Putting Patients First 4ward

QUALITY AND SAFETY IN NUMBERS

May 2021

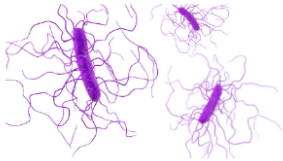
NHS Worcestershire Acute Hospitals NHS Trust

MRSA

0

ECOLI

4



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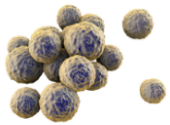


MSSA

1

Hand Hygiene

Participation	**91.82**
Compliance	**99.53**

SEPSIS

Sepsis

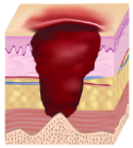
Screening Compliance	**85.52**
Sepsis 6 bundle compliance	**50.00**

ICE reports viewed

Radiology	**82.89**
Pathology	**95.79**

Falls per 1,000 bed days causing harm

1



Pressure Ulcers

All hospital acquired pressure ulcers	**6**
Serious incident pressure ulcers	**0**

Response Rate

A&E	**15.79**
Inpatients	**32.58**
Maternity	**15.82**
Outpatients	**10.03**

Recommended Rate

A&E	**83.72**
Inpatients	**96.68**
Maternity	**94.05**
Outpatients	**94.35**

HSMR 12 months rolling (Feb21) **98.34**

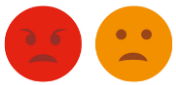
Mortality Reviews completed </=30 days (Nov-20) **35.50**

Risks overdue review **133**

Risks with overdue actions **171**

Discharged before midday

16.34



Complaints Responses </=25 days

89.79

Total Medicine incidents reported **160**

Medicine incidents causing harm (%) **6.25**

Putting Patients First 4ward

WORKFORCE COMPOSITION IN NUMBERS

NHS Worcestershire Acute Hospitals NHS Trust

May 2021

Employees

6,694

BAME employees

17.%

Part-time workers

44%

Female

82%

Registered nurses

1,896 (28%)

Registered midwives

264 (4%)

HCAs, helpers and assistants

1,304 (19%)

Doctors

713 (11%)

Other clinical and scientific staff

840 (13%)

>55

Over age 55

18%

≤30

30 years and under

21%

Staff with less than 2 years service

28%

Staff with 20 years service or over

10%

Committee Assurance Reports

Trust Board

15th July 2021

Finance & Performance Committee Assurance Report – 30th June 2021

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom Associate Non-Executive Director	Richard Oosterom Associate Non-Executive Director	Martin Wood Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 5, 6, 7, 8, 12

Executive Summary

The Finance & Performance Committee met virtually on 30 June 2021. Our focus was on the ICS, digital items, land sales and operational performance (A&E and discharges, waiting lists and reducing the backlog).

Annual Planning 2021/22: We received a verbal update noting that the annual plan 21/22 is to be presented to our next meeting. The H1 plan needs to set out (with system involvement) priorities and efficiencies. The H2 plans is dependent upon further guidance. As discussed in the "Finance" board workshop, a Medium Term Financial Plan will be delivered in 6 months time, underpinned by an operational plan containing the strategic initiatives to deliver the recovery, elements of the clinical services strategy, site configuration changes and transformational changes. The "plan for the plan", outlining the steps, accountabilities, dependencies, stakeholder engagement and some milestones to share progress with FPC/board will be presented in the July meeting.

We also received an update on the Single Improvement Methodology with further engagement taking place with the two remaining potential suppliers. Our internal capacity to implement SIM is being addressed with both the suppliers and our system partners, who might potentially be able to assist.

ICS Update: We received an update on the NHSE/I design framework and guidance for ICS operating model, the development of Worcestershire Place Partnership and current risks for development and delivery of Place. Our focus is on what is beneficial for our population rather than the national template and we are driving this approach with partners. Further guidance is awaited which will provide further clarity on the operational model such as responsibilities for individuals in the new framework and our involvement in the Place Board. A report is to be presented to our next meeting providing greater detail on the options. We are concerned that there has been limited quality time in the Committee devoted to the ICS and this is to be a topic for discussion at the September Board Development Session.

