 1. **Note** the content of the report and the oversight responsibilities required of Board members; 2. **Note** the formal adoption of the new framework from the 1 January 2024**;** 3. **Approve** the Patient Safety Incident Response Plan 2023/2024; 4. **Approve** the request to submit to the Integrated Care Board for final approval.
Executive Summary:	The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement of the NHS Serious Incident Framework. This Patient Safety Incident Response Plan (PSIRP) sets out how Worcestershire Acute Hospitals NHS Trust (WAHT) will seek to

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learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. Refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues;
b. Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents;
c. Transferring the emphasis from the quantity of serious incident investigations to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents;
d. Demonstrating the added value from the above approach.

This Patient Safety Incident Response Plan (PSIRP) sets out how Worcester Acute Hospital Trust (WAHT) intends to respond to patient safety events over a 12-month period, however, the plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

One of the underpinning principles of PSIRF is to carry out fewer 'investigations' but make them better. Better means taking the time to conduct systems-based learning responses by people that have been trained to do them. The PSIRP (Appendix 1) will describe how it all works, including, Nationally mandated PSII, changes to divisional incident responses, and enhanced governance arrangements. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for healthcare organisations.

What this means for us: This plan has been in production since May 2022 and has responded to ever changing National guidance. This plan aligns closely with the implementation of the Learning from Patient Safety Events (LFPSE), with a National implementation target of Autumn 2023. The plan details the

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	historic approach to Serious Incident investigation and has used thematic review analysis across the Trust incident reporting systems to determine our high risk areas and those areas that have the most potential for additional learning, utilising the new Patient Safety Incident Response Framework (PSIRF). This plan has been developed by the Patient Safety Team (PST) in collaboration with Governance leads, the ICS and subject matter experts across the trust. The plan has been agreed in principle with our ICS colleagues and should now follow the natural governance path for board sign off. Final sign off will be made by the ICS, prior to the document being made available to the public. In agreement with the ICS, the Trust has been using the PSIRF methodology since October 2023 in shadow form reporting into the Serious Incident Reporting and Learning Group. The Trust proposes to make the formal move to using the new framework and ceasing reporting on the old framework from the 1 January 2024.

Appendix:

1. Patient Safety Incident Response Plan 2023/2024;

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Worcester Acute Hospitals NHS Trust

Patient safety incident response plan 2023/24

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Contents

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Foreword

There have been many previous NHS initiatives designed to reduce harm, improve patient safety, and improve incident reporting, all with variable impacts on the safety and involvement of our patients. The Patient Safety Incident Response Framework (PSIRF) is a whole system change to how we think and respond when an incident happens to prevent recurrence. However, PSIRF is not a tweak or adaptation of what came before.

Previous frameworks have described when and how to investigate a serious incident, whilst the PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to but outside of that, it is up to us.

When asked “why do we investigate incidents?” the common response is to learn, but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that. How often is the answer to what did we do about an incident “we investigated it”? The question often asked is “how much has demonstrably changed/improved in 20 years using these methods?”

Worcestershire Acute Hospital Trust is embarking on a journey that will see fundamental changes made to the way that we review, respond to and investigate patient safety incidents.

We are developing systems in collaboration with our patient safety partners and staff to establish a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved.

It is important that we recognise that there are good reasons to carry out an investigation:

- Sharing findings
- Speaking with those involved
- Validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation.

Our approach acknowledges the importance of organisational culture and what it feels like to be involved in a patient safety incident.

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We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak. PSIRF is a core component in continuing this journey, ensuring we create a safe culture where people are confident to talk about patient safety events and to simply express their opinion.

We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF. We will talk, respond, and adapt as and when our approach is not achieving what we set out to achieve.

Allan Bailey

Associate Director of Clinical Governance, Patient Safety
And Risk

Wells Jo
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1. Purpose, scope, aims and objectives

1.1 Purpose

1.1.1 This Patient Safety Incident Response Plan (PSIRP) sets out how Worcestershire Acute Hospitals NHS Trust (WAHT) will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

1.1.2 This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. Refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues;

b. Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents;

c. Transferring the emphasis from the quantity of serious incident investigations to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents;

d. Demonstrating the added value from the above approach.

1.2 Scope

1.2.1 A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

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1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.3 Strategic aims

1.3.1 Improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it.

1.3.2 Further develop systems of care to continually improve their quality and efficiency.

1.3.3 Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

1.3.4 Improve the use of valuable healthcare resources.

1.3.5 Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

1.4 Strategic objectives

1.4.1 Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

1.4.2 Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents.

1.4.3 Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigor, expertise and efficacy.

1.4.4 Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- Engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors.

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[1] A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.

2. Situational analysis – national

2.1.1 Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

2.1.2 When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

2.1.3 Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

a. Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident. As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[2]

b. There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.[20]

2.1.4 An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations, are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become

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[2] Vincent C, Adams S, Chapman A et al (1999) *A protocol for the investigation and analysis of clinical incidents*.

inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[3,4,5,6,7]

2.1.5 In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (e.g. professional conduct or fitness to practise; establishing liability or avoid ability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

2.1.6 Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (e.g. the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

2.1.7 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (e.g. mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. Improving the quality of future PSIIs;
b. Conducting PSIIs purely from a patient safety perspective;
c. Reducing the number of PSIIs into the same type of incident;
d. Aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

2.1.8 This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

[3] Public Administration Select Committee (2015) *Investigating clinical incidents in the NHS. Sixth report of session 2014–15*.
[4] Parliamentary and Health Service Ombudsman (2015) *A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*.
[5] Care Quality Commission (2016) *Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*.
[6] NHS Improvement (2018) *The future of NHS patient safety investigation*.
[7] NHS Improvement (2018) *The future of NHS patient safety investigation: engagement feedback*.

a. Being explored and addressed as a priority in current PSII work or
b. The subject of current improvement work that can be shown to result in progress or
c. Listed for PSII work to be scheduled in the future.

2.1.9 In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

2.1.10 As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

a. Professional conduct/competence – referred to human resource teams
b. Establishing liability/avoid ability – referred to claims or legal teams
c. Cause of death – referred to the coroner's office
d. Criminal – referred to the police.

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3. Situational analysis – local

3.1 Results of a review of activity and resources

We are reviewing our local system to understand the people who are involved in patient safety activities across WAHT, as well as the systems and mechanisms that support us. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

WAHT is a complex system with many interrelated components that are crucial to ensuring that everything works.

There are 5 clinical divisions consisting of:

- Women and Children
- Urgent Care
- Speciality Medicine
- Surgery
- Specialised Clinical Services (SCSD)

Each clinical division has a dedicated governance function, supported by the central Patient Safety team.

Core patient safety activities undertaken at WAHT:

- NHS Patient Safety Strategy
- Audit programmes (Local and National)
- National quality improvement Programmes
- Path to Platinum ward accreditation scheme
- Patient Safety Culture
- Patient Safety Specialists
- Patient Safety Partners
- Risk Management
- Central Alert System (CAS)

Other activities within the Trust that provide patient safety include:

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- Structured Judgement Reviews,
- Learning from Deaths,
- Complaints and feedback, and
- Inquest responses.

The operational 'work-as-done' for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed withassistance from their respective Divisional Governance colleagues, who are supported through strategic, educational andsubject matter expert provision flowing from the Corporate Directorates.

This emergent system is being built to fit and respond to the size of our Trust and the nuances of the teams, services and structures we work in. This involves key people and teams within WAHT, who are integral in facilitating our patient safety system and the continued improvement of our patient safety culture, on our journey to implementing PSIRF.

System overview: "Our current Patient Safety Networks"

3.1.1 Patient safety incident investigation (PSII) activity: April 2019 to March 2023:

	2019-20	2020-21	2022-23	Ave
Never Events	5	2	4	4
Serious Incident investigations (i.e. StEIS reportable and including IMRs submitted to DHR, SCR etc.)	66	202	118	128
'Coroner-initiated' patient safety investigations	7	14	92	38
Patient/Family/Carer formal complaint-linked patient safety investigations	30	35	145	70

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	2019-20	2020-21	2022-23	Ave
Other PSIIs (INTERNAL / comprehensive investigations)	47	85	25	157
TOTAL patient safety (clinical) incidents	11987	18377	17065	15809
Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/PHE, etc.) for independent PSII	28	40	2	23

3.2 Service concerns Patient Safety Service Concerns Report
Quarter 4, 2021-22 – Quarter 1, 2022-23

Worcestershire Royal Hospital	Alexandra Hospital	Kidderminster treatment Centre	Offsite
71	39	1	4

116 service concerns were reported as minor harm

Themes

Discharge Issue, Pathways, Letters/EDS, Medicines management and Patient experience were the highest reported service concern for the 6-month period,

- Discharge Issue **(20),** related to Poor discharge planning, Inadequate follow up arrangements, missing medical paperwork, Missing electronic discharge summaries and Discharge without assessment.
- Pathways **(17),** related to Delayed/Refused access to service, Delayed/Missed diagnosis, Inadequate follow up/Delayed test results, Wrong pathway, Wrong diagnosis.
- Letters/EDS **(24),** related to Accuracy, Medication errors, Timeliness and not sent/received/missing.
- Patient Transfer (11)
- Patient Experience **(10),** all related to Quality of Care.

3.3 Conclusions from review of the local patient safety incident profile

3.3.1 The current top10 locally reported clinical incident categories for PSII 2022-23 are:

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	Incident category
1	Tissue viability
2	Bed management

	Incident category
3	Medication issue
4	Patient slip/trip
5	Cancellation/Delay
6	Non Adherence to standards
7	Infection control
8	Admission/Discharge/Transfer issue
9	Staffing issue
10	Mental Health / DoLS Issue

3.4 Gap analysis

3.4.1 We have referred to the national PSII standards to identify gaps in dedicated PSII personnel, seniority, PSII skills, etc. to enable delivery of the potential PSII programme; that is:

a. National priorities:

- Never Events
- 'Learning from Deaths'-related incidents (identified via structured judgement review to be more likely than not due to problems in care)
- unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.

b. Local priorities identified in 3.3.1 above.

c. Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

3.5 Strategic plan

3.5.1 Using the following steps, we have developed a strategic plan to address the above findings. We will;

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a. Plan consultation work with commissioners and other stakeholders, including patient and staff groups, to review and develop a prioritisation plan for local PSIIs.

b. Develop a prioritised register of patient safety incident types by identifying and ranking them according to the risk they present locally (severity, likelihood, concern, cost etc.) and the opportunity they present for new knowledge and improvement. Use the register as an active document.

c. Acknowledge that, wherever available, PSII findings and analysis from more than one similar incident provides an opportunity to identify common causal factors by cross-referencing and corroborating them. Robust thematic analysis can be achieved by selecting a few very recent and typically similar incidents and investigating each one individually with skill and detail to determine the causal factors that effective improvements can be designed to address. PSII of recent rather than historical incidents allow information gathering and analysis of the system as it currently is.

d. From the gap analysis, identify how many good quality PSII can be conducted each year.

e. Agree the number of PSIIs to be conducted for each very similar, prioritised incident-type, (three to six is suggested).

f. Divide the number of good quality PSIIs currently able to be conducted per year – (in (d) above), by the number of PSIIs to be conducted for each very similar, prioritised incident- type selected (in (e) above).

g. Subtract the anticipated number of 'national priority' PSIIs, to identify the number of incident types from the top priorities register that can be addressed during the period of the plan.

g. Declare the register of incident types to be investigated over the period of the plan, ensuring each type has a narrowly defined focus.

h. Declare the number of each of these incident types and the total number of PSIIs planned for the period of the plan.

I. Agree a means of selecting each of the top-ranking incidents (e.g. the first five or every 10th incident) to ensure the following criteria are met:

- Conduct up to five exemplar PSIIs for each incident type agreed in the plan
- Select very similar incident types to make up each set of five patient safety incidents for PSII
- Select a range of severity levels for each set of five incidents.

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j. Agree interventions for incidents that fall outside the PSII plan but require action or new insight, e.g.:

- incident report or timelines (for Duty of Candour disclosure)

- structured judgement review (to identify whether they are issues of concern)
- after-action review (for rapid local team review)
- audit (to measure/monitor compliance against policy/guidance)
- HR investigations (for concerns about individual competency/performance)
- Legal investigations (for concerns surrounding liability, avoid ability, etc.).

k. Document the data review process and rationale for prioritisation of local PSIIs.

l. Complete the PSIRP document together with stakeholders and agree it with them.

m. Publish a summary PSIRP on our website.

n. Plan activity for the immediate future based on the above plan.

o. Develop and implement plans to:

- address any shortfall identified in capacity and capability
- meet requirements of the PSIRF and PSII standards
- Maintain capacity and capability to sustain the meeting of these requirements.

3.5.2 For each comprehensive PSII: We will;

a. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8 and has received a minimum of two days' training.

b. Refer to training and the national PSII standards and conduct PSIIs as per the plan and in line with national good practice for PSII.

c. Use the national standard template to report the findings of the PSIIs.

d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

3.5.3 For each group of PSIIs dedicated to a similar/narrow focus incident type: We will;

a. Design strong/effective improvements to sustainably address common interconnected causal factors.

b. Develop an action plan for implementation of the planned improvements.

c. Monitor implementation of the improvements.

d. Monitor effectiveness of the improvements over time.

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3.5.4 Monitor the quality of PSII findings and progress against this PSIRP:

a. Are the actions likely to achieve improvement?
b. Is there evidence of improvement?

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4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1 PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.1.2 There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

4.1.3 There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

4.2 Selection of patient safety incidents for PSII

4.2.1 In view of the above, the selection of incidents for PSII is based on the:

a. actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)
b. likelihood of recurrence (including scale, scope and spread)
c. potential for new learning in terms of:

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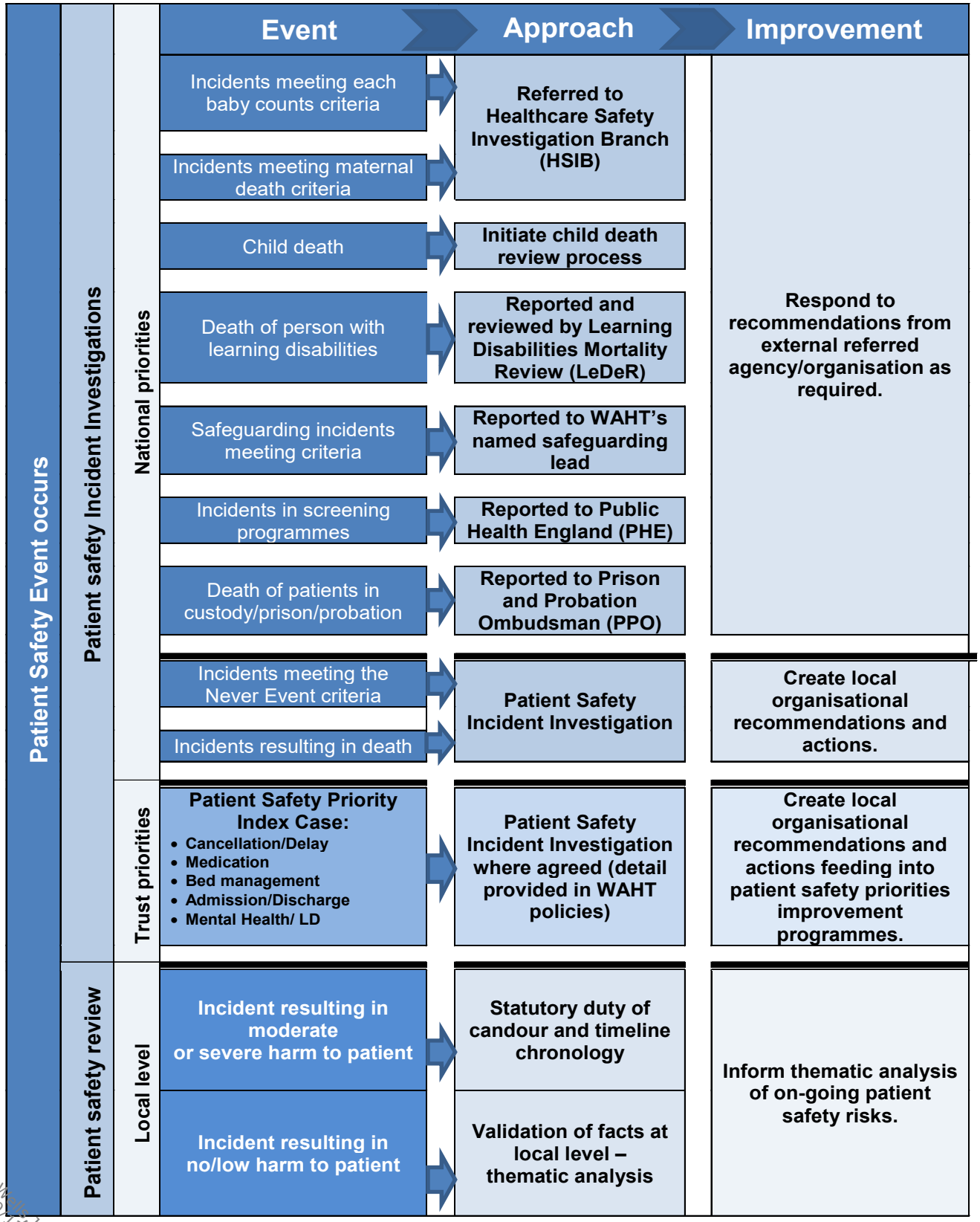
Worcestershire Acute Hospitals Trust
"How we will respond to Patient Safety Incidents"



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4.3 Timescales for patient safety PSII

4.3.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

4.3.2 The trust expectation is that PSIIs should ordinarily be completed within one to three months of their start date. The Trust standard will be set at a maximum of 60 working days per PSII, unless, there are exceptional circumstances that inhibit the ability to complete the PSII in this time frame or the PSII is a multiple of similar type, in which case an extension to 90 working days may be requested. Specific timeframes will be agreed with family, carers and other stakeholders to ensure that there is open and transparent communication process in place.

4.3.3 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

4.3.4 No local PSII should take longer than six months (120 days). A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (*Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity*.)

4.4 Nationally-defined priorities to be referred for PSII or review by another team

4.4.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2022 to 2024 are:

a. **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)

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- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- all perinatal and maternal deaths must be referred to MBRRACE

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

g. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi professional investigation

e. **incidents in screening programmes:**

- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

h. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

- Incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally-defined incidents requiring local PSII

4.5.1 Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2022 to 2024. These are:

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a. **incidents that meet the criteria set in the** Never Events list 2018

b. **incidents that meet the** 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised

method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:

i. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's** mortality review tool and which have been determined by case record review to be more likely than not due to problems in care

ii. **deaths of persons with learning disabilities** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review

iii. **deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

c. **Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.**

4.6 Locally-defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, and the thematic review of high impact Patient safety areas, local priorities for PSII have been set by this organisation for the period 2023-2026.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. **Locally-predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

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- **Criteria for selection of incidents for PSII:**

a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.)
b. likelihood of recurrence (including scale, scope and spread)
c. potential for learning in terms of:

- enhanced knowledge and understanding
- improved efficiency and effectiveness (control potential)
- Opportunity for influence on wider systems improvement.

4.7 Thematic analysis of high impact Patient safety areas.

4.7.1 A valuable and thorough examination of high impact Patient Safety areas has been conducted by the PST with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2 The findings from the thematic review have been collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

i. Causal factors from investigations into incidents and Never Events:
   a. Communication management issues, particularly related to flows to staff (up, down and across), including across organisational boundaries
   b. Communication issues with written communication where information was incomplete, did not convey risk, were difficult to read or was directed to the wrong people
   c. Recognising and responding to clinical changes or information
   d. Timeliness of appropriate escalation for review or treatment
   e. Care or Process pathway issues including across services

4.7.3 Thematic review findings:

Corporate risks register top 5 themes and areas February 2023:	Risk ID
Ambulance rapid release	4875
Overcrowding in the ED department	3482

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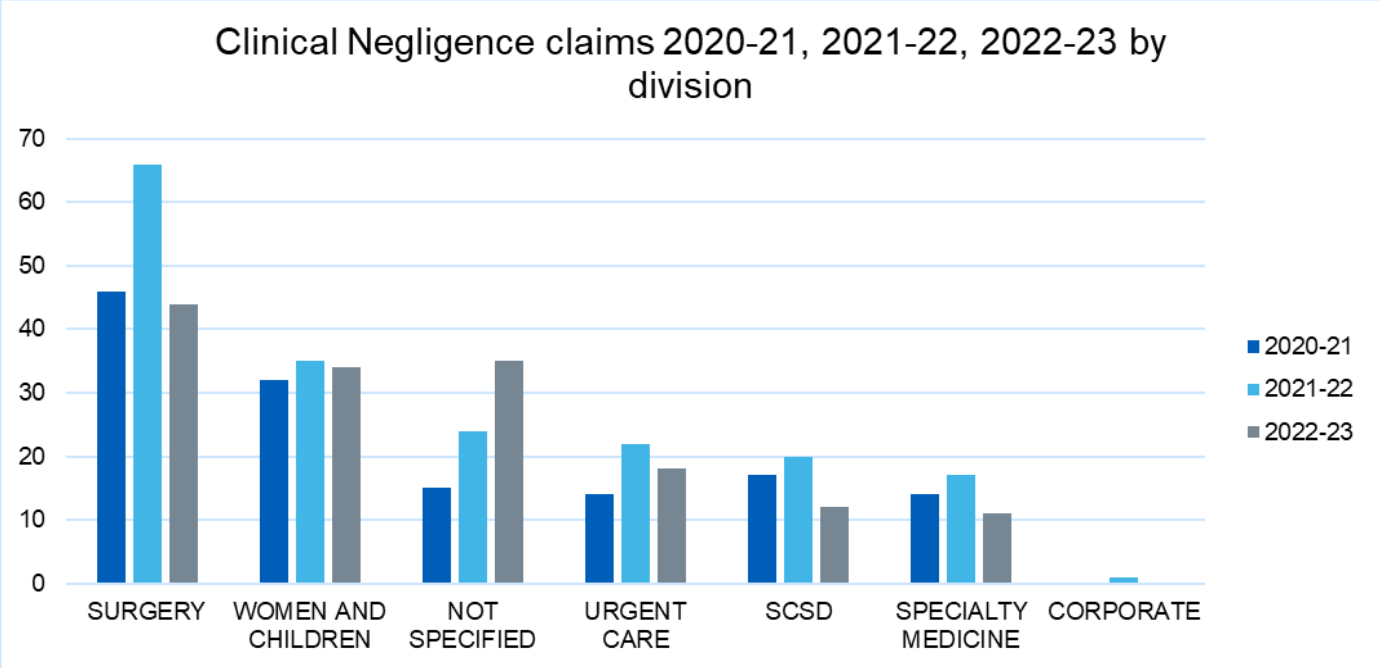
Implementation of the electronic Patient record	4773
Cybersecurity	3603
Workforce planning	3832



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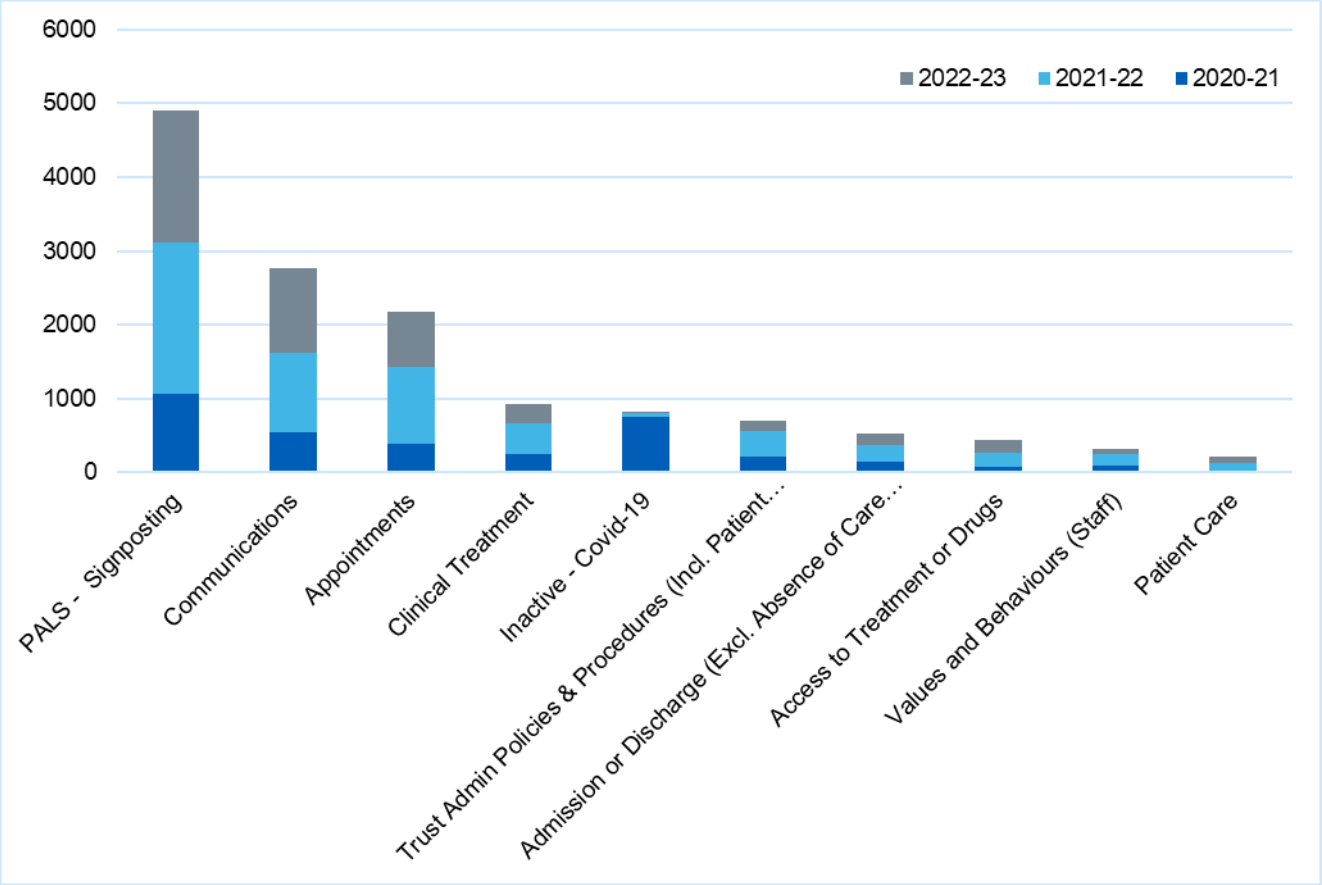

4.7.4 Serious incident investigation themes 2020-2023:

Category	2019/20	2020/21	2022-23	Total
HCAI infection control	6	111	50	167
Diagnostic incident	24	24	17	65
Slips, trips, falls	7	13	12	32
Treatment delay	10	12	7	29
Maternity/obstetrics	13	7	1	21
Pressure ulcer	5	5	1	11
Surgical (invasive)	8	6	6	20

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	Priority areas for PSII, priority areas will be reviewed as part of the established mechanism of monitoring. Adaptations to the priority areas, will be determined by evolving risk and may be subject to change, following wider discussion and agreement.	
1	Cancellation/Delay	Trust wide
2	Medication	Trust wide
3	Bed management	Trust wide
4	Admission/Discharge/Transfer	Trust wide
5	Mental Health/Learning Disability	Trust wide
6	Nationally mandated PSII	Trust wide

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Staffing implications:

1. The NPSS requires the PST team to play a greater role in trust wide and local level learning and improvement, with an increased focus on patient involvement, and complex case investigation that gives the greatest opportunity for organisational learning.

2. The NPSS outlines the requirements of the investigative posts being linked explicitly to the investigation standards, with an assumption the role will be pitched at Band 8a level. The national standards will allow for both standards and patient outcomes to be compared nationally, supported through a revised reporting system moving from NRLS to the Learning from Patient Safety Incidents (LFPSE) and the Patient Safety Incident Response Framework (PSIRF).

3. The number of required senior incident investigator roles has been influenced through initial mapping work and further thematic review throughout 2021/2. Process mapping the current SI process and through returns from divisions, the PST was able to view the overarching role the divisional CG teams provide in incident investigation. Through the assumptions gained from the detail of those returns and when collating all the time spent on progressing serious incidents, triangulated against high impact patient safety areas, to achieve our target and provide the organisation with the greatest learning opportunities our approach should be as follows:

5 priority areas, giving a total of 12 PSII to be conducted per year + Nationally mandated PSII.
Standard timeframe for completion will be mandated at 60 days as per existing SI policy.*Unless due to complexity of PSII or in the event that a multiple of similar investigations are to be conducted at once a 90 day completion timeframe may be requested.

Capacity	1 x 8c = 2 PSII per year 1 x 8b = 2PSII per year 2 x 8a = 4 PSII per year 2 x 7 = 4 per year 1 x Band 4 Administration support	Target 12 per year + Nationally mandated PSII

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5. Selection of incidents for review

5.1 Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

5.2 A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

5.3 Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. Damage to equipment or the environment.
Rapid Review	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
Screening Tool	Quick review and assessment	Could be used for frequent well known incidents such as Infection Prevention Incidents, Tissue Viability and Falls to determine if any learning to be gained or any areas to improve.

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6. Roles and responsibilities

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

6.1 **Trust boards (including board quality sub committees):**

- Ensure that the patient safety incident response framework (PSIRF) is implemented from board to ward.
- Ensure that wider strategy development and implementation is aligned with the principles and requirements of the PSIRF.
- Take responsibility for leading the development of a just, open and learning culture within the organisation – and for role modelling the behaviours required to achieve this.

6.2 **Chief executive**:

- Overall responsibility for ensuring the organisation has processes that support an appropriate response to patient safety incidents (including contribution to cross system/multi-agency reviews and/or patient safety incident investigations (PSIIs) where required).
- Overall responsibility for ensuring the development of a patient safety reporting, learning and improvement system.
- Ensures that systems and processes are adequately resourced: funding, management time, equipment and training.
- Appoints executive lead for supporting and overseeing implementation of the PSIRF.
- Approves publication and on-going review of the organisation's patient safety incident response plan (PSIRP).
- Ensures that the PSIRF, patient safety incident reporting data, patient safety incident investigation data, findings, improvement plans and progress are discussed at the board's quality subcommittee.
- Ensures that the organisation complies with internal and external reporting/notification requirements.
- Acts as spokesperson in complex/high profile cases where the media/public is engaged.

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6.3 **Governors (where applicable)**

Hold the board and non-executive directors to account for:

- ensuring implementation of the PSIRF from board to ward
- Developing a just, open and learning culture within the organisation – and for role modelling the leadership behaviours required to achieve this.

6.4 **Executive lead for supporting and overseeing implementation of the PSIRF**

The Chief Nursing Officer (CNO) is the Executive Lead for supporting and overseeing the implementation of PSIRF. They CNO is responsible for:

- Ensuring that the organisation has processes that support an appropriate response to patient safety incidents (including contribution to cross-system/multiagency reviews and/or investigation where required).
- Ensuring that processes for preparing for and responding to patient safety incidents are reviewed as part of the overarching governance arrangements.
- Ensuring that the executive and non-executive team can access relevant information about the organisation's preparation for and response to patient safety incidents including the impact of changes following incidents.
- Overseeing development and review of the organisation's PSIRP.
- Approving sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families and carers where required).
- Ensuring Duty that Duty of Candour is upheld.
- Ensuring that the organisation complies with the national PSII standards.
- Establishing procedures for agreeing patient safety investigation reports in line with the national PSII standards.
- Developing professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management.
- Providing leadership, advice and support in complex/high profile cases.
- Liaising with external bodies/supports the chief executive as a spokesperson for the organisation as required.

6.5 **Patient safety team**

- Ensures that PSIIs are undertaken for all incidents that require this level of response (as directed by the organisation's PSIRP).
- Develops and maintains local risk management systems and relevant incident reporting systems (including StEIS and its replacement once introduced) to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Supports the development and review of the organisation's PSIRP.

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- Ensures the organisation has procedures that support the management of patient safety incidents in line with the organisation's PSIRP (including convening review and PSII teams as required and appointing trained named contacts to support those affected).
- Establishes procedures to monitor/review PSII progress and the delivery of improvements.
- Works with the executive lead to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents, including gaps in resource including skills/training.
- Supports and advises staff involved in the patient safety incident response.

6.6 **Patient safety incident investigators**

Patient safety incident investigators must have been trained over a minimum of two days in systems-based PSII.

- Ensure that they undertake PSIIs in line with the national PSII standards.
- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.

6.7 **Named contacts for patients, families and carers**

- Identify those affected by patient safety incidents and their support needs.
- Provide them with timely and accessible information and advice.
- Facilitate their access to relevant support services.
- Obtain information from review/PSII teams to help set expectations.
- Work with the patient safety team and other services to prepare and inform the development of different support services.
- Support staff training in openness and transparency. All named contacts for patients, families and carers following patient safety incidents:
    - must have received relevant training in communication of patient safety incidents
    - should have experience of and been trained in 'being open' and Duty of Candour
    - must have sufficient time to undertake this role; that is, they should be staff dedicated to this role or with dedicated time for this role need to be closely linked to PSII teams and individuals.

When appointing staff to this role their characteristics should also be considered. They should:

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- be able to establish a relationship with those affected (and become known to and trusted by the patient, their family and carers)
- be able to offer a meaningful apology, reassurance and feedback to patients, their families and carers

- have a good grasp of the facts relevant to the incident but be sufficiently removed from the incident itself
- be senior enough or have sufficient experience of and expertise in the type of patient safety incident to be credible to the patient, their family and carers, and colleagues
- have excellent interpersonal skills, including being able to communicate with the patient, their family and carers in a way they can understand, without excessive use of medical jargon
- have a good understanding of how the incident will be responded to and ensure realistic expectations are set
- be able to liaise with several different individuals and be prepared to help those affected navigate complex systems/processes
- actively listen to patient, family and carer queries/concerns and engage with other staff to ensure these are responded to openly and honestly
- be knowledgeable about and provide access to different types of support (including independent advocacy services as required)
- be able to maintain a medium to long-term relationship with the patient, their family and carers where possible, and to provide continued support and information
- be culturally aware and informed about the specific needs of the patient, their family and carers.
- For continuity and consistency of communication, a co-contact should be assigned to support the lead contact and to act as lead contact during times when the first named contact is absent
- Junior staff or those in training must not be appointed as lead named contacts unless accompanied to all meetings with patients, families and carers and supported by a senior team member

6.8 **Named contacts for staff**

- Facilitate private and confidential conversations with staff affected by a patient safety incident.
- Work with line managers to provide advice and support to these staff.
- Facilitate their access to additional support services as required.
- Liaise between these staff and review/PSII teams as required.
- Support staff training in recognising the signs of stress and post-traumatic stress disorder in themselves and others and how to access help and support.
- Work with the patient safety team and other services to prepare/inform the development of different support services.

6.9 **Department leads/managers**

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- Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information.
- Ensure that incidents are reported and managed in line with internal and external requirements.

- Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in reviews/PSIIs as required.
- Work with the patient safety team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).

6.10 **All staff**

- Understand their responsibilities in relation to the organisation's PSIRP and act accordingly.
- Know how to access help and support in relation to the patient safety incident response process.

6.11 **Commissioners and commissioning organisations (including CCGs, NHS England and NHS Improvement, STPs, ICSs/ICPs) will:**

- Ensure that they are familiar with this introductory framework as they begin to consider how their roles and responsibilities will evolve to meet its requirements.
- Assess effectiveness of systems and processes to respond to patient safety incidents in NHS-funded provider services as demonstrated by the behaviours of openness and transparency; the existence of a just culture; evidence of continuous learning and improvement.
- Support/enable co-ordination of cross-system review/investigation where activity cannot be managed at the provider level because the incident is unusually complex/difficult or costly to manage due to multiple providers and/or services being involved across a care pathway.
- Provide improvement support where weaknesses are identified in a provider's systems and processes for responding to patient safety incidents.
- Share insights and information between organisations/services that have demonstrably improved care and or reduced risk.
- Annually review provider organisations' progress against investigation/review plans.

6.12 **Governance arrangements:**

Specific roles/responsibilities:

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- Patient safety incident response plans (PSIRPs):
- Work with providers to agree PSIRPs before their publication on providers' websites. The designated lead commissioner for the provider should lead for this work and involve associate commissioners proportionate to their level of interest in the provider.

- With local system leaders, assure effective application of local PSIRPs and national patient safety investigation standards.
- Monitoring and annual review of the PSIRP must form part of the overarching quality governance arrangements and be supported by clear financial planning to ensure that appropriate resources are allocated to review, investigation and improvement activities.
- In line with recommendations from the Kirkup Review of Liverpool Community Hospital Trust, where a regulator or oversight organisation has concerns regarding the safety of NHS-commissioned services, additional information and assurance will be sought from the provider. If this involves the commissioning of an independent investigation or review, this will be additional to those in the provider's PSIRP.

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7. Patient Safety Incident reporting arrangements

This section will include internal and external notification requirements for the reporting of patient safety-related incidents.

7.1 Reporting patient safety incidents on StEIS:

- Under the PSIRF, the 'StEIS' reporting platform will change from a system enabling commissioners to monitor the process and progress relating to individual investigations, to a reporting and monitoring system for providers.
- Commissioners should move to using StEIS to conduct a single, annual audit of progress against each local provider's PSIRP. In line with these changes:
- Reporting incidents previously defined as 'Serious Incidents' to StEIS will stop and providers will instead use StEIS to log and monitor all patient safety incidents identified as requiring a patient safety investigation (in line with national and locally identified priorities in their local PSIRPs.
- Management and monitoring of individual investigations should be picked up immediately by providers.

7.2 **Supporting cross-system patient safety investigations:**

- All commissioning systems (and/or STPs or ICSs/ICPs) must develop their capacity and capability, where these are insufficient, for coordinating cross-system investigation and have systems to recognise incidents that extend beyond local boundaries and may require coordination at a regional level.

7.3 **Information sharing to support patient safety investigations:**

- Records will need to be shared when commissioning and undertaking patient safety investigations, in line with information governance structures and relevant guidance, regulation and legislation. Commissioners should assist in this process.

7.4 **Continuous learning and improvement:**

- All NHS organisations including commissioners must have plans to support the continuous development of their improvement skills, practices and behaviours. Their leaders also need to identify, measure and develop behaviours that foster an organisational culture conducive to learning and improvement.

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- 7.5 **Testing processes in commissioning and oversight bodies**
- While providers are typically best placed to respond to patient safety incidents, commissioning and oversight bodies also have a role. They should therefore prepare, test and review their procedures in a similar way to providers, to ensure that they too are prepared to respond to patient safety incidents.

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8. Procedures to support patients, families and carers affected by PSIs

The national and local arrangements for supporting patients, families and carers following Patient Safety Incidents are:

'Being open' incorporates 10 principles that healthcare staff should follow when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

8.1 **Acknowledgement**

- All patient safety incidents should be acknowledged and reported as soon as they are identified. Where a patient, their family or carers inform healthcare staff that something has gone wrong, they must be taken seriously from the outset, and treated with compassion and understanding by all staff.

8.2 **Truthfulness, timeliness and clarity of communication**

- A nominated appropriate person should give patients, families and carers clear, unambiguous information in a truthful and open manner. This information should not come from different staff, and must not conflict, be unnecessarily complex or use medical jargon that a lay person may not understand.
- What happened should be explained step by step as soon as possible after the incident, based solely on what is known at the time and without making causal or outcome predictions. Staff should explain that new information may emerge from a patient safety incident investigation (PSII), and that patient, families and carers will be kept up to date on progress with the investigation process until the full findings are available.
- Patients, families and carers should be given a single point of contact for any questions or requests they may have.

8.3 **Apology**

- Patients, families and carers should receive a meaningful apology as soon as possible – one that is a sincere expression of sorrow and regret for the harm resulting from a patient safety incident. Delay is likely to increase patient, family and carer anxiety, anger or frustration and no reason justifies it.

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- Patient and public focus groups report that patients who do not quickly receive an apology are more likely to seek medico legal advice. A verbal face-to-face apology is essential as soon as staff become aware of an incident.
- A written apology must follow clearly stating the organisation is sorry for the suffering and distress resulting from the incident. Organisations should agree the words to be used and decide who is most suited to give the verbal and written apologies; by considering seniority, relationship to the patient, and experience and expertise in the type of patient safety incident.
- These staff must be made available.

8.4 **Recognising patient and carer expectations**

- Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding their patient safety incident, and its consequences, in a face-to face meeting with representatives from the organisation.
- They should be treated sympathetically and with equity, respect and consideration. Support should be provided for patients, families and carers across different protected characteristics and include tailored support such as an independent patient advocate or a translator.
- Where appropriate, they should be told about the Patient Advice and Liaison Service (PALS) and other support organisations like Cruse Bereavement Care and Action against Medical Accidents (AvMA).

8.5 **Professional support**

- Organisations must create an environment in which all staff (including those independently contracted) are encouraged to report patient safety incidents.
- Staff should be supported throughout the PSII process because they too may have been traumatised by their involvement.
- They should not unfairly face disciplinary action, increased medico legal risk or any threat to their registration.
- Supporting patients, families and carers organisations to follow the A just culture guide when concerns about individuals are raised.
- These concerns must be managed completely separately from the PSII.

8.6 **Confidentiality**

- Policies and procedures for ‘being open’ should fully consider and respect patient, family, carer and staff privacy and confidentiality.

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- The details of a patient safety incident are confidential: communications with parties outside the clinical team should be on a strictly need-to-know basis and, where practicable, records should be anonymised.
- Patients, families and carers must be told how information about them will be used in any PSII process.
- Advice on confidentiality and data protection must be sought from the relevant Caldicott Guardian and/or data protection officer as required to ensure the culture of openness and transparency is lawfully upheld.

8.7 **Sources of support**

- National guidance for Trusts engaging with bereaved families. *https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/*
- **Learning from deaths** – information for families. Learning from deaths – information for families explains what happens after a bereavement (including when a death is looked into by a coroner) and how families and carers should comment on care received.
- **Mental health homicide support materials for staff and families**. This information has been developed by the London Region Independent Investigation Team in collaboration with the Metropolitan Police. It is recommended that following a mental health homicide or attempted homicide the principles of the Duty of Candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.
- **Patient Advice and Liaison Services (PALS)** offers patients, families and carers confidential advice, support and information on health-related matters. As well as informally helping to resolve issues, PALS can guide people on filing a formal complaint and advise on accessing advocacy services.
- **NHS complaints.** Everyone has the right to make a complaint about any aspect of NHS care, treatment or service. The NHS website gives guidance complaints processes.
- **The independent NHS Complaints Advocacy Service** will provide someone to help navigate the NHS complaints system, attend meetings and review information given during the complaints process. Local Health watch also provides information about making a complaint, including sample letters.
- **Parliamentary and Health Service Ombudsman** makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.
- **Citizens Advice Bureau** provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

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9. Procedures to support staff affected by PSIs

The national and local arrangements for supporting staff following Patient Safety Incidents are:

9.1 **Mental Health First Aid (MHFA) – England**

Provides:

- Workplace guidance for employers and employees • information on mental health first aid training.

9.2 **Caring for the caregivers**

- The Improvement Academy hosts the 'second victim support website'. The term 'second victim' is under review but refers to healthcare workers who are impacted by patient safety incidents.
- While patients and families will always be the first priority following safety incidents, the wellbeing of staff involved is often overlooked but can leave staff lacking confidence, unable to perform their job, requiring time off or leaving their profession.
- There is existing evidence on the importance and effectiveness of support programmes for such staff and their potential to counter the negative impact outlined above to result in more positive impact for staff and patients alike.

9.2 **'Being open'**

- The "Being Open" framework (2009) includes guidance (p32) on supporting staff when things go wrong.

9.3 **Freedom to Speak Up**

- If staff, have a concern about the organisation failing to respond to a patient safety incident, or about the nature of its response, they can seek support from their organisation's Freedom to Speak Up Guardian.

9.4 **A just culture guide**

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- A just culture guide is useful when assessing concerns about individuals to ensure they are treated consistently, constructively and fairly. This should have a particularly positive effect on staff groups who have traditionally faced disproportionate disciplinary actions, e.g. Black, Asian and Minority Ethnic (BAME) groups.

9.5 **The ASSIST ME model**

- Managers and others can use the ASSIST ME model (produced by the Irish Health Service Executive) to guide appropriate conversations and to develop the necessary procedures to support staff following their involvement in patient safety incidents.

9.6 **Local occupational health services**

- Occupational health services help keep employees healthy and safe while in work and manage any risks in the workplace that are likely to give rise to work-related ill health. Occupational health teams keep people well at work – physically and mentally – and will be happy to talk to you about the services they can provide.

9.7 **A-EQUIP midwifery supervision model**

- A-EQUIP is an acronym for ‘advocating for education and quality improvement’. The A-EQUIP model is made up of four distinct functions: normative, restorative, personal action for quality improvement, and education and development. It supports a continuous improvement process that builds personal and professional resilience, enhances quality of care, and supports preparedness for appraisal and professional revalidation.
- The ultimate aim of using the A-EQUIP model is that through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone’s job, every day, in all parts of the system.

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10. Mechanisms to develop and support improvements following PSIIs

The national and local mechanisms to develop and support improvements are:

- Sharing the knowledge gained from activities associated with patient safety incident management – the 'lessons learned' – of itself may not achieve the desired outcome: that is, a lower risk of the same incident happening again or its prevention.

10.1 **Share safety insight**

- There are multiple opportunities through the incident management process to extract and share information, and this information can be used in different ways to support safety improvement. Information can be used at a team, department, organisation or system level to identify the most commonly reported incident types and insight about the nature of these incidents; triangulation with information from other sources (e.g. complaints, claims and coroner inquests) can provide further insight into the level of risk and potential opportunity for improvement.
- The Trust will ensure there are systems to explore incident reporting data 'with curiosity' and to use the intelligence it provides to identify the areas in most need of improvement, taking into account learning from PSIRF early adopter sites.