Digital Strategy Update: We received a presentation setting out the programme review. We noted key achievements and good progress to date against the 39 objectives originally outlined in the 2019 strategy, the challenges of delivering digital services and the introduction of new digital tools to the Trust during wave 1 and wave 2 of COVID pandemic and the continuing growth in demand for digital to support clinical transformation. The clinical engagement model has flourished during the first 18 months of the strategy, demonstrated by the delivery and the appointment of key clinical champions. We have received confidence that the PAS re-implementation will be delivered on time in terms of quality and budget with the additional resources being requested. The next stage is to develop an integrated roadmap with costings identifying levers for funding. We need to consider the resource requirements for other digital projects in addition to PAS. There are discussions within the ICS aligning the approach to digitalisation. We were informed of the work being undertaken at a system level on the potential costs and benefits of digitalisation which will require the participation of all partners. This will require investment where digital expenditure is benchmarked between 5% and 10% of turnover, but for us is 2.7% currently. We need to consider in the forthcoming months how we develop our organisational capacity to deliver the Strategy.

Finance & Performance Committee Assurance Report – 30th June 2021

Executive Summary (cont.)

DCR Programme Review: We received a presentation setting out the outcome of the review which has thoroughly investigated all aspects of the Full Programme. The review has identified costs for additional infrastructure requirements, additional resource requirements and contingency. We are disappointed that we are proposing to increase expenditure for which funding has not been identified. We consider this to be unacceptable and is not to be repeated in the future. The gateway process suggested is not adopted, because we have no alternative but to accept the additional costs. A further report is to be presented to our next meeting to identify the required funding and further detail on how we will achieve the earn back and next steps.

We reluctantly approved the additional infrastructure requirements noting the immediacy of this requirement to raise Purchase Orders before 1 July 2021 and to prevent further delays in the Programme. This has been approved by the Chair on behalf of the Trust Board.

Assurance level 4

Digital Aspirant Business Case: We received a presentation and noted progress in developing our application for participating in the Digital Aspirant Programme. If successful, it would not only realise £6m matched funding, but a considerable acceleration of our DCR programme and associated avoidance of costs and realisation of benefits. A portfolio of Digital Strategy developments has been evaluated for compliance with the requirements of the Programme. We expressed our appreciation for the initiative and look forward to discussing the full business case in our September meeting.

UEC Business Case Programme and Budget Update – June 2021: The considerable concerns raised at our last meeting (the increase in costs, the absence of detail on the revenue effects, risks and mitigations and governance arrangements) have been addressed and we are recommending approval of this business case. A separate report appears on the Trust agenda.

Sale of Land: We are recommending the sale of two pieces of land and a separate report appears on the Trust agenda.

Financial Performance Report Month 12: We noted that against the H1 plan £(2.9)m operational plan, the month 2 plan £(0.8)m deficit we report an actual surplus of £0.7m which is a positive variance of £1.5m. Employee expenses increased in month of which part relates to retrospective shifts added to the Medics booking system in May which related to April shifts. This is being reviewed by HR as it impacts on the accuracy of our weekly temporary staffing returns to NHSE&I. We expressed concern about the increase in staff costs and noted that all the drivers of Bank & Agency pointed in the wrong direction. A detailed review of the development of staff and Bank & Agency costs (including the increase in establishment) will be delivered and discussed in our July meeting.

Given the positive variance in YTD across the system (£3.1m), system CFOs have agreed to offset beneficial variances position to the unmitigated system risk in H1 (£6.4m). A further assessment of ERF achievement has been performed following the recent activity submissions. Our H1 revised plan, inclusive of ERF is a £1.1m surplus. Excluding ERF this would be a £(1.1)m deficit. Operational activity will not impact on ERF YTD but may change slightly when nationally validated.

The assurance levels remain unchanged with 4 for income and expenditure, 5 for capital and 6 cash.

Finance & Performance Committee Assurance Report – 30th June 2021

Executive Summary (cont.)