10.2 **Implementing improvements/solutions to prevent harm and monitor impact**

- Once a PSII has been finalised, recommendations can be formulated and actions developed to reduce the risk of an incident happening again by addressing the key underlying causal factors. This is where the improvement journey starts.
- People with relevant skills, experience and time to design and support technical aspects of improvement efforts are required, led by those skilled in supporting these efforts.
- Measurement is fundamental to any improvement programme. Without it, organisations may invest time and effort implementing changes that have little or no impact or, in the worst case, increase the risk of further harm.
- From the start, those responsible for implementing improvements/solutions will establish procedures to monitor actions and determine whether they are having the desired effect. Both outcome and process measures will be used to interpret the impact of actions and to inform how actions should be adapted if they fail to have the desired effect. Organisational escalation processes will be developed to manage situations

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where resources are insufficient to robustly implement actions or influence improvement, e.g. where an investment in technology or a widespread/systemic change may be the better option.

- The ultimate test of continuous learning and improvement in response to patient safety incidents is to ask: Have changes been made and have they led to measurable and sustainable risk reduction? A positive answer must be substantiated with evidence.

Figure 2: Example process for determining if an incident should be investigated

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11. Evaluating and monitoring outcomes of PSIIs, Reviews etc.

11.1 Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

11.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

11.3 Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

11.4 Reports to the TME/Board will be Quarterly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

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12. Complaints and appeals

12.1 Information regarding local and national arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are available at this link: Worcestershire Acute Hospitals NHS Trust – Comments & Complaints

12.2 The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a services provided by Worcestershire Acute Hospitals will be taken seriously and will be managed in a way that reflects the organisation's 4Ward Values

12.3 Worcestershire Acute Hospitals NHS Trust encourages service users to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff. The Trust's complaints policy focuses specifically on those concerns or complaints that require management through the Patient Advice and Liaison Service (PALS) and the Complaints Team.

12.4 The Trust's Complaints & Concerns Policy (WAHT-PS-005) sets out the principles and processes involved when any person wishes to raise a concern or complaint. This includes the need for the Trust to provide an apology and an opportunity for learning when complaints are responded to, where this is relevant.

12.5 If you wish to raise a concern or complaint, please contact the Complaints Team for advice in one of the following ways:

- email: wah-tr.Complaints@nhs.net
- telephone: 0300 123 1733
- In writing to:

  Complaints Team
  3 Kings Court (First Floor)
  Worcestershire Royal Hospital
  Charles Hastings Way
  Worcester
  WR5 1DD

12.6 The Complaints Team will support you to decide how the issues you are raising will be managed and liaise with the Patient Safety Team and Divisional Governance Teams on your behalf.

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Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme Report 2023

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

Accountable Director	Sarah Shingler, Chief Nursing Officer: Executive Board Maternity Safety Champion		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Jane Wardlaw, Lead Assurance and Compliance M/W and Susan Smith, Divisional Governance Lead

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

Recommendations	The Chief Nursing Officer has reviewed all of the CNST evidence contained within this report and recommends that the Board of Directors: 1. **Review** the evidence submitted against the ten safety actions, **agree** the suggested level of compliance and complete the declaration and submit to NHSR by 1st February 2024; 2. Trust Chief Executive Officer (CEO) to sign the declaration form, on behalf of the Trust Board and submit for signature by Accountable Officer (AO) of the Integrated Care Board.

Executive summary	This report provides an update on the maternity services current position and progress of collecting the required evidence to demonstrate compliance with the CNST 10 safety actions for the Maternity Incentive Scheme (MIS) year 5. The report provides all the available evidence to support the Board to complete the required declaration. **The maternity service is declaring full compliance with 9 of the 10 safety actions**. Analysis of the evidence across all elements of each safety action has been performed benchmarked against the Trust Board Declaration. It is noted that full compliance against met criteria (102 to meet in total) has been met in 99% of the elements, partial compliance 1% and non-compliance in only 0% of the elements.

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An action plan has been created and will be included in the Board declaration to support the application of any requests for future funding to deliver the scheme in 2024. This is attached as an appendix.

The Board declaration is required for submission to NHSR by 1st February 2024.

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	15	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	No	4	1
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	12	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes	8	0
			101	1

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

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

Financial Risk	Non delivery of total CNST contribution

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						

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Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Introduction/Background

The NHS Resolution Clinical Negligence Scheme for Trusts Maternity Incenive Scheme supports all acute Trusts to deliver safer maternity care. This scheme applies to all acute Trusts and incentivises ten safety actions that each Trust must provide evidence of achievement annually.

This report outlines the scheme and the required evidence to demonstrate compliance with the ten safety actions.

In order to be eligible for payment under the scheme, the Trust needs to report compliance with MIS by 1 February 2024 using the Board declaration form. The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System

Issues and options

Safety Action 1 – PMRT

Are you using the National Perinatal Mortality Review Tool to review deaths to the required standard?

Minimum evidential requirement for Trust Board

Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT.A report has been received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons or this should be documented within the PMRT review.

Safety Action 1 a) - Required Standard

All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

(1) 1a) PMRT - Compliant
• Trust Board Declaration SA1 (1) – Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?

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- Trust Board Declaration SA1 (2) – For deaths from 30th May 23 was MBRRACE-UK surveillance information completed within one calendar month of the death?

All cases where baby died in
Report rows are per baby; report date 07/12/23 12:57

Case ID	Baby	Live birth	Factual questions currently completed (%)	HSIB case	Eligible for CNST standards	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard b parents info	Standard b parents input	Standard c review	Standard c report drafted	Standard c report published	Standard c published deadline
90087	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	N/A	N/A	Post-qualifying date
89934	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89591	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89314	1 of 1	No	100%	Yes	Yes	Yes	Yes	Met	Met	Met	Met	N/A (HSIB	N/A	Post-qualifying date
89100	1 of 1	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89098	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
88432	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	Met	Not applicable
87864	1 of 2	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Not met	Met	07/12/2023
						% target expected		100%				60%	60%	
						% total achieved		100%	100%	100%	100%	62.50%	100% of eligible cases	

Safety Action 1b - Required Standard

For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.

(2) 1b) PMRT – Compliant

- Trust Board Declaration SA1 (3) – For at least 95% of all deaths of babies who died in your Trust from 30 May 2023 were parent's perspectives of care sought and were they given the opportunity to raise questions?

Standard Operating Procedure for comple

CaseListForYear - 07.12.2023 - CNST.xl

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All cases where baby died in
Report rows are per baby; report date 07/12/23 12:57

Case ID	Baby	Live birth	Factual questions currently completed (%)	HSIB case	Eligible for CNST standards	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report drafted	Standard c report published	Standard c published deadline
90087	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	N/A	N/A	Post-qualifying date
89934	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89591	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89314	1 of 1	No	100%	Yes	Yes	Yes	Yes	Met	Met	Met	Met	N/A (HSIB	N/A	Post-qualifying date
89100	1 of 1	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89098	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
88432	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	Met	Not applicable
87864	1 of 2	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Not met	Met	07/12/2023
						% target expected		100%	100%	95%	95%	60%	60%	
						% total achieved		100%	100%	100%	100%	62.50%	100% of eligible cases	

Safety Action 1c - Required Standard

For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary.

Update from NHS resolutions 23.10.23

Action 1 - PMRT:
Where MDT PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, this will be accepted provided there is an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period. Full dates can be viewed in email below.

Wells Jo
19/12/2023 11:32:38

FW_ Revised
maternity incentive sc

(3) 1c) PMRT - Compliant

Standard Operating Procedure for comple

CaseListForYear - 07.12.2023 - CNST.xl

- Trust Board Declaration SA1 (4) - Has a review using the Perinatal Mortality Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.

- Trust Board Declaration SA1 (5) – Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death.

- Trust Board Declaration SA1 (6) – Were 60% of the reports published within 6 months of death?

- Trust Board Declaration SA1 (7-10) – Not applicable as no PMRT sessions rescheduled

All cases where baby died in
Report rows are per baby; report date 07/12/23 12:57

Case ID	Baby	Live birth	Factual questions currently completed (%)	HSIB case	Eligible for CNST standards	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report drafted	Standard c report published	Standard c published deadline
90087	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	N/A	N/A	Post-qualifying date
89934	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89591	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89314	1 of 1	No	100%	Yes	Yes	Yes	Yes	Met	Met	Met	Met	N/A (HSIB	N/A	Post-qualifying date
89100	1 of 1	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
89098	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	N/A	Post-qualifying date
88432	1 of 1	No	100%		Yes	Yes	Yes	Met	Met	Met	Met	Met	Met	Not applicable
87864	1 of 2	Yes	100%		Yes	Yes	Yes	Met	Met	Met	Met	Not met	Met	07/12/2023
						% target expected		100%	100%	95%	95%	60%	60%	
						% total achieved		100%	100%	100%	100%	62.50%	100% of eligible cases	

Wells 19/12/2023 11:32:38

Safety Action 1d - Required Standard

Quarterly reports should be submitted to the Trust Executive Board from 30th May 2023.

(4) 1d) PMRT – Compliant

- Trust Board Declaration SA1 (11) – Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.

Q1 23-24 PMRT report.docx Maternity Safety Report July 2023 FIN

Quarter 1 Audit embedded in Maternity Safety Report July 23 for Trust Board

Q2 23-24 PMRT report.docx Maternity Safety Report Sept 2023 Fina

Quarter 2 Audit embedded in Maternity Safety Report Sept 23 for Trust Board

- Trust Board Declaration SA1 (12) – Were quarterly reports discussed with the Trust maternity safety level safety champions?

Please review agendas of Safety Champions meetings in Safety Action 9, these demonstrate PMRT are featured as an agenda item and presented by the Maternity Governance Lead Midwife.

Safety Action 2 - MSDS

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Minimum evidential requirement for Trust Board

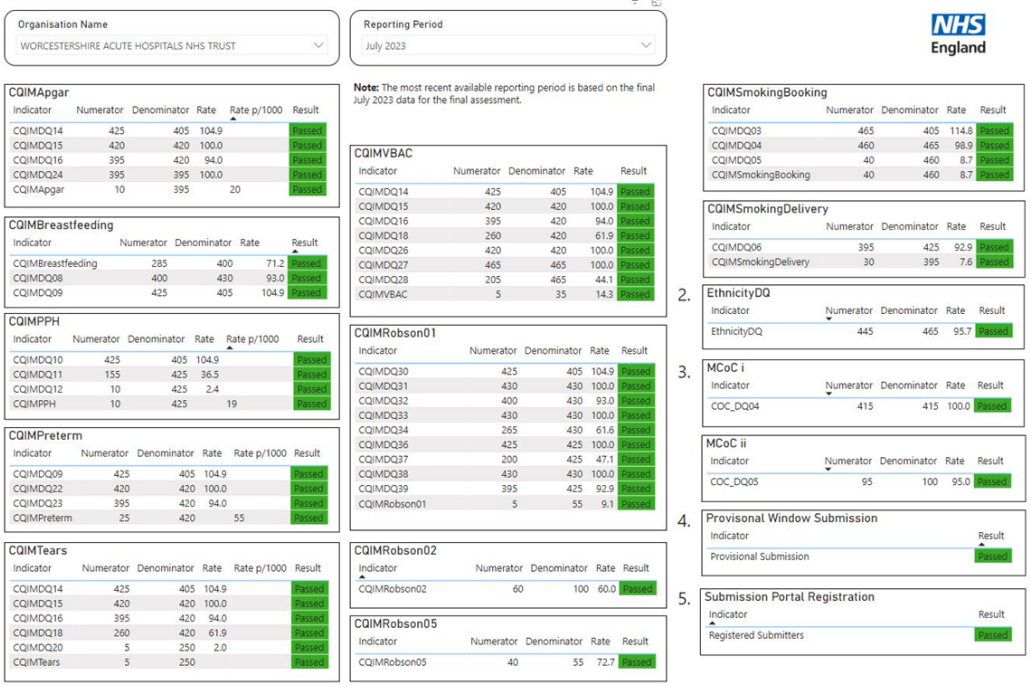
The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.

Safety Action 2) 1 - Required Standard

Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.

Wells J 19/12/2023 12:18

(5) 2)1. MSDS - Compliant



RE_ CNST Safety
Action 2 Final Positior

Confirmation email attached from informatics on 26.10.23 – Fully Compliant

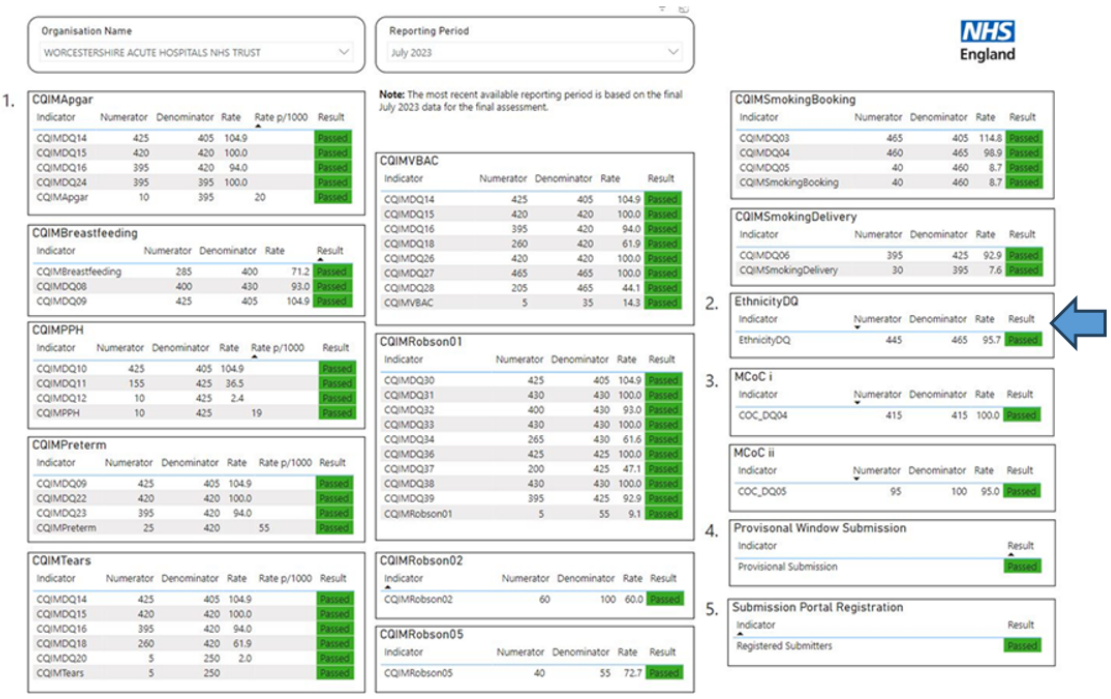
- Trust Board Declaration SA2 (1) - Was your Trust compliant with at least 10 out of 11 clinical quality improvement metrics.

Safety Action 2) 2. - Required Standard

July 23 data contained valid ethnic category (Mother)for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances.

Wells Jo
19/12/2023 11:32:38

(6) 2) 2. MSDS - Compliant



- Trust Board Declaration SA2 (2) – Did July's 23 data contain a valid ethnic category for at least 90% of women booked in the month?

Safety Action 2) 3. - Required Standard

Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:
Midwifery Continuity of carer (MCoC)

i i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

i ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.
These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.

Wells 19/12/2023 21:28:38

Final data for July 2023 will be published in October 2023.

If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).

(7) 2) 3. MSDS - Compliant

- Trust Board Declaration SA2 (3) – Over 5% of women who have an antenatal care plan recorded by 29 weeks also have the continuity of carer pathway indicator completed.

- Trust Board Declaration SA2 (4) – Over 5% of women recorded as being placed on a continuity of carer pathway where both care professional ID and Team ID have also been provided.

Safety Action 2) 4 - Required Standard

Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

Wells 19/12/2023 11:32:36

(8) 2) 4. MSDS - Compliant
Submission deadline met. • Trust Board Declaration SA2 (5) – Did the Trust make an MSDS submission before the provisional processing deadline for July 23 data by the end of August 23?

Safety Action 2) 5 - Required Standard

Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.

(9) 2) 5. MSDS – Compliant
SDCS+Cloud+DUC+Form+-+MSDS+v3.0. • Trust Board Declaration SA2 (6) – Has the Trust at least two people registered to submit MSDS data to SDCS who must still be working in the Trust?

Safety Action 3 – Transition Care Services

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Minimum evidential requirement for Trust Board

Evidence for standard a) to include:
Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:

- *There is evidence of neonatal involvement in care planning*
- *Admission criteria meets a minimum of at least one element of HRG XA04*
- *There is an explicit staffing model*
- *The policy is signed by maternity/neonatal clinical leads and should have auditable standards.*
- *The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.*

Wells Jo
19/12/2023 11:32:39

Safety Action 3a - Required Standard

Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

(10) 3a) TRANSITIONAL CARE – Compliant

- Trust Board Declaration SA3 (1) – Was a pathway (s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?


Safe Staffing and Utilisation of Human


NNU sitrep MASTER.pdf


Cot Management and Escalation - Loca

- Trust Board Declaration SA3 (2) – Are neonatal teams involved in decision making and planning care for all babies in transitional care?

Audit below of 5x babies per month. November data not available as this cannot be collated until January 24 as discharge information is needed.

Example of Audit template (to demonstrate the standards of the Audit):

Admission				
	Question	Yes	No	N/A
Criteria 1	34-36 weeks gestation	X		
	or			
	If <34 weeks assessed by consultant			
Criteria 2	1.5kg or more	x		
	or			
	>1.2kg & >34 weeks, if no significant illness			
Criteria 3	Appropriate admission to TCU	x		
	If the baby does not fulfill one of the criteria please say why below and what action was taken:			

Wells Jo
19/12/2023 11:32:38

Discharge	Question	Yes	No	N/A
	At least 33 weeks gestation	X		
	gaining weight & over 1.6kg (less at consultant discretion)	X		
	Maintaining temperature in cot for over 24 hours	X		
	No longer requiring monitoring for apnoea			x
	Established full oral feeds (minimum 2 full suck feeds)	x		
	Discharged to NCOT service if appropriate			x
	If the baby does not fulfill one of the criteria please say why below and what action was taken:			

Zip files of all individual Audits by month. All patient identifiable information removed.

Results TCU audit - 50 Babies Audited (Jan 23 - Oct 23)

Admission	Question	Yes	No	N/A
Criteria 1	34-36 weeks gestation or If <34 weeks assessed by consultant	72%	28%	0%
Criteria 2	1.5kg or more or >1.2kg & >34 weeks, if no significant illness	100%	0%	0%
Criteria 3	Appropriate admission to TCU	100%	0%	0%
Discharge	Question	Yes	No	N/A
	At least 33 weeks gestation	98%	2%	0%
	Gaining weight & over 1.6kg (less at consultant discretion)	100%	0%	0%
	Maintaining temperature in cot for over 24 hours	100%	0%	0%
	No longer requiring monitoring for apnoea	0%	0%	100%
	Established full oral feeds (minimum 2 full suck feeds)	100%	0%	0%
	Discharged to NCOT service if appropriate	32%	0%	68%

Wells 20
19/12/2023 11:32:36

Minimum evidential requirement for Trust Board

- *Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks.*
- *Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.*
- *Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan.*
- *Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.*

Safety Action 3b - Required Standard

A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.

(11) 3b) TRANSITIONAL CARE - Compliant

- Trust Board Declaration SA3 (3) – Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?

➢ *A multi professional meeting with Obstetric and Neonatal staff takes place monthly to review all babies 37 weeks and above who are admitted to NNU. An action plan is in place. There is a quarterly report produced following the reviews with themes identified and learning.*
➢ *This learning is shared with all Maternity & Neonatal staff in the form of an ATAIN newsletter.*
➢ *As part of the review meeting the group reflect on whether the baby could have been admitted to TCU rather than NNU.*
➢ *There is also an audit of 5 babies admitted to TCU monthly to ensure they reached the criteria for TCU. This information is included in the quarterly report.*

ATAIN proforma V2 2022.pdf
Oct - Dec Q3 2022-23.pdf
Q4 Jan-Mar 2022-23.pdf
ATAIN Report Q1 23-24.docx
ATAIN Report Q2 23-24.docx

Wells 19/12/2023 11:32:38

- Trust Board Declaration SA3 (4) – Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?

Action plan

ATAIN Action Plan
V14 October 2023.do

- Trust Board Declaration SA3 (5) – Is there evidence that the action plan has been signed off by the Dom/Hom, Clinical directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?

September 23 Safety report with Action plan embedded. Line of sight for Trust Board and LMNS.

Maternity Safety
Report Sept 2023 Fin

- Trust Board Declaration SA3 (6) – Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?

LMNS Board
meeting notes 08.11

Newsletters

ATAIN NEWSLETTER JAN-MARCH 2023.pd

ATAIN NEWSLETTER APRIL-JUNE 2023.pdf

ATAIN NEWSLETTER JUL-SEPT 2023.pdf

Safety Action 3c - Required Standard

Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

Wells Jo
19/12/2023 11:32:39

Minimum evidential requirement for Trust Board

Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring

OR

An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.

(12) 3c) TRANSITIONAL CARE – Compliant

- Trust Board Declaration SA3 (7-8) – Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occurring?

There is a 9 bedded Transitional Care Unit within the postnatal Ward. This is staffed by both Midwifery staffing and Neonatal. There is a robust guideline in place.
All term admissions to NNU are reviewed to see if they could have gone to TCU and 5 babies per month admitted to TCU are audited to ensure they reached the admission criteria.

PDF
Admission of babies
to the Neonatal Unit,

Safety Action 4 – Clinical Workforce

Can you demonstrate an effective system of clinical workforce planning to the required standard?

4 a) OBSTETRIC MEDICAL WORKFORCE (1,2,3,4)

Safety Action 4a 1. - Required Standard

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:
a. currently works in their unit on the tier 2 or 3 rota **OR**
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) **OR**
c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Wells Jo
19/12/2023 11:32:38

Minimum evidential requirement for Trust Board

Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses.

Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel
This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

(13) 4a 1. Obstetric Medical Workforce – Temp or Locum – Compliant

- Trust Board Declaration SA4 (1-3) – Has the Trust ensured that the criteria has been met for employing short term local doctors (2 weeks or less) in Obstetrics and Gynaecology on tier 2 or 3 rotas after Feb 23 following audit of 6 months activity.

No Audit required – WRH have not employed any short-term locums (2 weeks or less) during MIS year 5. For reference policy attached below – Clinical Supervision of temporary or locum members of junior medical staff policy. Guideline updated November 23 to align with RCOG guideline.

rcog-guidance-on-engagement-of-sho
0.0 AGENDA Maternity Governance
Clinical Supervision of Locum and Tempor

Safety Action 4a 2. - Required Standard

Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

Minimum evidential requirement for Trust Board

Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.

Wells Jo 19/12/2023 10:52:08

(14) 4a 2. Obstetric Medical Workforce – Long term Locum – Compliant

- Trust Board Declaration SA4 (4-5) – Has the Trust implemented the RCOG guidance on engagement of long term locums and provided assurance that they have evidence of compliance?