Integrated Performance Report: We noted that the main challenges are Emergency and Urgent Care demand including discharge capability, recovery and restoration of the elective programme including Outpatients and Diagnostics, Quality and Safety (Infection Prevention and Control, Sepsis, Never Events and Maternity) and People & Culture. We are supporting the Chief Executive in the escalation for all partner organisations to deliver on their commitments on discharges where there are currently the equivalent of two wards of medically fit patients for discharge. Demand is increasing partly as a result of unmet need over the last 18 months and the consequences of our waiting lists. We are concerned over system partner performance and have noted the discussions for better risk alignment. The number of Covid patients has risen slightly. New initiatives are being developed for restoration activity so that we can claim ERF, and more importantly can see a perspective of reducing the waiting lists (where current simulation models show waiting lists growing).

Assurance levels remain unchanged namely for urgent care and patient flow including Homefirst Worcestershire to 5, cancer 5 except 62 days which is 4, Outpatients and planned admissions 4, diagnostics 4, RTT 3 and stroke 5. The overall assurance level is 4.

BAF Risks – Finance and Performance Committee Section: Following our risk workshop, we have approved the first iteration of the revised BAF which will remain under ongoing and regular review. We will undertake a deep dive into one risk at every other meeting.

Contract Awards:

- **Roche Managed Service Contract:** We were disappointed to see this extension, because we already approved the termination of the contract in November. The lesson learned here is that we need to better manage the dependencies with the PFI partner. Since we have no alternative we recommend this for approval to the Board.
- **Orthopaedic Implants Contract:** We are recommending approval of this contract that benefits from good system collaboration.
- **Change Control Notice (CCN) DCR Extension:** We have approved and accept Allscripts agreement of a second 12 month delay to the start of the DCR programme.

Workplan: We noted the workplan which has been updated to reflect the new format of our agendas. We will review the workplan at six monthly intervals.

Recommendation(s)

The Board is requested to receive this report for assurance.

Quality Governance Committee Assurance Report – 1st July 2021

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore Non-Executive Director	Dame Julie Moore Non-Executive Director	

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	2, 3, 4, 5, 12

Executive Summary

Quality Governance Committee Assurance Report – 1st July 2021

Executive Summary (cont.)

Recommendation(s)

The Board is requested to receive this report for assurance.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F1

Nurse staffing report – May 2021

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

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Jackie Edwards, Deputy Chief Nurse	**Author /s**	Louise Pearson, Lead for N&M workforce

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	23/6/21	Approved

Recommendations	The TME/People and Culture Committees are asked to note: • Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout May 2021 has been achieved, this was supported when required through the booking of temporary workforce for short notice absences. • There were 2 staffing related patient moderate harms reported for May (awaiting review by divisions). No significant harms reported. this is on a backdrop where there was an increase in incident reporting of 19 related to nurse staffing.

Executive summary	This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during May 2021. Maternity staffing is provided as a separate report. Staffing of the wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients was achieved through out May 2021.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 x | 6 | 7 | N/A		
Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position and short term sickness.		

NHS Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F1

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

Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for May 2021

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

Issues and options

The provision of safe care and treatment
Staff support ongoing

A focus and priority for the trust remains the health and wellbeing of staff as the continued management of the COVID 19 pandemic is in place and enters its 14 month. Across the Nursing, Midwifery, Health Care Scientists and Allied health professional, all line managers are aware of staff support available both internally through HR and occupational health and externally to the trust. There is nursing representation on the Health and wellbeing group.

Divisions 'own' and maintain their staffing lists of staff absent and those returned, can touch base with staff to ensure ongoing updates and importantly support required.

The provision of staff support will continue to be a priority for June/July with the continued lockdown restriction and Covid management procedures in place. It has been and will remain essential that the Trust to continue support through:

- Health and well-being support through telephone helplines and various counselling services.
- Re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements.
- The Trust is supporting a pilot for introducing Professional Advocate (PA) model known as A-EQUIP. This model will aim to provide opportunities for development of reflection and builds resilience through the provision of restorative supervision, empowering the development of personal action to improve quality of care as an intrinsic part of their role. Training has commenced through the University of Worcester for 7 senior staff. This course is due to be completed July 2021. A strategy will be provided in September 2021. Introduction of the national red flags though the Allocate software for both nursing and midwifery.

Harms

There were 2 moderate patient harms reported for May 2021 due specifically to numbers of confused patients on the wards (Hazel elective and ward 17). Full reviews are underway to establish learning however, initial investigation have not identified patient harm. There has been an increase in datix reporting over May with a total of 19 incidents. This is on a backdrop with general reporting throughout the last quarter of an average of 11 month. This is a positive as staff are reflecting on the position and have capacity to report, as no harms have been found and no escalation of concerns through the wards daily safety huddles.

Good Governance

With the step down in command and control Covid 19 procedures the Senior Nursing, Midwifery and AHP team have moved to monthly meetings. There remains an assurance weekend staffing meeting held each week with the CNO and the monthly NWAG meeting.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)
"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwives in hospitals which are filled*". National rates are aimed at 95% across day and night RN and HCA fill

There are some areas that need consistent work to pull up to these levels.

Current Trust Position			What needs to happen to get us there	Current level of assurance
	Day % fill	Night % fill	All establishments reviewed 7/05/21 actions for June will be for final rotas to be updated by finance and sign off by CNO.	**5**
RN	95%	99%		
HCA	93%	103%		

Vacancy trust target is 7% Mays position is 10.94%

Current Trust Position WTE			What needs to happen to get us there	Current level of assurance
Division	RN/RM WTE	HCA WTE	Increased RN and RM recruitment to reduce vacancies. Rolling adverts for specialities have been ongoing and recruitment of the student nurses since paid deployment has reduced the vacancy factor.	4
Speciality Medicine	24	-2		
Urgent Care	56	16		
Surgery	40	22		
SCSD	-2	28		

Women's and Children's	2RN 24RM	3	Ensure HCA recruitment continues following the recruitment drive with HEE. International nurse recruitment – this will re commence from the end of June 2021.	

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

- Inpatient wards have deployed staff and employed use of bank and agency workers.
  Vacancies numbers has lead to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
  Urgent Care are currently carrying the majority of the RN vacancies but with active recruitment this will improve by September 2021.
  Hazel elective at Worcester Royal, which is a new temporary ward supporting restart of elective surgery is carrying a 48% vacancy factor. The fill rate for shifts has been achieved through redeployment of staff from Alexandra hospital and use of bank and agency. The vacancy position will increase in August to 77% as staff are redeployed back to base wards. With the ongoing realignment of surgical services, a targeted recruitment campaign will be launched in June 21 and surgical division are preparing for a move of ward to Alexandra hospital in July to mitigate risks from vacancies

Recruitment International nurse (IN) recruitment pipeline

The first 25 nurses from the 20/21 business case arrived in Through March and April 21. International nurse recruitment was paused nationally due to the COVID 19 pandemic in India. This is scheduled to resume at the end of June with a planned cohort of 12 due to arrive. The majority of our international recruitment is via India.

Domestic nursing and midwifery pipeline

NWAG has approved recruitment of the domestic pipeline to reduce RN vacancies by a successful bid with HEE to support the Registered Nurse Associate programme. This will see the opportunity for RNA to complete a top up to a Registered Nurse; the course runs over a 2 year period. There are 12 RNA's that have shown interest who will be interviewed in June to commence September

Bank and Agency Usage

Trust target is 7%- Currently monthly %10.94%

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
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Current Trust Position WTE			What needs to happen to get us there	Current level of assurance
Division	Bank	Agency	Sign up to the TWS11 workforce solutions – adhere to agency cap rates in line with NHSI cap rates. Reduce agency % and in short term increase bank % until recruitment of substantive staff at 97%. HR to support divisions in retention work stream bespoke for N&M workforce flexible working strategies.	5
Speciality Medicine	77 WTE	40		
Urgent Care	61WTE	45		
Surgery	67WTE	32		
SCSD	61WTE	46		
Women's and Children's	34WTE	11		