Copy of SA4 a) 2 - Long term Locums Au


rcog-guidance-on-the-engagement-of-l


Clinical Supervision of Locum and Tempor

Attached - Audit of Long term Locums and guideline.

Safety Action 4a 3. - Required Standard

Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-compensatory-rest.pdf

Minimum evidential requirement for Trust Board

Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making.

Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.

***NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG*

Wells Jo
19/12/2023 11:32:38

(15) 4a 3. Obstetric Medical Workforce – Compensatory Rest - Compliant

- Trust Board Declaration SA4 (6) – Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior speciality and specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?

No - Audit attached – Period 30th May until 7th Dec 23 – Demonstrates non-compliance with compensatory rest. Also email explaining current status of doctors competing demands on working pattens not allowing the ability to have compensatory rest.

Consultants on Call.msg

Copy of SA4 a) 3 - Compensatory Rest A

Technical Guidance within the MIS year 5 reviewed and statement as below to confirm compliant.

QUESTION - What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?

ANSWER - Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.

- Trust Board Declaration SA4 (7) – OR – Has an action plan presented to address any shortfalls in compliance, to the Trust board, Trust Board level safety champions and LMNS meetings.

September 23 Maternity Safety Reports displays appendix of updated Safe staffing Levels and Action plan outlined within report. The Maternity safety report is further shared to LMNS and Safety champions.

Monitoring action log – part of the medical staffing report.

Maternity Safety Report Sept 2023 Fina

Medical Staffing Report - Nov.docx

Medical Staffing Report - Dec (1).doc

Policy for management of Safe S

Wells 19/12/2023 11:32:38

Baylon Kamalarajan has further escalated the requirement of compensatory rest compliance to CMO (November 23).

Safety Action 4a 4. - Required Standard

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document:

'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

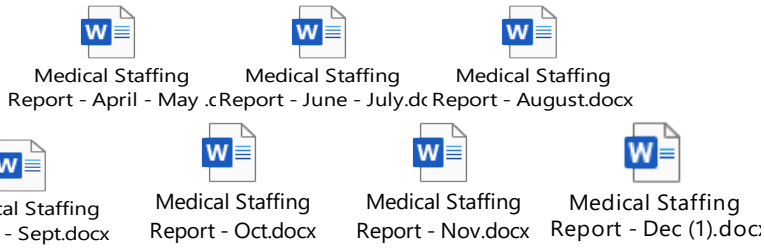
Minimum evidential requirement for Trust Board

Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

(16) 4a 4. Obstetric Medical Workforce – Consultant attendance - Compliant

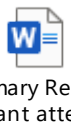
- Trust Board Declaration SA4 (8) – Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document?

Attached – Medical staffing reports which are attached to Maternity Safety Report monthly.

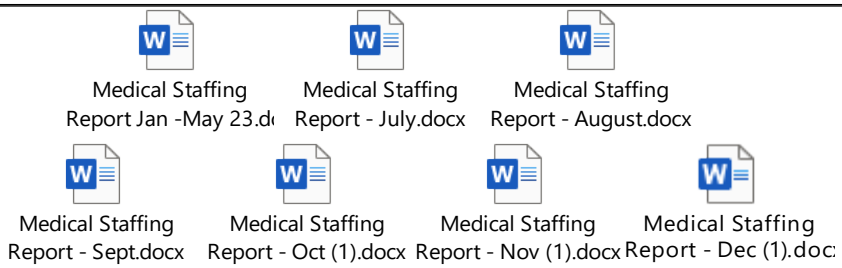


Shared with LMNS monthly – see Maternity Safety reports

- Trust Board Declaration SA4 (9) – Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?



Wells 19/12/2023 11:32:38



Summary report planned to be attached to next Perinatal safety report (November).

- Trust Board Declaration SA4 (10,11,12) – Do you have evidence that the Trust position with the above has been shared with Trust board, Safety champions, LMNS meetings.

All are Medical staffing reporting (as above) are sent through the process of the Maternity Safety/ safe staffing reporting process.

4 b) ANAESTHETIC MEDICAL WORKFORCE

Safety Action 4 b - Required Standard

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

Minimum evidential requirement for Trust Board

The rota should be used to evidence compliance with ACSA standard 1.7.2.1.

(17) 4b) Anaesthetic Medical Workforce – Compliant

- Trust Board Declaration SA4 (13 - 14) – Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? The rota should be used as evidence compliance with ACSA standard 1.7.2.1.

In confirmation there is one dedicated, obstetric trained anaesthetist for delivery suite only, between 6pm and 8 am.
This arrangement means that there would never be the need for any of these anaesthetists to delegate care of non-obstetric patients.

Wells 20 19/12/2023 11:28:38

Lines of escalation are made clear to junior anaesthetist covering delivery suite out of hours. Pager to senior registrar who supervises 3 separate areas overnight and then to a non-resident consultant available for advice and/or attendance as required. Anaesthetic rota for June 2023 attached above confirming consultant cover during elective operating 8-6 4 days per week and 24/7 specific obstetric emergency cover. This individual only has responsibilities on delivery suite.

Anaes. Rota June 2023.pdf

4 c) NEONATAL MEDICAL WORKFORCE

Safety Action 4c - Required Standard

The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.
If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.
Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Minimum evidential requirement for Trust Board

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

(18) 4c) Neonatal Medical Workforce - Compliant

- Trust Board Declaration SA4 (14) – Does the neonatal unit meet the BAPM national standards of medical staffing and is this formally recorded in Trust Board minutes?

No - the Neonatal Medical Workforce does not meet the standard.

Wells 20 19/12/2023 11:32:38

- Trust Board Declaration SA4 (19,20,21) – If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. Was the Action plan agreed with the LMNS and ODN?

Copy of 2023 V1 WMNODN NCCR Uni

Email to ODN - NCCR Action plans-U

LMNS Board meeting notes 08.11

Action plan attached and evidence of email submission sent to the Operational Delivery Network.

4 d) NEONATAL NURSING WORKFORCE

Safety Action 4d - *Required Standard*

The neonatal unit meets the BAPM neonatal nursing standards.

If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies.

If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies.
Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Minimum evidential requirement for Trust Board

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

(19) 4d) Neonatal Nursing Workforce - Compliant

- Trust Board Declaration SA4 (18) – Does the neonatal unit meet the BAPM national standards of nursing staffing, and is this formally recorded in Trust Board Minutes?

Wells 20 19/12/2023 11:32:38

Position statement August 23 - 70% of Staff are QIS trained. The unit is staffed to BAPM following funding from NHSEI with evidence attached. Neonatal Critical Care standards action plan compliant with BAPM staffing.

Copy of WMNODN NCCR WRH Unit Imp

NNU Nurse staffing Jan-May 2023.pdf

Copy of Action plan attached to Septembers Maternity Safety Report

Maternity Safety Report Sept 2023 Fina

- Trust Board Declaration SA4 (19, 20) – Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. Also shared with LMNS.

Position November 2023 – Updated NCCR action plan attached below. Change to compliance now at 68% (below BAPM) this is due to recruitment of newly qualified band 5's that have diluted the compliance. Ongoing recruitment into QIS roles. Discussed at LMNS – Divisional – Directorate levels in Oct/Nov 23. BAPM staffing data monitored monthly through safe staffing reports and NCCR action plan updated quarterly. Narrative present in Octobers Perinatal Safety report (page 11) – informing trust board and LMNS. LMNS meeting minutes not available due to restricted administrative support currently.

Copy of WMNODN NCCR Unit Implemen

Perinatal Safety Report Oct 2023 v4 (1

- Trust Board Declaration SA4 (21) – Agreed action plan shared with ODN

ODN receiving quarterly reports, last quarter was completed for Quarter 2 (attached below), Quarter 3 cannot be completed till end of December 23. Matron will be submitting January 23.

Copy of Neonatal Workforce 2023-4 WI

Wells Jo
19/12/2023 11:32:38

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Safety Action 5 – Midwifery Workforce

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Minimum evidential requirement for Trust Board

The report submitted will comprise evidence to support a, b and c progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.
- The plan to address the findings from the full audit or table top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.
- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
- The midwife to birth ratio.
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Safety Action 5a - Required Standard

A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

Wells Jo
19/12/2023 11:32:38

(20) 5a) MIDWIFERY STAFFING – Compliant

- Trust Board Declaration SA5 (1) Evidence that there is a systematic, evidence-based process to calculate midwifery staffing establishment, Evidence should include a clear breakdown of BirthRate + or equivalent calculations.

Midwifery Safe Staffing Report Octob

Maternity Safe Staffing Report Oct 22 demonstrates the results of Birthrate Plus Audit (3 yearly). The results of the recently published Birthrate Plus Audit are presented in the report. No additional funding is required as the recommended clinical and leadership requirement is currently funded following significant national investment in 2021/22.

Midwifery Safe Staffing Report July 2

Maternity Safe Staffing Report July 23 demonstrates Birthrate Plus 6 monthly desktop audit. The total requirement to deliver a safe maternity service is 230.16 WTE. The current funded midwifery establishment is 242 WTE therefore no additional funding is currently required.

Safety Action 5b - Required Standard

Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

(21) 5b) MIDWIFERY STAFFING - Compliant

- Trust Board Declaration SA5 (2) – Can the Trust board evidence midwifery staffing budget reflects establishment as calculated in SA5 (1).

Midwifery Safe Staffing Report July 2

Wells, Jo 19/12/2023 11:32:38

Safety Action 5c - Required Standard

The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

(22) 5c) MIDWIFERY STAFFING – Non Compliant

- Trust Board Declaration SA5 (3) – The midwifery co-ordinator is charge of labour ward must have supernumerary status.

See emailed attached. Standard not met.

FW_ Advice re Safety Action 5 - Non - Com

PLAN - Maternity Improvement Advisor Monthly Progress Report embedded into May 23 Maternity Safety Report. This demonstrates the plan for maternity staffing. Maternity Safe staffing reports from June – Sept providing narrative of months CNST Safety Action 5 not met.

MSSP Report Detail (June 23).docx
MSSP August Report.docx
MIA Slide worcesterAug23.pptx
Midwifery Safe Staffing Report June 2
09.2 Maternity Safe Staffing Report July 2
07.1 Maternity Safety Report Aug 2023 (2).c
02.10 Midwifery Safe Staffing Report Septe

April 2023 – Risk register entry for maternity staffing

4. Midwifery Safe Staffing Report April 2

Risk Register –staffing

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

Wells Jo
19/12/2023 11:32:28

Safety Action 5d - Required Standard

- Trust Board Declaration SA5 (4,5,6) Have all women had one to one care (5 & 6 not applicable as met standard)

All women in active labour receive one-to-one midwifery care.

(23) 5d) MIDWIFERY STAFFING - Compliant

See safe staffing reports for narrative.

January 2023	100% 1:1 Care
February 2023	100% 1:1 Care
March 2023	100% 1:1 Care
April 2023	100% 1:1 Care
May 2023	100% 1:1 Care
June 2023	100% 1:1 Care
July 2023	100% 1:1 Care
August 2023	100% 1:1 Care
September 2023	100% 1:1 Care
October 2023	100% 1:1 Care
November 2023	100% 1:1 Care

Safety Action 5e - Required Standard

Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

(24) 5e) MIDWIFERY STAFFING – Compliant

- Trust Board Declaration SA5 (7) – Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to board every 6 months?

1. Midwifery Safe Staffing Report Janua
2. Midwifery Safe Staffing Report Febru
3. Midwifery Safe Staffing Report March
4. Midwifery Safe Staffing Report April 2
Midwifery Safe Staffing Report May 2
Midwifery Safe Staffing Report June 2
09.2 Maternity Safe Staffing Report July 2
07.1 Maternity Safety Report Aug 2
02.10 Midwifery Safe Staffing Report Septe
Midwifery Safe Staffing Report Oct

Safety Action 6 – Saving Babies Lives Implementation

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies Lives care bundle version 3?

Wells Jo
19/12/2023 11:32:38

Safety Action 6) 1. - Required Standard

Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

Minimum evidential requirement for Trust Board

The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024.

A new implementation tool will be available by the end of June to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element.

Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available, and share this with the Trust Board and ICB

To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation.

(25) 6)1 SAVING BABIES LIVES - Compliant

- Trust Board Declaration SA6 (1) – Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?

April 23 Maternity Assurance and Com | May 23 Maternity Assurance and Com | 11.1 June 23 Maternity Assurance | 11.1 4th August 23 Maternity Assurance

11.1 September 23 Maternity Assurance | 11.1 October 9th 23 COSMOS - Mater | 11.1 October 9th 23 COSMOS - Mater | 11.1 November 9th 23 COSMOS - Mater | December 6th 23 COSMOS - Maternit

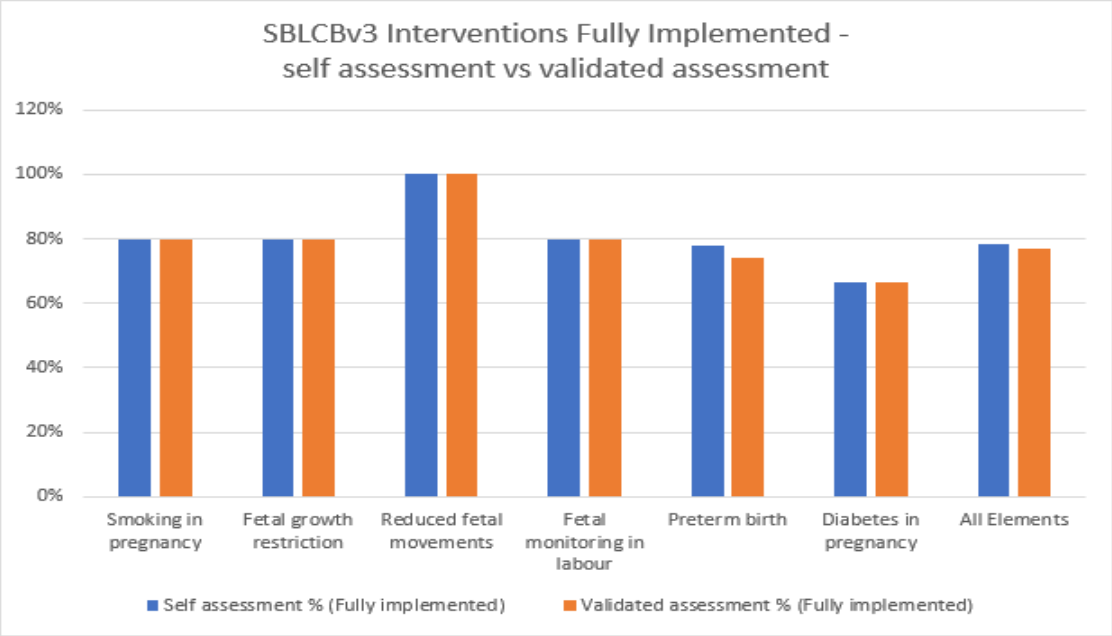
All COSMOS reports are presented at Maternity Governance, Senior Midwives Meeting, Divisional Governance and a summary is given in the Maternity Safety Report (sent to Trust board monthly).

- Trust Board Declaration SA6 (3) – Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across all 6 elements overall?

Wells 20
19/12/2023 11:32:38

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	78%	Partially implemented	74%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	79%	Partially implemented	77%	CNST Met

- Trust Board Declaration SA1 (4) – Using the national implantation tool, can the Trust demonstrate implementation of at least 50% of interventions within each of the 6 individual elements?



Safety Action 6) 2. - Required Standard

Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available.

Wells Jo 19/12/2023 13:32:38

Minimum evidential requirement for Trust Board

Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following:

• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

• Progress against locally agreed improvement aims.

• Evidence of sustained improvement where high levels of reliability have already been achieved.

• Regular review of local themes and trends with regards to potential harms in each of the six elements.

- *Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.*

(26) 6) 2. SAVING BABIES LIVES - Compliant

- Trust Board Declaration SA6 (2) – Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool

- First quarter meeting held on 18th September 2023 with LMNS. Minutes attached below

SBL agenda WAHT 180923 (1).docx

WAHT SBLCBv3 Meeting minutes 18.0

- Second quarter meeting held on 29th November 2023 with LMNS.

SBL agenda WAHT 291123.docx

Safety Action 7 – MNVP

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Email from NHS Resolutions received on 30.11.23;

Trusts will note that the MNVP Guidance was published on 28 November and can be found here.

It is acknowledged that the timing of the publication of the MNVP guidance did not easily align with the reporting period for MIS Year 5. Therefore, the board notification form you have received focusses on meeting the requirements of the Three-year delivery plan for maternity and neonatal services that was published in March 2023. The expectation is that evidence submitted by Trusts related to Safety Action 7 is based on meeting the requirements of the Three-year delivery plan for maternity and neonatal services, as detailed in the board notification form found here.

Wells Jr
19/12/2023 11:32:38

Minimum evidential requirement for Trust Board

- Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.
- Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.
- The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it.
- Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.
- Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

Safety Action 7) 1. - Required Standard

Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.

(27) 7) 1. – Funding for MNVP – Compliant

Updated Budget.docx | FW Worcs MNVP - HWIN sign up and cla | HWCCG Volunteer Expenses Policy and P | HWCCG Volunteer policy.pdf | 2023-2024 MVP budget.docx

- Trust Board Declaration SA7 (1) – Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP in place which is in line with the Delivery plan?
- Trust Board Declaration SA7 (5) – Do you have evidence that MNVP's have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?
- Trust Board Declaration SA7 (7) – Do you have evidence that the MNVP's leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?

Wells Fargo 19/12/2023 11:23:38

Safety Action 7) 2. - Required Standard

Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

(28) 7) 2. – Action Plan MNVP – Compliant

- Trust Board Declaration SA7 (2) – Has an action plan been co-produced with the MNVP following annual CQC maternity survey data published (Jan 23), including analysis of free text data, and progress monitored regularly by safety champions and LMNS board.

Nov 22 - Picker survey (MVP).docx
MVP Picker action plan.docx
2023-2024 MVP Annual report - part 1
2023-2024 MVP annual report - part 2
2023-2024 MVP Annual report - part 3

Maternity Safety Report monitors the Action plan from the Picker Survey and is forwarded to LMNS monthly. The monthly safety report is part of the monthly agenda for the Maternity and Neonatal Safety Champions.

- Trust Board Declaration SA7 (6) – Can you provide the local MNVP's work plan and evidence that it is funded?

Progress with MVP 2023-24 workplan Jul
Progress with MVP 2023-24 priority actic
Worcestershire MNVP Meeting Agenc

Safety Action 7)3. - Required Standard

Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

(29) 7) 3. MNVP - Compliant

- Trust Board Declaration SA7 (4) – Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?

MNVP TOR

3b. WMVP TOR proposed agreed by n
3b proposed changes to TOR appendix 1 Me

Wells 19/12/2023 11:32:38

MNVP Meetings Feb 23


MVP, agenda for February 2023 meetir


MVP Meeting notes 13.02.23.docx

MNVP Meeting July 23


Worcestershire MNVP Meeting Agenc


MNVP Meeting notes 14.07.23 v2.docx

MNVP Meeting Sept 23


Worcestershire MNVP Meeting Agenc


Worcestershire MNVP Minutes 29.09.

MNVP Meeting Dec 23


1. Worcestershire MNVP Meeting Agenc

- Trust Board Declaration SA7 (3) – Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?

MNVP 15 steps Kidderminster


Fifteen Steps for Maternity Report - Kic

15 Steps Redditch


4c. Fifteen Steps for Maternity Report - Re

Parent Panel Group


6a. Proposals for Service user feedback


3b DRAFT MNVP Parent panel v2.pdf

Highlight reports for LMNS


2. WMNVP Highlight Report for LMNS Boa


4a. WMNVP Highlight Report for L

Maternity and Neonatal Safety Champions – See Safety Action 9 for agenda's.

NED and CNO met with MNVP on 15th November 23

Wells 20 19/12/2023 11:32:48

Schedule of MNVP engagement from April 2021

Schedule of MNVP Engagement from Apı

Over view narrative of MNVP Engagement

Overview narrative re MNVP engagement aı

Service users views/feedback

2023 09 28 Note on Infographics.docx

2022 08 24 Interest in tours of Meadow.p

2022 08 18 Contacting Maternity

What would you like to know about IOL pr

2022 08 07 Experience of CoC - F

2020 08 20 Worcestershire MVP F

2021 09 16 Caesarean Service use

FW The Big Quality Conversation - please

3. Experiences of Triage July - Nov 23.d

MNVP leaflet

MNVP leaflet - DIGITAL.pdf

Maternity Hub Champion

4b. MNVP Local Maternity Hub Champ

LGBTQ+ engagement

- Event cancelled in 2023 (multiple factors)
- Relaunch set for Feb 24
- Planned Survey
- Advertisement in clinic areas beginning of December.
- Event staged on Eventbrite.
- Online evening event and a face-to-face event
- David Morgan – Lead for Equality, Diversity & inclusion (ICB) supporting event.

- Trust Board Declaration SA7 (8) – Can you provide evidence that the MNVP is prioritising hearing voices of families revieing neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic Backgrounds and women living in areas with high levels of deprivation?

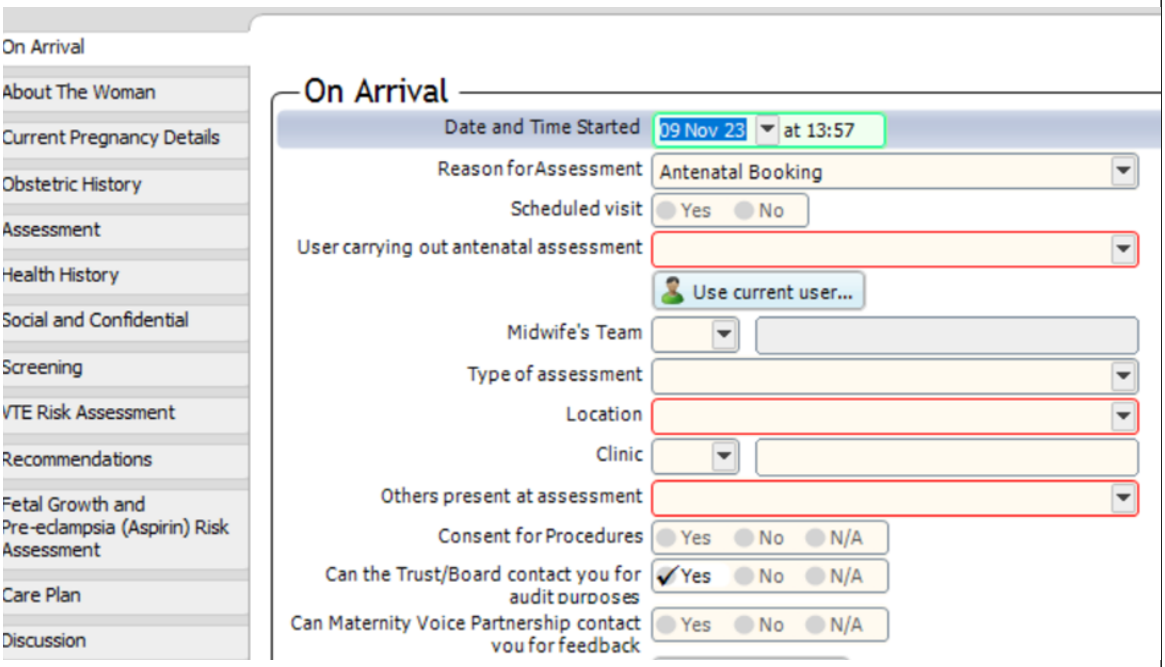
- Worcester MNVP have a lead member for Neonatal services.

Wells 19/12/2023 11:32:38

- MNVP leaflet has been redesigned to make greater reference to neonatal care and from mid-October a neonatal feature will run each Wednesday on MNVP social media.
- MNVP have linked with bereavement services and specific contact links have been made

Engagement with every woman and birthing person

- Tick box available for contact to be made by MNVP on Badgernet
- Available on very first page smart form
- Available on Antenatal follow up form.
- Informatics to produce a report for all women who have consented to contact and for this to be split by ethnicity/ vulnerable characteristics.



Wells Jo
19/12/2023 11:32:38

Safety Action 8 – Multi professional training

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Safety Action 8)1. - Required Standard

A local training plan is in place for implementation of Version 2 of the Core Competency Framework.

(30) 8)1. TRAINING - Compliant

Maternity Training and Preceptorship Pol

WRH Maternity Training -core-compe

Local Learning evidence is embedded with the Xcel spreadsheet on last tab.

- Trust Board Declaration SA8 (1) Implementation of CCF V2

Safety Action 8)2. - Required Standard

The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.

(31) 8) 2. – TRAINING - Compliant

- Trust Board Declaration number SA8 (3) Evidence of Trust Board agreement

Maternity training and preceptorship policy and WRH maternity training – core competency framework excel spreadsheet presented at Maternity Governance 18.10.23. Both documents also attached to September 23 Maternity Safety Report

Maternity Safety Report Sept 2023 Fina

Wells 19/12/2023 11:32:38

- Trust Board Declaration number SA8 (2) Evidence Quad confirmation of agreement to TNA

___INDIVIDUAL ACTION REQUIRED F(
Laura Veal - CNST SA 8____ - Agreemen
Wasi Shinwari Response required
Sinead Tullett - _Response required
Becky Fox _____INDIVIDUAL ACTIC

- Trust Board Declaration number SA8 (4) Evidence - Confirmation of agreement via LMNS

LMNS Board meeting notes 08.11

- Trust Board Declaration number SA8 (8) – Evidence you promote multidisciplinary team.

Example Attendance Sheets of PROMPT co

- Trust Board Declaration number SA8 (9) – Evidence that you promote shared learning across a LMNS.

Working across LMNS demonstrated in attachments. PDM's monthly meetings and cross boundary training events.

Record of Activity 8.8.23.docx
Record of Activity 19.9.23.docx
Record of Activity 13.10.23.docx

Safety Action 8)3. - Required Standard

The plan is developed based on the "How to" Guide developed by NHS England.

(32) 8) 3. TRAINING - Compliant

- Trust Board Declaration SA8 (5) Plan developed using How to Guide

'How to' guide - A resource pack to support implementing the Core Competency Framework (england.nhs.uk)

CNST Element 8 - Core Competency frai

Wells 19/12/2023 11:32:38

Review Evidence in 8) 1 demonstrating compliance with the how to guide.

- Trust Board Declaration SA8 (6) Service user involvement in developing training.

FW_ Reports on service user feedback.

2. WMNVP Highlight Report for LMNS Boa

Email from MNVP confirming meeting with PDM and the sharing of local cases that have been added to the TNA. Also included in LMNS highlight report.

Local Cases that are used for training can be viewed in the Xcel spreadsheet – TNA under the tab – local cases

WRH Maternity Training -core-compe

Safety Action 8) Training Compliance - Required Standard

Compliance levels of Maternity training against the core competency framework

Minimum evidential requirement for Trust Board

12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for Trust boards to review.

It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Update from NHS resolutions 23.10.23

Action 8 - Training:

80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12-month period) will be accepted. See full email below.

FW_ Revised maternity incentive sc

Revised-maternity-incentive-scheme-guida

Wells Jo
19/12/2023 11:32:38

(33) 8) – Training Compliance - Compliant

- Trust Board Declaration SA8 (10-12) – Fetal Monitoring surveillance - Compliance of 80%

SA8 (10)	Obstetric Consultants	100%
SA8 (11)	All other Obstetric Doctors	100%
SA8 (12)	Midwives	84%

PLAN – As per instructions by CNST a plan is required to meet 90% in 12 weeks' time (@ 4th March 24). Previous months have seen compliance from the midwifery cohort of over 90% but unfortunately, the December deadline compliance fell to 84%. Currently online training on K2 platform.

Action Plan	Due Date	Lead
- To roster members of staff who are noncompliant as a priority in Jan, Feb 2024 onto face-to-face training.	2.1.24	Fetal Monitoring Lead
- Individual emails to staff members with reminders	1.12.24	Fetal Monitoring Lead
- Communications on platforms such as Facebook and effective handover	2.1.24	Fetal Monitoring Lead
- Track compliance over next monthly	Ongoing	Fetal Monitoring Lead
- 2nd Email to staff in 4 weeks (copy in line managers/matrons)	4.1.24	Fetal Monitoring Lead
- After 6 weeks letter to home address, also informing HOM.	18.1.24	Fetal Monitoring Lead
- Individual appointments with staff if no completion after 10 weeks	15.2.24	Fetal Monitoring Lead

- Trust Board Declaration SA8 (13-18 and 20) – Maternity Emergencies and multi-professional training

SA8 (13)	Obstetric Consultants	100%
SA8 (14)	All other Obstetric Doctors	97%
SA8 (15)	Midwives	96%
SA8 (16)	MSW's/ HCA's	96%
SA8 (17)	Anaesthetic Consultants	100%
SA8 (18)	All other Anaesthetic Doctors	100%
SA8 (20) – All Prompts sessions have taken place in the clinical area		

Wells 19/12/2023 11:32:36

- Trust Board Declaration SA8 (19) – Demonstrate at least one emergency scenario is conducted in a clinical area.

PROMPT 2023 SCHEDULING SHEET

20/10/23

Registration	Human Factors	Emergencies	LUNCH BREAK	Bladder care session	EFM	NLS
08.45-0900	0900-1000 CHEC	Group A-10.00-11.30 Obs Unit Group B- 10.00-11.30 CHEC (15 minute - cross over period only) Group A-11.45-13.15 CHEC Group B- 11.45-13.15 Obs Unit	13.30-14.00	1400-1500	1400-1530 CHEC	1530-1700 CHEC
	All Delegates Attend	All Delegates attend	All Delegates	**MSW's/MCA's only**	**Midwives & Doctors only**	Midwives, MSW's and MCA's
				Faculty		
	Practice Development Midwife	Midwife Anaesthetist Midwife Obstetrician		Practice Development Midwife	Alice Snell	NLS Instructor
	Classification	Obs Unit		Intrapartum bladder care	IA	Prepare
	Escalation	PPH		Postnatal bladder care	Use of Local CTG Machine	Identify
	Psychological Safety	Pre-eclampsia			Intrapartum CTG	Algorithm
	Situational	Sepsis			Antenatal CTG	Timing
	Awareness	CHEC				How to call
		Breech				SBAR
		Cord prolapse Shoulder Dystocia				

Saving Babies Lives Annual training.

Compliance is combined online and face to face training. Currently part of MMT (Mandatory Maternity Training). 2024 will see face to face training annually as a stand-alone training event, with individual staff members allocated onto a date. There will also be a Saving Babies Lives Midwife to support this going forward.

Obstetric Doctors	82%
Midwives	87%

PLAN – SBL compliance Midwives with plan for completion to 90% within 12 weeks (@ 4th March 24).

Action Plan	Due Date	Lead
- To roster members of staff who are noncompliant as a priority in Jan, Feb 2024 onto face-to-face training.	2.1.24	PDM
- Individual emails to staff members with reminders	1.12.24	PDM

Wells 19/12/2023 11:32:38

- Communications on platforms such as Facebook and effective handover	2.1.24	PDM
- Track compliance over next monthly	Ongoing	PDM
- 2nd Email to staff in 4 weeks (copy in line managers/matrons)	4.1.24	PDM
- After 6 weeks letter to home address, also informing HOM.	18.1.24	PDM
- Individual appointments with staff if no completion after 10 weeks	15.2.24	PDM

- Trust Declaration Number 21-25 – Neonatal basic life support

SA8 (21)	Neo/Pead Consultants	100%
SA8 (22)	Neonatal Junior Doctors	91%
SA8 (23)	Neonatal Nurses	98%
SA8 (24)	ANNP	100%
SA8 (25)	Midwives	96%

- Trust Declaration Number 26 - Register of NLS Instructors delivering Basic Life Support on PROMPT course.

Instructor Certificate-2.pdf
IWRM2366_Attendance certificate.pdf
Instructor Certificate - NLS 202
NLS confirmation for your document.
FW_ Confirmation of RCUK Instructor s

Current PROMPT faculty members that hold an instructor certificate.

- Linda Haynes (certificate above)
- Mel People (certificate above)
- Caitlin Wilson (confirmation email above)
- Helen Tipper (Couse completed - will be fully qualified once completed 2x sessions on 29.11.23 and 5.12.23). Email attached to demonstrate HT has completed this process and is a qualified instructor as of 6.12.23.

2024 plan for NLS instructors – will be appointed to each PROMPT session.
Email below from current PDM.

Neonatal resuscitation sessio

Wells 20
19/12/2023 11:32:38

Safety Action 9 – Assurance of Safety and Quality issues

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Safety Action 9a - Required Standard

All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

Minimum evidential requirement for Trust Board

Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:
• Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues.
• Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).
• To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.

(34) 9a) ASSURANCE OF SAFETY (SAFETY CHAMPIONS) - Compliant

- Trust Board Declaration SA9 (3) – Evidence at every Trust board meeting a review report of maternity and neonatal quality is undertaken.

Maternity Safety Report Jan 2023.docx
Maternity Safety Report Feb 2023.docx
Maternity Safety Report Mar 2023.doc
Maternity Safety Report Apr 2023 V2.d
Maternity Safety Report May 2023.doc
Maternity Safety Report June 2023.doc
Maternity Safety Report July 2023 FIN
Maternity Safety Report Aug 2023.doc
Maternity Safety Report Sept 2023 Fin
Perinatal Safety Report Oct 2023 v4.

- Trust Board Declaration SA9 (2) NED appointed.

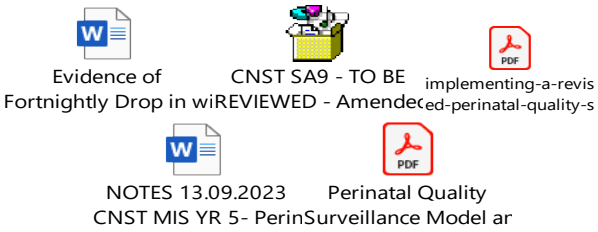
Non-Exec employed – Sue Sinclair

Safety Champions (2).png
annex-role-of-the-non-exec-board-safety-c

- Trust Board Declaration SA9 (1) 6 requirements of Principle 1 of the perinatal quality surveillance model have been fully embedded.

Wells 19/12/2023 11:32:38

Perinatal Quality Surveillance Model Revised Guideline embedded in Septembers Maternity Safety Report also on the following approved at the following platforms, Mat Gov Sep 15th, Pead's Gov 15th Sept, CNST meeting Sept 23



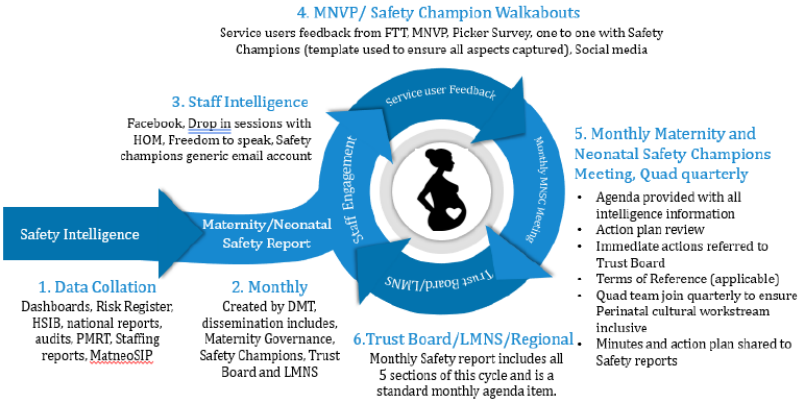
- Trust Board Declaration SA9 (4) – Evidence that the model has been reviewed with LMNS lead and regional midwife? This evidence show how Trust level intelligence is being shared to ensure early action and support for areas of concern or need.

Page 10 of the Perinatal Quality Surveillance Model (attached above) demonstrates how Safety intelligence is escalated up to regional systems.

5. Implementation

5.1 The integration of Safety Champions

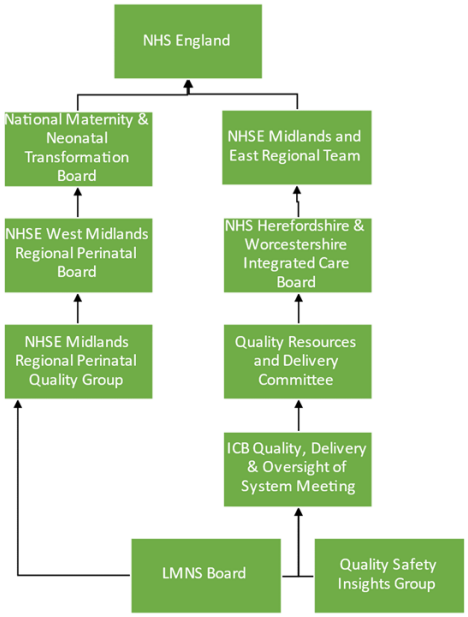
The following diagram displays how the safety champions integrate perinatal safety into the maternity and neonatal system.



Please note that the key documents are not designed to be printed, but to be used on-line. This is to ensure that the correct and most up-to-date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours and should be read in conjunction with the key document supporting information and/or Key Document intranet page, which will provide approval and review information.

Wells 19/12/2023 11:32:38

LMNS programme Director confirmed LMNS board reports into Regional Perinatal Quality Group which in turn reports into Regional Perinatal Services Board.



The Perinatal Quality Surveillance Model and M&N safety champion guideline can be viewed as an attachment of CNST documents (9) in the September Maternity Safety Report (page 19). Reviewed at LMNS Board on 8.11.23.

Maternity Safety Report Sept 2023 Fin

LMNS Board meeting notes 08.11

In addition, Insight visit with Regional team on 27th September 23 – Sandra Smith present (Regional Midwife). Meeting with Lead Assurance and Compliance Midwife at 1300 – Discussed CNST/ SBLCB.

LMNS Insight Visit schedule 27 09 2023

Safety Action 9b - Required Standard

Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

Wells, J (RWR) 19/12/2023 12:18

Minimum evidential requirement for Trust Board

Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.

(35) 9b) ASSURANCE OF SAFETY (SAFETY CHAMPIONS) - Compliant

- Trust Board Declaration SA9 (8) – Evidence of Trust claims scorecard is reviewed alongside incidents and complains data? Quarterly discussions held at least twice in the MIS reporting period at a Trust level quality meeting.

Attached Agenda's above of Safety Champions meeting with discussion of claims score card.

Claims and incidents Q1 2023-2024 FINAL
AGENDA - MNSChampions Ager
Claims and incidents Q2 2023-2024.pptx
AGENDA - MNSChampions Ager

- Trust Board Declaration SA9 (5,6) – Safety intelligence submitted to Trust board and LMNS

Meeting notes from Safety Champions meetings (Jan, March, April, May, June, July, Aug, Oct, Nov) all attached to Maternity safety Report with is fed up to board and LMNS

Safety Champions Meeting Record 09.(
Safety Champions Meeting Record 13.(
Maternity and Neonatal Safety Wal
Maternity and Neonatal Safety Wal
Maternity and Neonatal Safety Wal
Maternity and Neonatal Safety Wal
MSC meeting notes 31 08 2023 (5).docx
MSC meeting notes 20 10 2023.docx
MSC meeting notes 28 11 2023.docx

Wells 19/12/2023 11:32:38

- Trust Board Declaration SA9 (7) – Evidence that progress with actioning named concerns from staff feedback sessions is visible to staff.


Final MNSC Our Staff Said-WL Mar Apr 202


Maternity and Neonatal Safety upda


Maternity and Neonatal Safety upda

You said we did posters are disseminated to all staff via effective handover and Staff Facebook group.

Safety Action 9c - Required Standard

Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

Minimum evidential requirement for Trust Board

Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include:
• Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.
• Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented.

(36) 9c) ASSURANCE OF SAFETY (SAFETY CHAMPIONS) - Compliant

Perinatal Culture Work commenced in 2023. Quad attended the Leadership programme in October 23.


CNST Yr 5 - SA9 - Culture and Leadershi

- Trust Board Declaration SA9 (10) – NED and CNO have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit.

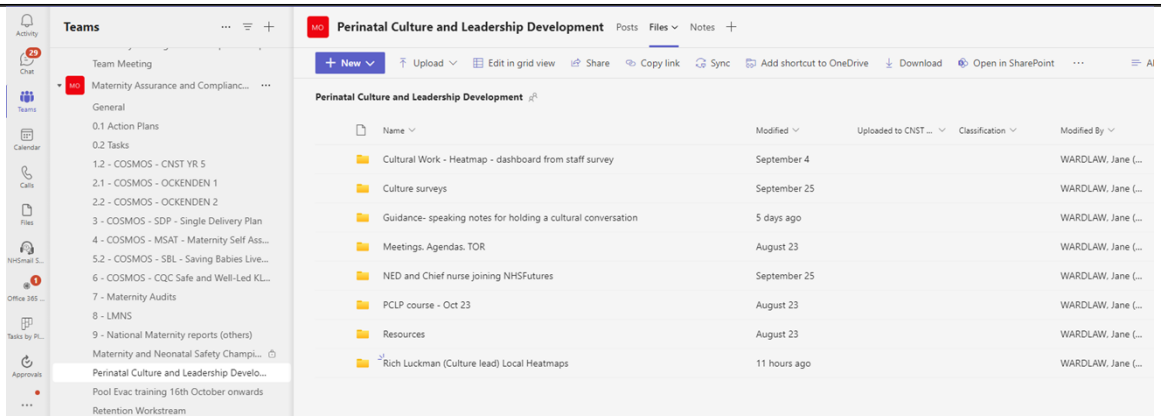

Sarah Shingler (CNO) confirmation of regist


Sue Sinclair (NED) confirmation of regist


SSi - SSh - Evidence of joining NHSFuture

Wells 20 19/12/2023 11:32:38

Teams channel created with all resources and space to save local data and resources. This is an agenda item at each Safety champion meeting. Quad only attended course at the end of October 23 therefore, work has not been embedded to date.



Terms of Reference for the Safety Champions meeting

TOR - Maternity and Neonatal Safety

- Trust Board Declaration SA9 (11) – A minimum of two quarterly meeting with champions and quad between 30th May 23 – 1st Feb 23

Safety Champions met with Quad to discuss Perinatal Culture in both August and November 23

MSC meeting notes 31 08 2023 (5).docx

MSC meeting notes 28 11 2023.docx

Perinatal Culture Leadership Programm

- Trust Board Declaration SA9 (9) – Evidence that Champions are supporting Quad in their work to better understand how this has benefit.

Reviewing meeting notes from each safety champion meeting demonstrates the links being made with Quad. Quad workstream discussed at meeting on 28th November 23 and champions are supporting this.

- Trust Board Declaration SA9 (12) – Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?

None identified as work not yet commenced. Review 28.11.23 meeting notes attached above.

Wells 19
19/12/2023 11:32:38

Safety Action 10 – HSIB

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (know as Maternity and Newborn safety investigations special health authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

Safety Action 10a - Required Standard

Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023.

Minimum evidential requirement for Trust Board

Trust Board *sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution.*
Trust Board *sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme.*
Trust Board *sight of evidence of compliance with the statutory duty of candour.*

(37) 10a) HSIB - Compliant

- Trust Board Declaration SA10 (4) – The family have received information on the role of HSIB/MNSI and NHS Resolution's EN Scheme.

HSIB information and DOC are sent together along with information of the EN Scheme. Example of letter below.

DoC letter - example for MIS.doc

- Trust Board Declaration SA10 (5) – There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect to duty of candour.

Demonstrated on page 6&7 of attached Perinatal Safety Report (formally Maternity Safety Report). Further reporting will be present in Novembers Perinatal Safety Report.

Perinatal Safety Report Oct 2023 v4.d

Wells 20 19/12/2023 11:32:38

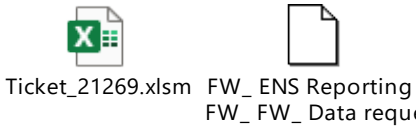
Safety Action 10b - Required Standard

Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**.

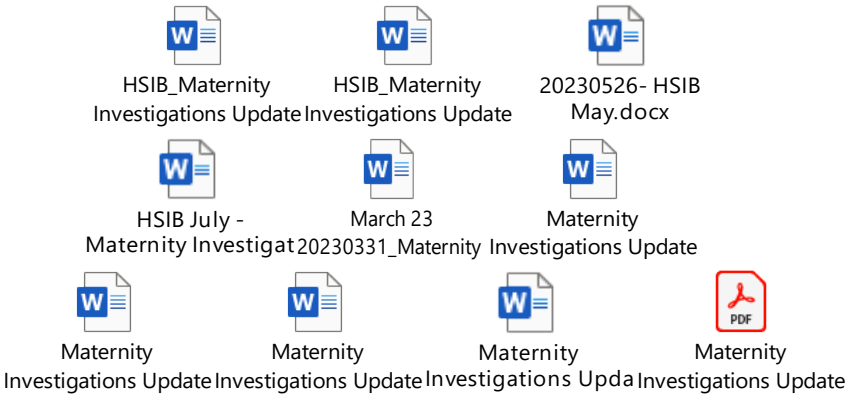
(38) 10b) HSIB – Compliant

- Trust Board Declaration SA10 (1) – Complete the field on the Claims Reporting Wizard (CMS) whether families have been informed of NHS Resolutions involvement, completion of this will also be monitored and externally validated.

Email attached below confirming that Claims Reporting Wizard has been completed on 7.12.23 (additional cases to Xcel spreadsheet attached).