Sickness –
The Trust Target for Sickness is 4%, May position is 4.68%

Current Trust Position			What needs to happen to get us to level 6	Current Level of Assurance
	Monthly	Stress related	Divisions to ensure Sickness reviews in place staff signposted to Health and wellbeing package of support. Sickness has increased in Divisions in month with an increase in stress related reports. Discussion in NWAG given increased risk and reports at clinical/divisional level for a request HR to provide weekly data to provide real time focus for hotspot clinical areas. Revisit to Communications of support services available.	4
Spec Med	5.06%	0.78%		
Urgent care	4.53%	1.24%		
Surgery	4.36%	0.89%		
SCSD	4.55%	1.43%		
W & C's	5.72%	2.56%		

Turnover

Trust target for turnover 11%. May is RN/RM 8.93% HCA 12.06%

Current Trust Position			What needs to happen to get us to level 6	Current level of Assurance
Division	RN/RM	HCA	HR to update retention policy – staff development in house for all staff groups Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3	5
Speciality Medicine	7.43%	13.03%		
Urgent Care	7.67%	11.3%		
Surgery	9.07%	9.27%		
SCSD	10.94%	12.93%		
Women's and Children's	6,5%	11.04%		

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HCA turnover is higher than trust target across all divisions –	– level 7 are available through the apprenticeship Levy. A career pathway is being explored through Educational Faculty that will address training and will support of retention. Exit interviews need to be reviewed for RN and HCA identify themes and areas of support needed.	

Recommendations

The TME/People and Culture Committees are asked to note:

- Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout May 2021 has been achieved, this was supported when required through the booking of temporary workforce for short notice absences.
- There were 2 staffing related patient moderate harms reported for May (awaiting review by divisions). No significant harms reported. this is on a backdrop where there was an increase in incident reporting of 19 related to nurse staffing.

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Midwifery Safe Staffing Report May 2021

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	May 2021	
TME	23 June 2021	

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

Executive summary	This report provides a breakdown of the monitoring of maternity staffing in May 2021. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Unify data • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) • Sickness absence rates Throughout May it has remained challenging to maintain safe staffing levels due to sickness absence and vacancies. Following the engagement events with the CNO and CEO an accelerator action plan was developed which resulted in the availability of midwifery workforce data, the utilisation of agency staff and additional roles (registered nurses in postnatal care) to support the midwifery team. The reporting culture remains healthy during this period and all staffing incidents were reviewed and no harm was identified. One to one care was provided to 100% of women in established labour and there were no

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reports of the shift leader not being able to maintain supernummary status however a recent audit demonstrates 95% compliance. A further audit is panned.

The escalation policy was enacted to maintain safe staffing levels. The deployment of staff and the cancelling of non- clinical working days provided additional staff to maintain safe levels and provided appropriate mitigation. Role specific mandatory training was completed in month however some training was cancelled to support the clinical areas. Despite these actions there was one reported delay in care for women undergoing induction of labour; this is a significant improvement.

Acuity was reported to be higher than the actual staffing levels in 50% of occasions throughout this period. This is an overall six monthly improvement but slightly lower than April. Acuity report identified that completion rates were reduced during this period which will affect the overall results.

A continuous recruitment programme remains in place for staffing in both inpatient and community. All new starters for inpatient services are now in post with the community staff expected in June. Of the 17 WTE posts offered to cover vacancies, planned maternity leave and turnover in Q3 & 4, fifteen midwives are expected to commence employment by the end of quarter 2.

Sickness absence rates continue to be higher than the Trusts target at 8% across all areas. This represents a significant drop in sickness absence rates. The program of work with HR support to address both long term and short term sickness is now in place and ward managers are working with the HR team to focus on managing long term sickness.