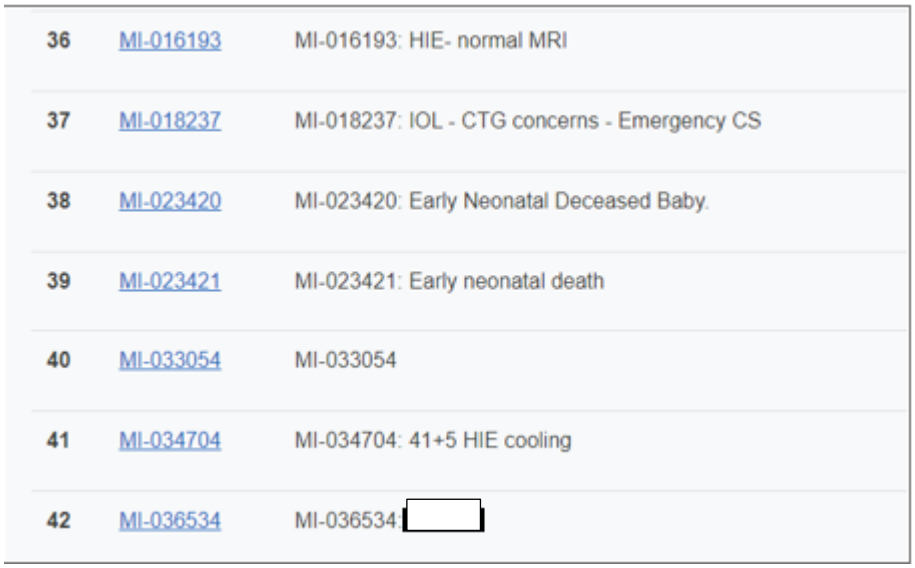
Dec 22, Jan 23, March 23, May 23, July 23, August 23, September 23, October 23, November 23, December 23



Wells 19/12/2023 11:32:38

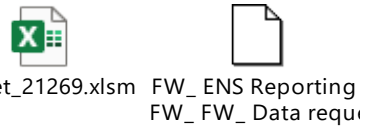
- Trust Board Declaration SA10 (2) – Have you reported all qualifying cases to HSIB/CQC/MNSI from 6th December 2022 to 7th December 23?

  MNSI Screenshot of cases – taken 7.12.23



36	MI-016193	MI-016193: HIE- normal MRI
37	MI-018237	MI-018237: IOL - CTG concerns - Emergency CS
38	MI-023420	MI-023420: Early Neonatal Deceased Baby.
39	MI-023421	MI-023421: Early neonatal death
40	MI-033054	MI-033054
41	MI-034704	MI-034704: 41+5 HIE cooling
42	MI-036534	MI-036534:

- Trust Board Declaration SA10 (3) Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2022 until 7th December 2023?



Safety Action 10 c) i - Required Standard

For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme.

i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and

ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Wells Jo
19/12/2023 11:32:38

(39) 10c) i – HSIB – Compliant

All families receive information on the role of HSIB.

DoC letter - example for MIS.doc

- Trust Board Declaration SA10 (6) – Can you confirm that the Trust Board has sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolutions?

Trust Board receive information on a monthly basis via the Maternity Safety Report (see Safety Action 9).

- Trust Board Declaration SA10 (7) – Can you confirm that the Trust Board has sight of evidence of compliance with the statutory duty of candour?

4. Maternity and Neonatal Safety Investigations (MNSI formerly known as HSIB) and Maternity Serious Incidents (SIs)

4.1 Background

The National Maternity Safety Ambition, initially launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. All cases which meet the following defined criteria are reported to MNSI (Appendix 1) and are reported in detail to the Board alongside all maternity Serious Incidents:

All term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- *Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or*
- *Was therapeutically cooled (active cooling only) or*
- *Had decreased central tone and was comatose and had seizures of any kind*

HSIB became Maternity and Neonatal Safety Investigations in October 2023. They are now hosted by the CQC. Their remit and current processes are the same at present however there are some changes to current practices.

Current MNSI cases:
A summary of the current MNSI cases is below:

MNSI reference	Date of case	DOC completed	Stage of investigation
MI023420	February 2023	Yes	Draft report returned to MNSI
MI023421	February 2023	Yes	Draft report returned to MNSI
MI033054	September 2023	Yes	Investigation ongoing – interviews arranged

We had one case referred to MNSI in October 2023, concerning a baby who required transfer for therapeutic hypothermia. Family consent has been given. Duty of Candour has been completed with this family, and the appropriate paperwork and information shared with them in accordance with the expected timeframe.

MNSI Quality Review Meetings

The maternity governance and leadership team along with the Chief Nursing Officer, continue to attend the MNSI QRM meetings; the next meeting is currently timetabled for December 2023.

Perinatal Safety Report October 2023 | Page | 7

Review Perinatal Safety Report October 2023, Further evidence will be present in Novembers Perinatal Safety Report 23.

Wells 20 19/12/2023 11:32:38

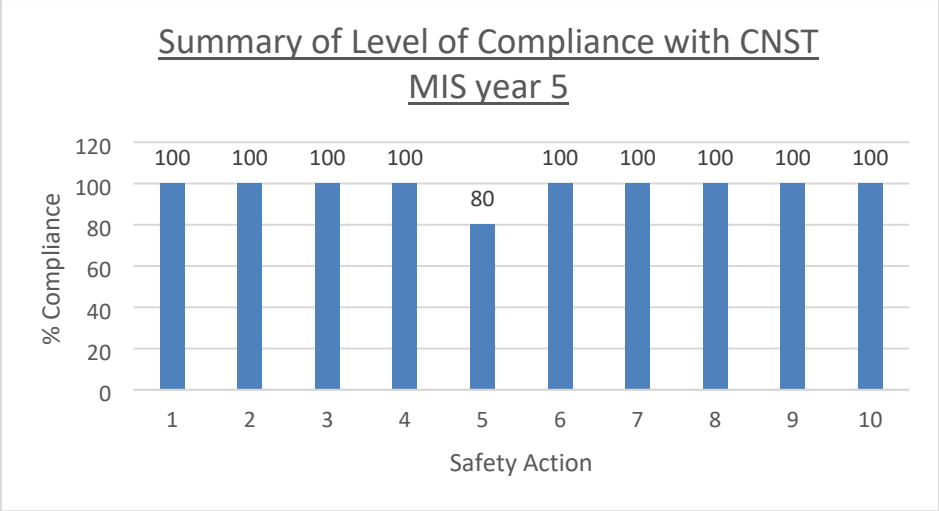
(40) 10c) ii – HSIB – Compliant
All families receive duty of candour. • Trust Board Declaration SA10 (8) – Can you confirm that the Trust Board has sight of evidence of compliance with the statutory duty of candour? *See screen shot above of Perinatal Safety Report.*

Conclusion

This report provides an update on the maternity services current position and progress of collecting the required evidence to demonstrate compliance with the CNST 10 safety actions for the Maternity Incentive Scheme (MIS) year 5.

The report provides all the available to support the Board to complete the required declaration.

The maternity service is declaring full compliance with 9 of the 10 safety actions as detailed below:



Analysis of the evidence across all elements of each safety action has been performed. Data in the above chart is taken from the CNST board declaration document total 102 minimum evidence requirements. It is noted that full compliance has been met with 99% of minimum evidence requirements, partial compliance 1% and non-compliance in only 0% of the elements.

Full breakdown of compliance can be viewed below;

Wells Jo
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Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	13	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	No	4	1	0	0	0
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	12	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes	8	0	0	0	0
			99	1			

An action plan has been created and will be included in the Board's declaration to support the request for future funding from NHSR to deliver the scheme in 2024.

The Board declaration is required for submission to NHSR on 1st February 2024 12 noon and is attached as an appendix to this report.

Recommendations

The Trust Board are asked to review the evidence submitted against the ten safety actions, agree the suggested level of compliance, complete the declaration and agree the proposed action plan, share with the ICB and submit to NHSR by 1st February 2024 12 noon.

Wells 19/12/2023 12:38

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Appendices

Trust Board Declaration

WAHT MIS_SafetyAction_2024_V12 - Board Declaration.xlsx

Further actions for total completeness

To be added to Novembers Perinatal Safety Report	
SA4	Summary Report of Consultant attendance
SA6	Minutes from SBL LMNS meeting 29.11.23
SA8	12 week training plan for compliance levels 80-90%
SA10	HSIB assurance to board summary of Duty of Candour

Wells Jo
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Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Request to exit NHS England Maternity Safety Support programme (MSSP)

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

Accountable Director	Sarah Shingler, Chief Nursing Officer: Executive Board Maternity Safety Champion		
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

Recommendations	The Quality Governance Committee is invited to: 1. **NOTE** the contents of the paper and the significant progress that has been made and; 2. Make a **RECOMMENDATION** to the Board of Directors to support the application to exit MSSP.

Executive summary	Worcestershire Acute Hospitals NHS Trust entered the NHS England Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of maternity services in December 2020. The CQC report was published on 19th February 2021 and the MSSP commenced in April 2021. At this time the maternity service was rated as Requires Improvement in the 'Safe' and 'Well Led' domains. Following the MSSP diagnostic phase, the diagnostic report with MSSP exit criteria was completed. This paper summarises the improvement journey since commencing the programme, as well as the work currently underway to continue to improve the quality and safety of maternity services. The key points outlined in this paper are: • The process for entering (at the time of the Trust entering the MSSP) and exiting the MSSP • Progress with actions from the 2020 CQC visit • Compliance with Ockenden IEAs and CNST • Progress with the MSSP exit criteria. • Ongoing actions and progress • Sustainability plans and ongoing oversight

Wells Jo 19/12/2023 11:32:23

	It is felt that sufficient improvement has been made and that the MSSP exit criteria has been met. The ongoing actions and continued improvement will be monitored via the oversight of the ICB and NHSE Regional Perinatal Team.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 x 7 | N/A		
Financial Risk	*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**					

Wells Jo 19/12/2023 11:32:28

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Introduction/Background

Introduction

Worcestershire Acute Hospitals NHS Trust (WHAT) entered the NHS England Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of maternity services in December 2020. The report was published on the 19th of February 2021 and the MSSP commenced in April 2021. At this time the maternity service was rated as Requires Improvement in the 'Safe' and 'Well Led' domains.

The NHS England Maternity Safety Support Programme (MSSP)

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP in 2021 were maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain
- Been issued with a CQC warning notice
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains*
- DHSC or NHS England /Improvement request for a review of services or inquiry
- Been identified to CQC with concerns by HSIB

*This prompted MSSP support to WAHT.

Issues and options

A Maternity Improvement Advisor was allocated to WAHT in April 2021, to work with the executive, divisional and directorate leaders to support the delivery outcomes identified in the CQC Report.

The key areas of focus of the MIA have been-

- Professional support and guidance for the senior midwifery team via 121s and joining key meetings.
- Professional support and guidance to the obstetric team alongside Richard Kennedy, NHSE Advisor
- Undertaking site walk-rounds, meeting staff and giving feedback to the senior team
- Meeting with HR team to support the improvement of recruitment pathway and HR metrics.
- Given feedback following sites visits to the two maternity Hubs; including environmental and staffing suggestions.
- Formalising criteria for off-site DAUs

Wells Jo 19/12/2023 11:32:28

- Participation in staff engagement events.
- Attendance at Incident review and Q&S meetings.
- Support with the improvement of visibility of maternity staffing, activity and acuity across the Trust.
- Support with actions taken following the publication of the Ockenden Emerging Findings report (Dec 2020). More focused support given around the provision of the review of the MCoC model at WAHT.
- Participating in the Ockenden and regional oversight visits.
- Supporting with HEE action plan in response to student midwife feedback.
- Support with reviewing the maternity theatre scrub staffing provision and subsequent business case.
- Sharing of best practice examples, JDs etc.

MSSP Exit Criteria.

The following areas for improvement and MSSP exit criteria were agreed in February 2022.

Improvement and service development identified.	**Expected outcome measure for consideration of exiting the MSSP and movement moving into the sustainability phase**
Workforce	
Review and implement the upcoming Birthrate Plus review. This should include-	Completed – re-audit planned for 2024.
A review of the establishment and rostering of each clinical area to ensure alignment and safety.	Full alignment of budgeted Midwifery establishment with best practice safety measures.
A review of the midwifery and maternity support worker support offered to obstetric antenatal clinics across the service.	Reviewed and aligned to BR Plus recommendations
A review of the reception, midwifery and maternity support working staffing in the Maternity Hubs to clearly align with the daily workload.	Ongoing full alignment of budgeted Midwifery establishment with best practice safety measures.
The glucose tolerance test pathway should be reviewed to see if any staffing efficiencies can be achieved.	Completed review with implementation plan.
A review of midwifery leadership and specialist roles to ensure that best practice recommendations are met	Reviewed and aligned to recommendations from both Ockenden and NHSE Self-assessment tool.
There should be a clear plan and succession planning for the Maternity CD role.	CD in post with succession plan in place

Wells 19/12/2023 11:32:34

Efficiency	
Recruitment process- timeliness and efficiency	Minimal delays in recruitment of staff. Effective and efficient process in place.
High number of staff with informally agreed flexible working arrangements.	All Flexible working agreements are formally agreed and in line with Trust Processes.
Lack of out of hours' theatre scrub capacity. There should be a review, risk assessment and formal options appraisal (continuation of work underway)	Plan in place
Implementation of revised maternity escalation policy.	Plan in place and evidence of effectiveness.
Safety	
Clear written guidance is needed regarding the offsite Day Assessment Units in particular the pathway for women deemed at higher risk should be articulated documented and audited.	SoP or clear guideline in place. Evidence of audit.
IoL pathway.	Evidence of ongoing monitoring, auditing and improvement work in relation to IoL.
Effectiveness	
Implementation of midwifery continuity of care.	A clear plan based on the review of current model and implications on overall safe staffing.
Some band 7 midwives would benefit from clear performance appraisal and leadership development.	-Compliance with PDRs. -Evidence of effective PDRs -Leadership development program in place for all Band 7 midwives.
A review of 'first contact' appointments and how that aligns with the antenatal pathway.	Completed review
Experience	
The maternity directorate should explore and develop a clear plan or business case to upgrade/relocate the Alexandra Maternity Hub to bring this in line with current requirements and women's expectations.	Plan in place
The maternity service should develop and plan for implementation of the Professional Midwifery Advocate role/A-EQUIP model.	Embedded A-EQUIP model Clear staffing model for implementation and sustainability.
The program to give clarity regarding the job descriptions, banding and training	Embedded MSW role within the service.

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requirements for Maternity Support Workers should be continued. This should clearly be communicated to include maternity support worker staff in the maternity hubs.	
The recommendations of the external OD obstetric review should be implemented	Progress with implementation of recommendations.
Completion and review of the pilot of self-rostering for midwifery and maternity support workers.	Clear follow up on the pilot review findings.
Midwifery Continuity of Care- Impact on staff experience and morale	Any further expansion of MCoC should have a clear communication and engagement plan.

The progress of the MSSP has been monitored via spreadsheet presented in Appendix 1. This was updated in September 2023. The document describes the current situation regarding.

- MSSP Exit criteria (including progress with the Actions agreed by WAHT Board as part of the CoC options appraisal, May 2022)
- Midwifery and Obstetric leadership team current position
- Current position re the recommendations of the Commissioned overview of Obstetrics March 2022

Current position and Supporting evidence to Exit MSSP

Progress with Actions following the CQC Inspection of Maternity in 2020

The attachment below provides information on the current position.

RAIT Summary Slide Report Sept 2023.ppt

There are currently two outstanding Must Do actions (September 2023):

- Mandatory Training – current rate 77%
- Non-medical Appraisals – current rate 70%

Compliance with Ockenden IEAs

In July 2023 the LMNS Programme Lead completed a touchpoint visit - the current compliance with Ockenden is presented in the attached document.

Copy of WAHT Ockenden Next Steps

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The areas for focus and ongoing work are as follows:

- Maternity & Neonatal Trust website
- Consultant attendance at SC meetings
- Evidence of attendance at ward rounds
- SBL v3 toolkit completion and implementation
- BRAIN to be introduced to aid informed conversations

Year 5 NHSR Maternity Incentive Scheme current position

Element	Current Status	Actions
1. PMRT		Quarterly reporting in place. Q1 report presented in Julys report. Q2 included in the appendices
2. MSDS		Ethnicity issue resolved and MCoC to be included. No issues currently identified and verified externally.
3. ATAIN		Quarterly reporting in place. Q1 report presented in Julys report. New updated action plan in appendix.
4. Clinical Workforce		To merge neonatal and maternity safety reports to ensure all workforce data reported monthly and sighted at Board – NCCR implementation plan in appendices.
5. Midwifery Workforce		Monthly staffing report presented in appendices SN status of the shift leader not met in July, August. Or September. Agreed action plan progressed.
6.Saving Babies Lives		Q2 reports will be included on October 2023 report sent in November 2023 – implementation toolkit validated by LMNS – included in CNST appendix
7.MVP		Chair and Vice-Chair working very hard on additional engagement across Worcestershire
8.MDT Training		Training plan meeting current trajectory overall – SBL training under close monitoring. Training Policy and TNA was agreed with LMNS in September. Excel calculator from CCFv2 included in CNST appendix.
9. Safety Champions		Information required available within report and appendices.
10. NHSR EN Scheme		Reporting process in place – externally validated.

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Sustainability

To give assurance regarding the sustainability of the MSSP improvements the table presented in Appendix 2 summarises the sustainability plan for the MSSP and ongoing actions.

Conclusion

It is the view of the Maternity Improvement Advisor and the Regional Chief Midwife that the criteria for leaving the programme has been met and oversight of the remaining actions can be undertaken by the ICB and Regional Teams. Therefore, the Trust seeks to exit the programme through this formal paper presented to the Regional Provider Oversight Committee.

Recommendations

The Quality Governance Committee is invited to:

1. **NOTE** the contents of the paper and the significant progress that has been made and;
2. Make a **RECOMMENDATION** to the Board of Directors to support the application to exit MSSP.

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Appendix 1 MSSP Progress

MSSP Monthly progress report Worc

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Appendix 2 Sustainability Plan

	Improvement actions	Current progress	Plan for Sustainability/ongoing progress	Trust Lead	Monitoring arrangements
Actions following the CQC Inspection of Maternity	Staff Training Compliance	77%	Provide staff with rostered time to train. Funding currently available for role specific training in midwifery budget only. Ensure rotating medical staff can 'passport' previously completed training	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team
	Appraisal Compliance	71%	Recruit to all leadership roles to ensure that there are an adequate number of leaders to complete appraisals. Agree trajectories with the directorate triumverate and manage performance via local PRMs.	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team
Y5 MIS compliance	Midwifery Staffing	9/10	Workforce team to continue to supply timely and quality data to divisional team to support reliable workforce planning.	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board.

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			Recruit to all midwifery vacancies. Maintain funding to meet BR Plus requirement. Implement agreed Theatre Business case to free up midwifery hours and reinvest hours back into delivery suite. Continue to report monthly to Board.		Oversight by ICB via LMNS Programme Team
Compliance with Ockenden IEAs	- Maternity & Neonatal Trust website - Evidence of attendance at ward rounds - SBL v3 toolkit completion and implementation - BRAIN to be introduced to aid informed conversations	88%	Continue to fund Compliance & Assurance role to monitor and coordinate progress against national documents/policy. Cross system working to continue to embed and train staff in BRAIN. Complete purchase of finger print machine to log attendance at ward rounds.	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team during Insight Visits.

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Recommendations of the Commissioned overview of Obstetrics March 2022 (two outstanding actions)	The Division should urgently consider provision of informatics/IT/data analyst resource to support timely and comprehensive clinical and workforce data flows and up to date clinical outcomes dashboard aligned with national QI indicators and priorities.		A reorganisation of the Trust Informatics team has been undertaken as it was recognised that maternity and neonatal requirements were outstripping the current available resource. There is now a dedicated informatics lead for maternity services. The maternity directorate has a substantively funded digital midwife.		
	The Directorate should develop a plan to have a consultant obstetrician/ gynaecologist rostered to all elective CS lists to ensure trainee supervision and safeguard patient safety.		Recruit to vacancies. Complete and review job plans	CD	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.
Progress with recruitment to Midwifery Leadership/Specialist	LW Lead Obstetrician		Advertise and recruit	CD	Monthly via Maternity Safety Report to Trust Board and LMNS Board.

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Team and Obstetric Leadership Team.					Oversight by ICB via LMNS Programme Team.
	Professional Midwifery Advocate Lead		This is a substantively funded post. Once recruitment is completed the role will become embedded	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.
	Diabetic Specialist MW/Mat medicine		This is a substantively funded post. Once recruitment is completed the role will become embedded	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.
Outstanding Action agreed as part of the Board CoC Options Appraisal.	Provision of Scrub RNs to eliminate the need to Midwives to scrub for Elective and Emergency CSs		Business case agreed. Cost pressure to division. Recruitment underway.	DoM	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.
Other actions in progress (MSSP Exit Criteria)	A review of the reception, midwifery and maternity support working staffing in the Maternity Hubs to clearly align with the daily workload.		Progress against this action will be monitored via the maternity directorate meeting.	Directorate Manager	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.

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	The glucose tolerance test pathway should be reviewed to see if any staffing efficiencies can be achieved.		Progress against this action will be monitored via the maternity directorate meeting.	Directorate Manager	Monthly via Maternity Safety Report to Trust Board and LMNS Board. Oversight by ICB via LMNS Programme Team.
	Clear written guidance is needed regarding the offsite Day Assessment Units in particular the pathway for women deemed at higher risk should be articulated documented and audited.		Audit completed and is included in the maternity audit plan. 11.5 Satellite DAU Audit presentation.pp	DoM	Monitored via maternity governance. Oversight by ICB via LMNS Programme Team.

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	The maternity directorate should explore and develop a clear plan or business case to upgrade or relocate the Redditch Maternity Hub to bring this in line with current requirements and women's expectations.		Currently no capital funding allocated to change/remodel estate.  AGH Maternity Hub action plan Sept 23.dc		Action plan will be monitored via directorate meeting. Oversight by ICB via LMNS Programme Team.

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Report Detail:	**Maternity Improvement Advisor Monthly Progress Report.**
Name of Trust and Maternity service	Worcester Acute Hospital NHS Trust- Worcester Royal Hospital Site
Name of Maternity Improvement Advisor	Scott Johnston
Date	9/10/23
Meetings/forums attended	MIA support has continued via MS Teams and site visits, including attendance at recent LMNS insight visit.
Summary of findings and progress to date	Executive Engagement • Oversight of Maternity is in place. There are clear lines of communication to and from the Board etc. Senior Maternity Team • DoM remit is embedded with clear reporting lines. • Dep HoM is in post. • Matron appointments. Community Matron post has been appointed. Development posts for the Intrapartum and Inpatient Matrons have been appointed. • Approval has also been given to recruit a PMA Lead and a Diabetic/Maternal medicine Specialist Midwife. These are progressing and MIA support has been offered. The plan for appointment will be key to progressing within MSSP framework. • PDM to support MCA/MSW workforce. Appointed and in place. • R&R Midwife appointed to. • The Quadrumvirate will beginning on the National Quad programme. • A new Directorate Manager for maternity has started and is leading on key areas of work. Midwifery Staffing • Matrons reporting improved staffing position moving froward due to newly qualified midwives starting. Flexible working agreements in place where required.

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	• Recruitment of New preceptor midwives on track. • No out of hours maternity theatre scrub staffing, midwifery staff undertake this role out of hours and when a second theatre is needed in hours. TME have approved the recruitment of RN scrub nurses to eliminate the need for Midwives to scrub. This is the key next step to boost midwifery staffing and exit the MSSP. • The work to align band 3 MSW role has been completed and roles are becoming embedded. • Midwifery recruitment remains on track. With an expectation of the position approaching full establishment in the Autumn of 2023. • Midwifery led NIPE service is embedded on the PN ward. Caseloading Midwifery model • The senior team have developed their implementation plan in line with national assurance processes. There is a clear understanding regarding the importance of maintaining safe staffing and communication to all stakeholders regarding any future plans. Clinical pathways • Induction of labour delays have reduced following the improvement in midwifery staffing levels. However recently, there have been times of high activity combined with midwifery staffing challenges that have impacted on flow. This continues to be closely monitored. Staff wellbeing and professional support • A number of Professional Midwifery Advocates are in place. Plan remains to employ a FT PMA, funding has now been secured. Role to be advertised shortly. Trust processes. • A much improved recruitment approval process is in place. Triage • A refresh of the BSOTs tool has been undertaken.
Specific Challenges/ interdependencies Identified	Ongoing challenges include- Lack of out of hours theatre scrub capacity- Important issue. Progressing- as above.

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Consultant Staffing for ELCS lists. Currently not all CS lists have allocated consultant presence. Lists are planned to ensure cases are allocated appropriately. However the service would benefit from additional consultants to allow all lists to be consultant led.

Lack of full time PMA support. Plans in place.

As reported previously, there are actions agreed as part of the Board CoC Options Appraisal.

These are-

1. Each MCoC team must fill all availability shifts to ensure no transfer of intrapartum care to inpatient staff- This is in place and rosters are only approved when all on calls are covered.
2. Following the completion of Birthrate plus ensure that all midwives are working in the correct area and divert any surplus staff to the inpatient area. This work is in progress.
3. Continue to manage sickness absence as per Trust policy- Support now in place and sickness is reducing.
4. Continue with active recruitment of midwives and consider incentives e.g. automatic recruitment of Worcester University students upon qualification. In place. Recruitment is on track.
5. Employment of retention midwife to improve recruitment and retention.
6. Review the provision for scrub cover in Maternity Theatre. Being followed up by MIA in September. As above, this is a key safety issue and is being followed up by the DoM and MIA. Interim DoN is sighted on the issue.
7. Ensure that there is funded backfill for Midwife sonographers. This alignment is now clear on the Establishments. Complete.

Actions / Recommendations made

Immediate recommendations and actions to date.

Action/recommendation made BY MIA	To whom	Completion date agreed	Progress since last visit
Focused HR support for maternity regarding HR information, roster management, sickness management and flexible working requests	Director of HR	TBC along with detail of the support plan	Support now in place. Completed
Review and approve Trust IoL guideline	CD	August 21	Completed
Introduce IoL prioritisation SoP	LW Lead /CD	August 21	Completed

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Integrate Maternity service into main trust Ops Centre and Site Management/Escalation processes.	DoM/Ops Lead	September 21	Last site visit- Sitreps are being provided to the site team. Team reporting that they are escalating issues. Completed
Engage the support of National CoC lead.	Consultant Midwife	July 21	Completed- Local plan has been developed
All band 7s to be given access and training on use of Eroster	DoM	August 21	Access has now been granted. Completed
External OD support for Obstetric team	Divisional MD	August 21	External support has been identified by Obs MIA. Report has been submitted to the Trust. The recommendations have been included in the Exit plan and have been updated by the Divisional Director. Good progress.
Engagement work streams with staff	DoM and Cons MW	TBC	Now restarting after COVID pause. In place.
MIA engagement with community midwives	MIA	11/11/21	Completed
Introduce clear self rostering guidance.	DoM	Aug 22	Good progress
Review of Maternity Escalation Policy	DoM	Sept 22	In progress.
Participation in International recruitment of Midwives	DoM		Completed.

Further actions to be developed to date-

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	• Follow through of Board CoC paper decision. (Including RN scrub provision). In progress • Review of the Maternity Escalation policy. In progress.
Next steps	This progress has been reported to the Regional Strategic Oversight Group. Progress has been discussed with the Regional Team and discussions held regarding moving into the sustainability and exiting phase of the MSSP. This was agreed and the sustainability plan is being formulated.
Next visit planned	Contact and support will continue via MS Teams with site visit next month.

This monthly report will be shared with:

Deputy Chief Midwifery Officer for England for maternity safety and Quality Improvement.

The trust executive and maternity clinical leadership team

The Regional Chief Midwife and the Regional Chief Nurse and Medical director.

This will be reported to the Regional JSOG

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Assurance levels Nov 2020

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Communications and Engagement Update

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

Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	**Author /s**	Richard Haynes

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	Board members are asked to note the report.

Executive summary	This report provides Board members with examples of significant communications and engagement activities (including charity and fundraising activities where relevant) which have taken place since the last update (September 2023) as well as looking ahead to key communications events/milestones in coming months. It also includes recent examples of our more successful proactive media and social media work which help to improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 12: If we have a poor reputation then we will be unable to recruit or retain staff, resulting in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care

Assurance Level (x)	0	1	2	3	4	5	x	6	7	N/A	
Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes.										

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

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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	X	
Timescales to achieve next level of assurance	**Communications and engagement priorities for 23/24 are aligned with Trust planning priorities and timelines in ways which are consistent with our Communications Strategy, subject to capacity constraints. Progress and issues will be reflected in future Board updates**				

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Introduction/Background

This report provides Board members with examples of significant communications and engagement activities (including charity and fundraising activities where relevant) which have taken place since the last update (September 2023) as well as looking ahead to key communications events/milestones in coming months.

It also includes recent examples of our more successful proactive media and social media work which help to further improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff.

Issues and options

New Trust Internet Goes Live

After several months of planning and development (reported in a previous update to Board) our new Trust website went live in October at www.worcsacute.nhs.uk

Our public website – the 'shop window' of our Trust – is visited by more than half a million people every year. The previous version, which had been in place for several years, was built on an ageing and outdated platform which as well as limiting development opportunities also made it more difficult for us to fulfil our statutory duties under national web content accessibility guidelines.

Working with a stakeholder engagement panel, which included members of our Patient and Public Forum, we looked at potential design ideas and talked through the visitor experience when visiting our website.

Their input informed the final look of the website as well as the navigation and helped us to deliver a more streamlined design, which uses simpler, clearer navigation and offers improved signposting to high-traffic areas. The new site also makes it easier to add alerts to highlight and promote key messages, with simpler, more user-friendly templates.

The accessibility regulations for public sector bodies were most recently updated in October this year. They require public sector organisations to make sure websites and apps meet accessibility requirements to ensure they can be used by as many people as possible. This includes those with impaired vision, motor difficulties, cognitive impairments or learning disabilities, deafness, or impaired hearing.

Our new website fulfils more accessibility requirements than the previous version but there is more work to do – for example ensuring that documents uploaded to the website, including patient information leaflets, and reports, also meet accessibility standards.

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Over the coming months we will be working with teams who wish to update their content to advise on accessibility and the steps teams can make to ensure that the content that they are producing is accessible if it needs to be published on the public website.

Work is now also under way on moving to a new Intranet, which should offer staff across the Trust improved access to a range of important information. An update on that programme will follow in future Board updates.

Theatre Recruitment Campaign

The opening of two new operating theatres at the Alexandra provided an opportunity for the communications team to work with clinical and recruitment colleagues on a recruitment campaign built around an open day event at the Alexandra in November.

The campaign included:

- A co-ordinated and targeted online recruitment plan incorporating organic and paid-for advertising on social media networks.
- The #WAHT messaging developed for general recruitment for the Trust was incorporated into new theatre recruitment specific graphics with a focus on two key messages.
- Brand new Theatre Recruitment Brochure using new #WAHT message.
- Pull-up banners
- Press releases
- Video content for social media
- Work for us webpages on the Trust website.
- Promotion of content with support from ICB and Worcestershire County Council particularly aimed at schools and colleges.

Free exposure via our own social media channels was supplemented with the use of paid for Facebook advertising, creating an 'Event' which uses the Facebook algorithm to target people with a likely interest. This helped us to build interest with a targeted audience (those who ticked 'Interested' or 'Going') who could receive notifications when additional content was published and could also ask questions about the event and receive direct messages from the recruitment or theatre teams.

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Results of the Facebook Event advertising showed a good return on investment:
Total Budget: £416
Duration: 19 days.
Ads shown to 27,556 different people a total of 89,884 times
Discussion page: 320 registered an interest with another 39 confirming they were going.

A pre-event media release also attracted significant coverage in local press as well as a radio interview request from BBC Radio Hereford and Worcester.

The event proved to be busy and successful with more than 60 potential candidates attending over the course of the day.

Following the campaign and the event the team received seven applicants for Operating Department Practitioner roles (Band 5) and have shortlisted five for interview.

More than 50 people applied for Theatre Support Worker roles (Band 2) and 17 have been shortlisted for interview.

On the day evaluation provided some further insight into how those attending had been reached

Further evaluation will follow the completion of the interview process and will be used to shape future recruitment campaigns (including a soon to be launched campaign to support our pharmacy service.

Staff Recognition Awards 2023

More than 300 colleagues, sponsors and guests gathered at the studios of our friends at DRP Group in Hartlebury on 24 November for a memorable evening that showcased some of the brilliant work that has been going on across our hospitals and recognised some of our most outstanding people and their extraordinary efforts.

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Our host for the evening, comedian Zoe Lyons, was supported in fine style by our Chair Russell Hardy and Managing Director Stephen Collman.

Winners on the night spanned a wide range of services across all our sites.

Among the most popular were Lesley Fage and her therapy dogs Aero and Casper, who picked up the Outstanding Volunteering Award.

Thank you to all our sponsors for their generous support of the event and to members of the our charity and communications teams who worked so hard to plan and deliver such an enjoyable and uplifting event.

Worcestershire Acute Hospitals Charity Christmas Appeal

Worcestershire Acute Hospitals Charity has launched a Festive Appeal to raise £20,000 this Christmas to provide extra comfort and rest for the families of patients who are at the end of their lives in our hospitals.

The appeal aims to raise funds to provide 20 additional day beds for our Palliative and End of Life Care team. Day beds are comfortable reclining chairs suitable for wards that can be adjusted to various positions and laid completely flat.

Our Palliative and End of Life Care team is committed to providing high quality, supportive care for patients and their loved ones at the end of their life, and families are able to stay in hospital with their loved ones around the clock when a patient is at the end of their life. However, trying to rest during this difficult time can be tough when on a ward, and often loved ones have to try and get what sleep they can, sat up in a chair.

The Charity has previously funded five day beds which have been in constant use and these additional beds will provide a greater degree of comfort and better rest for more families at a difficult and emotional time.

Online donations can be made at https://bit.ly/JGDayBeds or by texting text 'DAYBED' to 70460 to donate £5. Texts will cost the donation amount plus one standard network rate message.

Worcestershire Winter Brief

Through the Worcestershire Place Comms Cell, a winter briefing for staff from across our local health and care system was arranged and delivered in November. The briefing was online (via Teams) with presentations from our Trust and colleagues from the Health and Care Trust, ICB, County Council and voluntary sector.

Around 300 members of staff joined the live briefing, and a recording was also shared through organisational internal communications channels.

Other issues which have required significant communications support since the last Board update include:

Industrial action: Continued internal and external communications support has been required for our response to industrial action by a number of health service unions – and will continue with further industrial action expected (at the time of writing) by Junior Doctors in December and January.

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And finally…

Among the best received stories we have shared recently was that of a young cancer patient, Ewan Lugg, who had been receiving treatment in our Paediatric Oncology Clinic at Worcestershire Royal Hospital for over three years for Acute Lymphoblastic Leukaemia. After going through an intense chemotherapy plan with our team, he finally got to celebrate completing his treatment in October with a special afternoon in the clinic's garden where he rang our End of Treatment Bell alongside his family.

To mark the occasion and help huge Queen fan Ewan to celebrate the good news, our Children's Clinic team dressed up as members of the band and planned a special performance with our Children's Services Directorate Manager, Michael Croutear who moonlights as an impressive on-stage Freddie Mercury.

We helped arrange media interviews with Ewan's family, who were pleased to take part, and got coverage of Ewan's story and his end of treatment celebrations across regional television, radio, online news, and print.

We also shared our video capturing the celebrations on our Trust's social media channels, which was seen over 15,000 times, 'liked' over 1,000 times, and commented on by hundreds of local people.

Conclusion

Demand for communications and engagement support continues to grow. With finite capacity we are trying to focus our time and skills on those areas which will provide most value to the Trust's wider strategic and operational priorities.

Recommendations

Board members are asked to note the report.

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WAHT Finance Recovery Board

TERMS OF REFERENCE

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

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	• Aim to prevent the realisation of adverse impacts through early identification of risks and issues. • Receive remedial proposals where significant variation exists from plans to deliver the elective activity / income. • Receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources. • Provide assurance to the Trust Management Board and Board that the programmes of work are being progressed as required and will escalate any significant concerns or variance to plan that have the potential to adversely impact delivery of the Trust's plans. • Test the assumptions and mechanics of the plan providing assurance to FPE / Board that the plan is reasonably based including triangulation with activity / performance and workforce metrics. • Ensure that an action plan with specific ownership is created for each component of the plan and is tracked to completion. • Seek formal assurance from SROs that financial controls on key drivers of the deficit are operating effectively through regular reports. • Agree status reporting and items of escalation to TMB/Trust Board/ICB & NHSE • Agree internal / external communications regarding progress on FRP • Ensure that Quality Impact assessments are considered as appropriate.
Membership / Attendance	Members of the FRB are: • Non-Executive Directors • Chief Executive • Managing Director • Chief Officers • Turnaround Director • Director of Strategy Improvement & Planning • Director of Estates and Facilities • Director of Communications and Engagement • Head of PMO

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

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Administration	A member of the PMO Team shall agree the agenda with the Chair and Turnaround Director, organise the collation and distribution of the papers and keep a record of actions/matters arising to be carried forward. Papers will be issued 48 hours before and in exceptional circumstances tabled as necessary given the live status of the programme.
Date Approved	WAHT Board
Date Review	To be reviewed annually. Next review due by

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SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

WAHT Minutes of the Public Foundation Group Boards Meeting
Held on Wednesday 1 November 2023 at 1.30pm via Microsoft Teams
In Parallel with GEH, SWFT and WVT

Present:

Russell Hardy	(RH)	Group Chairman
Glen Burley	(GB)	Group Chief Executive
Christine Blanchard	(CB)	Chief Medical Officer WAHT
Tony Bramley	(TB)	NED WAHT
Neil Cook	(NC)	Chief Finance Officer WAHT
Richard Haynes	(RH)	Director of Communications WAHT
Helen Lancaster	(HL)	Chief Operating Officer WAHT
Michelle Lynch	(ML)	NED WAHT
Karen Martin	(KM)	NED WAHT
Julie Moore	(JM)	NED WAHT
Richard Oosterom	(RO)	NED WAHT
Tina Ricketts	(TR)	Director of People and Culture WAHT
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
Sue Sinclair	(SS)	ANED WAHT

GEH:

Catherine Free	(CF)	Managing Director GEH
Natalie Green	(NG)	Chief Nursing Officer GEH
Gavin Hawes	(GH)	Communications and Engagement Manager GEH
Mark Hetherington	(MH)	ANED GEH
Julie Houlder	(JH)	NED GEH
Haq Khan	(HK)	Chief Finance Officer GEH
Rosie Kneafsey	(RK)	NED GEH
Jenni Northcote	(JN)	Chief Strategy Officer GEH
Gertie Nic Philib	(GP)	Chief People Officer GEH
Sarah Raistrick	(SR)	NED GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Jackie Richards	(JR)	ANED GEH
Robin Snead	(RS)	Chief Operating Officer GEH
Umar Zamman	(UZ)	NED GEH

SWFT:

Charles Ashton	(CA)	Chief Medical Officer SWFT
Varadarajan Baskar	(VB)	Deputy Medical Director SWFT
Adam Carson	(AC)	Managing Director SWFT
Oliver Cofler	(OC)	ANED SWFT
Richard Colley	(RC)	NED SWFT
Phil Gilbert	(PG)	NED SWFT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Paramjit Gill	(PG)	NED SWFT
Harkamal Heran	(HH)	Chief Operating Officer SWT
Oli Hiscoe	(OH)	ANED SWFT
Kim Li	(KL)	Chief Finance Officer SWFT
Simon Page	(SP)	NED SWFT
David Spraggett	(DS)	NED SWFT
Ellie Ward	(EW)	Deputy Chief Nursing Officer SWFT (deputising for Fiona Burton)

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SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

WAHT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

Sue Whelan Tracy	(SWT)	NED SWFT
Leigh Tranter	(LT)	Communications SWFT

WVT:

Chizo Agwu	(CA)	Chief Medical Director WVT
Jon Barnes	(JB)	Chief Transformation Officer WVT
Ellie Bulmer	(EB)	Associate Non-Executive Director WVT
John Burnett	(JBu)	Head of Communications WVT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Geoffrey Etule	(GE)	Chief People Officer WVT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Kieran Lappin	(KL)	ANED WVT
Frances Martin	(FM)	NED WVT
Frank Myers	(FMy)	ANED WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Jo Rouse	(JR)	NED WVT
Nicola Twigg	(NGi)	NED WVT

Foundation Group:

Vanessa Nicholls	(VN)	GEH Board Secretary (deputising for the Foundation Group EA)

There were five SWFT Governors and two members of the public also in attendance.

MINUTE		**ACTION**
23.074	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Yasmin Becker (NED SWFT); Fiona Burton (Chief Nursing Officer SWFT); Paul Capener (ANED GEH); Andrew Cottom (NED WVT); Becky Hale (Chief Commissioning Officer SWFT); Erica Hermon (Associate Director of Corporate Governance / Company Secretary WVT); Sharon Hill (ANED WVT); Colin Horwath (NED WAHT); Simone Jordan (NED GEH); Vikki Lewis (Chief Digital Officer WAHT); Anil Majithia (NED GEH); Simon Murphy (NED/Deputy Chair WAHT); Jo Newton (Director of Strategy and Planning WAHT); Katie Osmond (Chief Finance Officer WVT), Bharti Patel (ANED SWFT) and Mary Powell (Head of Strategic Communications) and. **Resolved – that the position be noted.**	
23.075	**DECLARATIONS OF INTEREST** Frank Myers (ANED WVT) declared his appointment as Chair of Community First Herefordshire and Worcestershire.	

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WAHT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

MINUTE		ACTION
	Standing down as NHS's longest serving Non-Executive Director in December 2023, the Group Chairman took time to thank Frank Myers for his hard work and commitment during his tenure at WVT and wished him well in his new role. **Resolved – that the position be noted.**	
23.076	**GEH PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the GEH public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.077	**SWFT PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the SWFT public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.078	**WVT PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the WVT public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.079	**CHAIRMAN'S REMARKS** The Group Chairman welcomed to the Foundation Group: • Chizo Agwu as the new Chief Medical Officer for WVT, and • Oli Hiscoe, Oliver Cofler and Bharti Patel as new Associate Non-Executive Directors for SWFT. A note of thanks was also extended to WVT's former Chief Medical Officer, David Mowbray, who had taken up appointment as Chief Medical Advisor for SWFT Clinical Services Ltd. With the Foundation Group celebrating a number of special days throughout November 2023 like Remembrance Day, the Group Chairman spoke proudly of the close working relationship with veteran organisations across the Foundation Group, as part of the signed covenant with the Veterans Covenant Healthcare Alliance. On behalf of the Foundation Group, the Group Chairman took the time to thank veterans and their families for their enormous commitment to service over the years. Other special events being celebrated as part of the Foundation Group's Equality, Diversity and Inclusion (EDI) agenda throughout November 2023 included Diwali; Transgender Awareness Week; UK Disability Month; Islamophobia Month and White Ribbon Day.	

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MINUTE		ACTION
	Resolved – that the Chairman's Remarks be received and noted.	
23.080	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.080.01	Foundation Group Performance Report (Minute 23.058 refers) The Managing Director at WVT informed the Foundation Group Boards that work to understand how many diagnoses of cancer each trust had in their Emergency Departments (EDs) remained ongoing. Whilst Information Leads were confident that the data could be produced, it was noted that this may take some time as changes to Information Technology (IT) systems may be required in order to provide an accurate position.	**JI/CF/AC**
	Resolved – that the Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust.	
23.081	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chairman provided an overview on some of the interesting topics covered at the Foundation Group Boards Workshop earlier that day. Presentations included 'Big Move' updates on the work being done around Carbon Reduction, of which the Foundation Group was at the forefront of within the NHS, and the Home First agenda which updated on the important work happening as a whole with partners across health, social care and the voluntary sector to help provide the right care for patients in the right place and by the right team. A focused discussion also took place on agency and locum controls across the Foundation Group, which had indicated early signs of progress in agency and locum reduction. A presentation then followed by Guest Speaker Sir Thomas Hughes-Hallet from Helpforce, who spoke positively about the work of volunteers and the important role they played within the NHS. With GEH recognised at the National Helpforce Champions Awards in October 2023, the Group Chairman thanked the GEH Head of Patient Experience and Volunteering and team for their phenomenal volunteering work which had won them the Volunteering Collaboration of the Year Award. With volunteering known to be beneficial for one's health, and vital in enabling the NHS to provide better care for the citizens we served, the Group Chairman encouraged anyone considering volunteering to contact any of the four organisations to express an interest in becoming a valued member of the team.	

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	Reflecting on those Board Workshop presentations heard earlier that day, the Group Chief Executive remarked that this had reinforced the opportunity across the Foundation Group for sharing some of the great practice that was happening. In particularly on areas like the Carbon Reduction Big Move, which in all four trusts had shown action underway, and a lot of engagement with different disciplines and staff that meant carbon reduction was being positively looked at from all angles. Opportunities for shared learning across the Foundation Group had also seen great progress being made around agency and locum controls. **Resolved – that the position be noted.**	
23.082	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director at WVT provided the Foundation Group Boards with an overview of the performance at WVT. She informed the Foundation Group Boards that for the period July to September 2023, WVT had been ranked top performing Trust across the region for delivering on average 117% of its value weighted elective activity; compared with pre-Covid elective activity in 2019/20. Although an area for celebration, WVT recognised that there were still opportunities to explore and improve theatre productivity further. The Managing Director at WVT explained that whilst WVT's performance against the national 28 Day Faster Diagnosis Standard (28 Day FDS) remained on track, delays in histopathology reporting had been sighted as one of the main issues impacting on performance. Despite outsourcing arrangements and mutual aid being in place, this had led to longer turnaround times and thus, extending waiting times for patient's diagnosis and treatment. Notwithstanding, she highlighted a real opportunity for Chief Medical Officers across the Foundation Group to lead the way on a histopathology network solution to improve reporting times for all patients across the Foundation Group. Raising WVT's ED performance as an area for concern, the Managing Director at WVT reported that one of the biggest drivers for underperformance had been the deterioration in medically fit for discharge patients, who had been delayed in hospital. Notwithstanding, she was confident that following the recent delegation of the Better Care Fund, this would provide opportunity for improved ownership as to how resources would be used across Herefordshire; particularly to help drive improvement around Discharge to Assess (D2A) pathways. Other opportunities to help improve ED performance via the Virtual Ward model included going live that day with Docobo, a system that enabled patient's vital signs to be monitored remotely and the Surgical Same Day Emergency Care (SDEC) facility that would go live later that month. The Group Chairman invited questions and perspectives, and of particular note were the following points.	

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	For context, the Group Chairman explained that keeping patients in an acute setting when fit for discharge cost the NHS approximately £300 per night, opposed to £50 per night for a domiciliary care package in the community. Acknowledging that more could be done to improve the HomeFirst model, he stressed that without the support of social care and domiciliary care providing capacity in the community, this not only posed a risk of hospital acquired decline for the patient but also meant a significant net loss to the taxpayer, of approximately £250 per day, per patient. Nicola Twigg (NED WVT) queried if there was any specific reason why breast cancer related 28 Day FDS statistics were particularly low for WVT. As previously mentioned, the Managing Director at WVT explained that the deterioration in performance had been due to delays in histopathology reporting and thus, reiterating a big opportunity to improve histopathology by networking the service across the Foundation Group to ensure turnaround times remained consistent for patients across all four trusts. The Managing Director at SWFT provided the Foundation Group Boards with an overview of the performance at WVT. Reporting an incredibly busy month for SWFT's ED during September 2023, he highlighted that despite higher attendances, the A&E 4-hour performance was better when compared with the same period in 2022/23, maintaining SWFT's place within the top ten trusts nationally. Record number of attendances had also been seen through WVT's SDEC areas in September 2023; positively reflecting the level transformation work happening within Emergency Care Services. The Managing Director at SWFT highlighted significant concern as to the high number of patients arriving via intelligence conveyancing (IC) from West Midlands Ambulance Service (WMAS). He reported that during September 2023, SWFT admitted 81 'out of area' patients of which a number had been deemed inappropriate. With 'out of area' patients often proving difficult to discharge; impacting on both length of stay (LoS) and bed occupancy, and with the number of IC cases increasing month on month, the Foundation Group Boards was informed that the Trust was working with WMAS and the Integrated Care Board (ICB) to address the issue, as this was a particular concern heading into winter. Updating on Cancer Services, the Managing Director at SWFT explained that one of the biggest challenges for the Trust had been around the sustained increase in Cancer two week wait (2WW) referrals seen in recent months. Despite this, SWFT had made notable improvements in the 28 Day FDS and good progress in reducing the number of patients waiting over 62 days for treatment; placing SWFT ahead of the fair shares Integrated Care System (ICS) trajectory. With the majority of SWFT's oncologist cover provided by University Hospitals Coventry and Warwickshire NHS Trust (UHCW), the Managing Director at SWFT assured the Foundation Group Boards that the Trust	

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	continued to work with UHCW to improve waiting times for first oncology appointments. Focussing on Referral Time to Treatment (RTT) performance, the Managing Director at SWFT was pleased to report a continued reduction in 65 week waits, with SWFT on track to eliminate both admitted and non-admitted elective waits by 31 March 2024. Good progress had also been made on reducing 52 week waits, supported by the learning from the Getting it Right First Time (GIRFT) Further Faster programme and general improvements seen across specialties in elective care. The Managing Director at SWFT celebrated the Trust's improvement work done with the Endoscopy Service. Achieving over 98% utilisation in recent months had ranked SWFT favourably as one of the highest performing organisations within the country. The Group Chairman invited questions and perspectives, but no further comments were raised. The Managing Director at GEH provided the Foundation Group Boards with an overview of the performance at GEH. With high bed occupancy a consistent theme to that experienced across the Foundation Group, the Managing Director at GEH explained that this had been particularly challenging for GEH, inevitably impacting on flow and performance metrics. In order to maintain flow, she reported that extra capacity had been opened, with patients (where safe to do so) boarding on wards to help maintain safe care for patients. The Managing Director at GEH reported that the Trust's A&E 4-hour performance continued to perform well when compared nationally, with a slight improvement seen in the performance metric for September 2023. It had also been positive to note that GEH continued to perform well in regard to low numbers of ambulance handovers waiting over 60 minutes. Notwithstanding, GEH had seen the number of ambulances waiting between 30 and 60 minutes increase, something the ED was keen to eliminate so that patients could be admitted and treated as soon as possible. With sickness absence rates remaining high, the Managing Director at GEH assured the Foundation Group Boards that a lot of work had been done around staff wellbeing and supporting individuals to manage sickness levels. An area which would continue to be an ongoing focus for the Trust. Although GEH's position regarding the Cancer 28 Day FDS had been as predicted, the Foundation Group Boards were informed that the Trust was forecasting some deterioration in that position over the coming months due to some fragility around staffing in the Urology Service. Although staffing issues had been mitigated, this and the impact of industrial action were likely to have some effect on urology pathways, given the need for specialist consultants to	

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deliver the whole of the cancer pathway, including things like Multi-Disciplinary Team (MDT) meetings, which were important for decision making in cancer.

Focusing on RTT performance, the Managing Director at GEH was pleased to report that GEH continued to have low numbers of patients waiting over 65 weeks for treatment. Whilst there had been an increase in the number of patients waiting over 52 weeks, the Trust remained focused on treating long waiters and providing mutual aid to patients in gynaecology from UHCW.

For context, the Group Chairman remarked that as a result of SWFT and GEH performing relatively well on ED and Maternity performance, this had seen an increase in demand for both trusts, which combined meant that they were providing circa 60% of the ED and Maternity flow for Coventry and Warwickshire.

The Group Chairman invited questions and perspectives, but no further comments were raised.

The Group Chief Executive on behalf of WAHT provided the Foundation Group Boards with an overview of the performance at WAHT.

The Group Chairman announced that as of 6 November 2023, Stephen Coleman would take up position of Managing Director at WAHT.

On behalf of the Foundation Group Boards, the Group Chief Executive thanked the Head of Information at WVT for coordinating the Performance Report across the Foundation Group. He also thanked WAHT's Information Team for producing the Trust's data in line with the rest of the Foundation Group as having a consistent overview enabled the Foundation Group to get to the heart of performance issues and opportunities.

With WAHT subject to a degree of regional scrutiny on performance as a tier two level Trust, the Group Chief Executive remarked that WAHT's A&E 4-hour standard and ambulance handover times remained the Trust's biggest cause for concern. The Trust was therefore focusing on flow and opportunities to do more activity through SDEC.

Positive to note that WAHT's mortality figures remained within expected range, the Group Chief Executive was particularly pleased to report the WAHT's theatre utilisation performance was ranked the strongest across the Foundation Group, achieving 87% on the uncapped touch time indicator, presenting a real opportunity for shared learning.

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With WAHT's cancer performance ranked as a significant outlier 12 months ago, it had been positive to report that performance had been on a steady improvement trajectory with performance around 2WWs and 28 Day FDS on track. Acknowledging that Cancer 62-day waits were longer than would like,

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	the Group Chief Executive was hopeful that the GIRFT Faster Further programme would lead to further improvement in the future. The Group Chief Executive informed the Foundation Group Boards that WAHT had been removed from tier two monitoring in respect of its RTT 52 week wait performance. Whilst positive, he highlighted that with RTT performance at 49% and a worryingly increase in 52 week wait numbers, this was something the Trust would need to focus on. However, he was optimistic that the opening of additional theatres last month at the Alexandra Hospital would provide that additional capacity moving forward. Asked by the Group Chairman to give an overview on NHS England's (NHSE's) Ten-Point Plan (10PP) initiated to improve WAHT's performance, the Group Chief Executive explained that the 10PP's main focus was an emphasis on flow and the need to improve processes within the hospital. In particular around medical specialities as that would enable patients to be pulled from ED and treated by the right speciality and discharged home as early as possible. There was also an opportunity identified within the 10PP to have more HomeFirst and supported discharges through community services. Elements within the 10PP also included the need to focus on improving WAHT's approach to staff, like improving areas like car parking, to help improve on sickness absence levels and organisational recruitment, and simplifying the Trust's approach to improvement by having as many people as possible trained in improvement methodologies so that they could be responsive to immediate issues like flow. The Group Chairman invited questions and perspectives, but no further comments were raised. The Group Chairman remarked that despite best endeavours by all four trusts within the Foundation Group to deliver the level of service they aspired to for the citizens they served, he wanted to apologise on behalf of the Foundation Group Boards to patients and their families for the long waits being experienced. An apology was also extended to ambulance crews hindered by capacity constraints delaying patient handovers. **Resolved – that the Foundation Group Performance Report be received and noted.**	
23.083	**OUTPATIENT PRODUCTIVITY** The Chief Operating Officer at WAHT opened the presentation on outpatient productivity. This set out the progress being made across the Foundation Group in the delivery of improving outpatient productivity and how that aligned with the transformational work happening and the Further Faster programme.	

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With the appointment of a Group Analyst in October 2023, the Chief Operating Officer at WAHT was pleased to report that the role would be supporting the outpatient productivity peace of work, using internal and external benchmark data to help further identify opportunities for improvement.

In more detail the presentation focused on the work around the Further Faster programme, Patient Initiated Follow Up (PIFU), NHSE Transformation Ask and any other national involvement initiatives like the NHS Elective Recovery Programme and GIRFT.

Having identified a number of similarities from each of the Trust's Outpatient Transformation Programmes, the Foundation Group Boards were notified of three key areas of focus which would be driven collectively by the Foundation Group to improve productivity; which included:

a) improving communication to our patients;
b) using IT to support improvements around productivity, and
c) undertaking specialty deep dives and service reviews.

Focusing on RTT performance for each of the organisations, the Chief Operating Officer at WAHT talked through those factors driving the increase in waiting list numbers, together with the combined actions being taken by the Foundation Group to address that increase. It was noted that with the exception of WAHT who had seen a slight decrease in the number of patients on the waiting list, performance charts for SWFT, GEH and WVT had shown a gradual increase in their waiting list position.

Focusing on Cancer 2WW performance, the Chief Operating Officer at WAHT reported that all four organisations had seen a significant increase in Cancer 2WW referrals across a range of specialities. However, it had been particularly interesting to note that the pattern in 2WW surges had been very similar across the Foundation Group. The Chief Operating Officers would therefore undertake a deep dive into that 2WW referral pattern to help understand and predict where surge areas were likely to arise for particular specialities and help understand what that meant for the rest of the pathway, particularly around cancers.

The Chief Operating Officer at WVT explained that PIFU was a patient led activation of their follow up appointment, based on their symptoms and individual circumstances. Emphasising that PIFUs should not be used in place of discharging patients appropriately, it was noted that this would be a key measure that would need to be embedded correctly across the Foundation Group. With all four trusts currently at different stages in delivering PIFU, particularly within specialty plans, it had been positive to note that there was clear clinical leadership and pathways being developed. He remarked that looking at best practice across the 28 trusts involved in the Faster Further programme and looking at case studies and benchmarking, together with using the average and mean across PIFU, would be key for the Foundation Group;

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including the need to look at local solutions where case studies could be amended as necessary.

Opportunities being considered by the Foundation Group included PIFU case studies to drive down Do Not Attends (DNAs) for new appointments and patient reactivation rates for PIFU specialties. Although nationally GIRFT evidence suggested that most patients returned less often when empowered to manage their own follow up pathway.

With DNAs a core area of focus of operational delivery in outpatients, the Foundation Group Boards were informed that Chief Operating Officers were focusing on a number of opportunities and solutions using GIRFT best practice to minimise the impact of unused appointments. In particular through using digital solutions and working with the Volunteer Service to make reminder calls in services with the highest DNA rates.

Focusing on outpatient utilisation, the Foundation Group Boards were briefed on the approach being taken to adopt the 6-4-2 scheduling process commonly used in theatre processes to reduce clinic cancellations. As part of the Faster Further programme it was noted that there had been job plans, best practice and specialty based best practice clinic templates released to help trusts improve outpatient utilisation. There would also be a focus on clinic comparison data including the percentage of follow ups and percentage of new patients at specialty and subspecialty level.

With varying degrees of success across the Foundation Group in regard to virtual appointments, the Foundation Group Boards heard that there were areas which clinical teams could take learning from in terms of best practice. There were also various examples across the Foundation Group around getting virtual clinics right and striking the right balance, so that appointments were adding value to the patients' treatment and pathway. Discharge rates for virtual appointments versus face-to-face appointments would also be an area of focus.

With SWFT, GEH and WVT fortunate to be part of NHSE's GIRFT Further Faster programme lead by Professor Tim Briggs, the presentation outlined some of the opportunities implemented by other member trusts to improve a number of outpatient and inpatients metrics. Whilst WAHT would join the second phase of the Further Faster programme, the Chief Operating Officer at SWFT explained that by virtue of working together as a Foundation Group had provided an opportunity to build a solid foundation for shared learning, and with a Group Analyst in place to make sure that Model Hospital data was accurate across the Foundation Group, that would enable the trusts to accurately measure and compare performance.

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Drawing out areas of best practice across the Foundation Group which included GEH's focus on health inequalities and volunteering, SWFT's focus on endoscopy utilisation, WVT's focus on validation and WAHT's approach to

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reducing DNAs, the Foundation Group Boards were informed that with such positive work happening within each trust, the Chief Operating Officers were really keen to share approaches and learning in order to adopt and replicate areas of best practice to drive those benefits across the Foundation Group.

Recognising that the work being done across the Foundation Group had been extremely beneficial, the Chief Operating Officer at GEH highlighted that whilst there were commonalities in the task ahead, there were also commonalities in the challenges impeding not only current performance but also the Foundation Group's ability to deliver collective improvements around outpatient productivity like, industrial action, impact of emergency pressures, increased referrals and workforce availability.

Concluding the presentation, the Chief Operating Officer at GEH outlined some of the initiatives being collectively worked on as a Foundation Group in order to share best practice, take learning from other trusts and develop Group-based solutions to help drive forward improvements.

The Group Chairman invited questions and perspectives, and of particular note were the following points:

Taking time to thank the Chief Operating Officers, the Group Chairman remarked on how pleasing and encouraging it had been to see the level of cross Foundation Group discussion happening to drive forward improvements.

Remarking on Jackie Richard's (GEH NED) comment in the Microsoft Teams chat box, which suggested the use of digital solutions to help patients manage appointments and improve DNA performance, the Group Chairman remarked that whilst he welcomed the approach to find digital solutions at pace as part of the Faster Further work to improve productivity, he counselled for digital solutions to be identical to enable conformity and economies of scale across the Foundation Group.

With the Patient Initiated Digital Mutual Aid System (PIDMAS) a new phenomenon across the NHS, the Group Chief Executive sought views from Chief Operating Officers as to how the implementation of that was going.

Overall, the Chief Operating Officers reported a similar position in regard to the number of patients expressing an interest to travel for treatment since recently going live with PIDMAS. Whilst early feedback had indicated some reluctance from patients wanting to travel further than 50 miles with visiting, travel and accommodation cited as areas of concern, overall patients had been keen to opt for the PIDMAS solution. Initial thoughts on the process itself had also highlighted learning around the need to refine the administration process as currently this was proving time consuming.

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MINUTE		ACTION
	Resolved – that the Outpatient Productivity Update be received and noted.	
23.084	**FOUNDATION GROUP BOARDS CALENDAR OF MEETINGS 2024/25** The Group Chairman presented the Foundation Group Boards 2024/25 Calendar of Meeting for consideration and approval. The Group Chairman invited questions and perspectives, but no further comments were raised. **Resolved – that the Foundation Group Boards Calendar of Meetings for 2024/25 be approved.**	
23.085	**GENDER PAY GAP ANNUAL REPORT** The Chief People Officer at WAHT introduced this report. Taken as read, the paper set out the rationale for the report, the overarching position when exploring the Gender Pay Gap across each trust within the Foundation Group when comparing data between 2022/23 and 2021/22 and actions being taken by each organisation to address any inequalities in pay, in order to improve staff experience, retention and maintain each trust's reputation, as a fair and equitable employer. For clarity, it was explained to the Foundation Group Boards that although there was no scope to offer bonus payments to colleagues on Agenda for Change (AfC) Term and Conditions (T&Cs), there was a national requirement to contractually offer Clinical Excellence Awards (CEAs) for medical and dental staff. The Chief People Officer for GEH presented the key headlines which included the following: a) on average there was an 80% / 20% female to male split across most of the trusts. b) upper quartile for pay broadly showed GEH, WAHT and WVT consistent at circa 60% female to 30% male, with the exception of SWFT who had a much higher 84% female to 16% male split, reflecting the outsourcing of Estates and Facilities and auxiliary staff. c) lower middle and lower quartile for pay, again was broadly in line across GEH, WAHT and WVT with a circa 85% / 15% female to male split, with SWFT's lower quartiles circa 75% / 25% female to male, as a result of outsourcing Estates and Facilities, and d) across all four organisations there had been an increase to the mean and median salary; with a corresponding increase in the pay gap across GEH, WAHT and GEH. WVT reported an improved position with a decrease in their 2022/23 Pay Gap.	

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With the Chief People Officers committed to ensuring an equitable workforce across the Foundation Group, a number of consistent actions to respond to and improve the gender pay gap were outlined as follows:

e) leadership programmes offered as an opportunity to support and develop colleagues to move into more senior roles.
f) a focus on being a flexible employer, enabling manager skills to support an increased compassionate and flexible workplace.
g) offering inclusive or reverse mentoring to not only support female colleagues but also focus on all nine protected characteristics which should see an improvement in terms of the Foundation Group's Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).
h) talent for all sessions to identify aspirant talent and put support and development opportunities in place.
i) using staff networks to help identify problems and understand what interventions were needed to address them.
j) promoting and embedding inclusive recruitment toolkits across the Foundation Group to help reduce bias across recruitment processes, and
k) work with colleagues as part of the EDI agenda to develop a levelling up programme that supports international nurse recruits into senior roles within the Foundation Group.

With the CEA bonus historically given out on an application basis, it was noted that since Covid, CEAs had been shared out on a fair shares basis giving everyone eligible an equal share.

In addition, the Foundation Group Boards were informed that the Foundation Group had also signed up to the Sexual Safety at Work Charter and that the Chief People Officers would be working together over the coming year to look more closely as to whether each trust had ample female representation at all senior levels and likewise, looking at whether the workforce was representative of the local community.

The Group Chairman invited questions and perspectives and of particular note were the following points.

Responding to Grace Quantock's (WVT NED) question in the Microsoft Teams chat box, the Chief People Officer at WAHT confirmed that all trusts in the Foundation Group did measure the pay gap between other protected characteristics under the WDES, WRES and NHS Rainbow Badge Scheme. This was also addressed through a positive recruitment process, with interviews guaranteed for colleagues with protected characteristics if they met the person specification for Bands 8a and above with a view to expanding that offer to lower bands going forward.

Wells Jo
19/12/2023 11:32:38

MINUTE		ACTION
	In order to get a more meaningful measure regarding the gender pay gap, the Managing Director of WVT suggested a further breakdown which showed the female/male pay gap by professional group and across each of the nine protected characteristic areas. The Chief People Officer at GEH confirmed that there was a more detailed breakdown available, however the Gender Pay Gap was a nationally prescribed report, which provided the granular data across the different protected characteristics within the WRES and WDES reports, different genders and different staff groups. The Group Chairman asked that the Chief People Officers presented the Gender Pay Gap report back to their respective Trust Boards, which included a more granular breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic groups, to give added assurance that women or colleagues from those protected characteristic groups were not being disadvantaged in terms of pay. With Birmingham City Council recently declaring itself in a state of 'effective bankruptcy' as a result of being sued by employees for unequal pay under the Equality Act 2010, the Group Chairman asked if there was a potential risk of such a claim being brought against the NHS. The Chief People Officer at GEH explained that there had been an unequal pay risk with the introduction of AfC back in 2005 but was assured that was far less of a risk now in terms of how the NHS undertook job evaluation and reviewed posts. With the introduction of AfC T&Cs initially aimed at addressing equal pay issues, the Group Chief Executive remarked that in his opinion the data now exposed opportunities for improvement around equality issues relating to things like progression, training and providing flexible working opportunities. **Resolved – that,** **(A) the Chief People Officers include a detailed breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic, and** **(B) the Gender Pay Gap Annual Report be received and noted.**	**CPOs** **CPOs**
23.086	**ANY OTHER BUSINESS**	
23.086.01	Glen Burley – 40 Years Service in NHS Celebrating the Group Chief Executive's 40 years of service in the NHS, the Group Chairman recapped on his career history that commenced back on 1 September 1983 as a Finance Trainee in the then South Warwickshire Health Authority. From then, the Group Chief Executive took on a variety of roles throughout his career and was seconded to SWFT from 1 October 2006 as Chief Executive and formally appointed substantive on 1 April 2008.	

Wells Jo 19/12/2023 11:32:36

MINUTE		ACTION
	With such a significant, broad-based career spanning the past 40 years, the Group Chairman remarked on how fortunate the citizens of Warwickshire were to have him join as SWFT's Chief Executive back in 2008. In keeping with the Group Chief Executive's approach to sharing interesting and general facts that happened during the years for colleagues receiving long service awards, the Group Chairman shared the a number of facts from 1983 when the Group Chief Executive joined the NHS and 2006 when he was seconded to SWFT as the Chief Executive. Recognising the Group Chief Executive for his extraordinary commitment as a public servant and speaking highly of his conviction, clarity of thought and desire to improve and drive performance, the Group Chairman on behalf of the Foundation Group Boards thanked the Group Chief Executive for his valued and continued commitment to the NHS. **Resolved – that the position be noted.**	
23.087	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS** No questions were raised. **Resolved – that the position be noted.**	
23.088	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
23.089	**APOLOGIES FOR ABSENCE**	
23.090	**DECLARATIONS OF INTEREST**	
23.091	**GEH CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.092	**SWFT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.093	**WVT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.094	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.095	**ANY OTHER CONFIDENTIAL BUSINESS**	
23.096	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 7 February 2024 at 1.30pm via Microsoft Teams.	

Wed, 29 Nov 2023 11:32:3

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

WAHT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

Signed _____ (Group Chairman) Date: 7 February 2024
Russell Hardy

Wells Jo
19/12/2023 11:32:38

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE: FOUNDATION GROUP BOARDS MEETING – 7 FEBRUARY 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
23.080.01 (01.11.2023) 23.058 (02.08.2023) Foundation Group Performance Report	The Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust.	J Ives / A Carson / C Free	Whilst Information Leads were confident that the data could be produced, it was noted that this may take some time as changes to Information Technology (IT) systems may be required in order to provide an accurate position.
23.060 (02.08.2023) Deep Dive into Additional Performance Measures – Theatre Productivity	The Chief Operating Officers look into recording theatre utilisation data by cost per minute rather than by a percentage.	H Heran / R Snead / A Parker	- Chief Operating Officers are in the process of recalculating theatre productivity to include an indication of the resource cost per unit.
23.084 Gender Pay Gap Annual Report	The Chief People Officers include a detailed breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic.	G Nic Philib / G Etule / T Rickets	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

Wellington
19/02/2024 11:32:38