The level of assurance provided for safe maternity staffing is 4. This is the same assurance level from the previous month as although there has been an improvement in staffing levels, a reduction in staffing incidents, a reduction in delays in care and a reduction in vacancies this is not yet sustained. A higher level of assurance will be offered when the current position is sustained with no vacancies recorded and the sickness absence rate is at the Trust target.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0 | 1 | 2 | 3 | 4 x | 5 | 6 | 7 | N/A		
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*		

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Paper number	Enc F1

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**					

Introduction/Background

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

Safe staffing is monitored monthly by the following actions:

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

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

Issues and options

Completion of the Birthrate plus acuity tool (4 hourly)

Acuity of women is recorded in the tool every 4 hours (6 times per day). Acuity was reported to be higher than the actual staffing levels in 50% of occasions throughout this period. This is lower than April although an improvement on the average reporting over the last six months. Acuity report identified that completion rates were reduced during this period which will affect the overall results.

In the minority of cases (23%) a shortfall of 2 midwives (red) was reported in the intrapartum area and in 27% of cases a shortfall of one member (amber) of staff was recoded due to staff sickness and/or a midwife scrubbing in theatre. Staff were redeployed from other clinical areas to mitigate the risk. In 50% of the periods staffing either met or exceeded required staffing.

Following procurement of the new acuity tools it is anticipated that the tools will be available to staff by the end of quarter 2.

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Monitoring the midwife to birth ratio

The monthly birth to midwife ratio is recorded on the maternity dashboard. The outcomes are reviewed in Maternity Governance meeting monthly. The ratio in May was 1:24 (in post) and 1:22 (funded). This is within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit (1:28).

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

Shiftleader supernummary

All red flags continue to be reported via Datix until the implementation of the new and updated acuity tools. In May there were no reports that the shift leader did not remain supernummary. It is recognised that the current process may not be reliable and therefore a snapshot audit was planned for the beginning of June to provide assurance. At the time of writing this report the audit demonstrated 95% compliance in maintaining supernummary status for the shift leader. This was due to the shift leader providing care for a postnatal woman whist awaiting transfer to the ward on one occasion. A further audit is planned to provide assurance until the acuity tools are embedded.

One to one care in labour

One to one care is recorded in Badgernet (Maternity Information System). The system reports that all women in labour received 1:1 care in labour in May 2021.

Staffing incidents

There were 15 staffing incidents reported in May demonstrating a decrease in the number of incidents. The themes reported this month are:

- Availability of CoC midwives – ongoing work to improve reporting of availability.
- In escalation and requirement to request support from the community midwifery service
- In escalation and requirement to reduce antenatal and postnatal ward to agreed minimum staffing levels to deploy staff to delivery suite to ensure that 1:1 care is provided and the shift leader remains supernummary.

Staffing levels were maintained at or above minimum agreed levels and no harm was reported in this period. There was only one report of women experiencing delays in care in the induction of labour process which again is a reduction on previous months.

It is acknowledged that any reduction in available staff can result in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and increasing concern about staffing levels, burnout and staff health and well – being; this will be addressed in the work planned in the maternity improvement plan.

Medication Incidents

There were 13 medication incidents noting 1 caused minimum harm. In the postoperative period a woman was administered a higher dose of IV Morphine, additional monitoring was undertaken and duty of candour was completed. No further concerns were reported. Medication stock had to be disposed due to the fridge temperature rising as the fridge had been accidently switched off. Fridge temperature checking continues daily.

The themes reported are:

- Late medication
- Availability of stock

The remaining clinical red flags (as listed in the NICE Safe staffing guidance) can be reported on Safecare. Training has now been completed after some delays and robust data is expected in June.

Unify data

The fill rates presented in the table below reflect the position of all inpatient ward areas. Currently the Birth Centre is closed and the staff from this are have been deployed to Delivery Suite which will improve the % fill rates for Delivery Suite. The availability of an agency midwife has also supported an improving position.

Whilst many of these rates fall below the 95% national target there is an additional six Continuity of Carer teams who provide care to 1300 women annually across the entire maternity pathway. This availability is captured on ERoster retrospectively and is not presented in the information provided below.

Inpatient Area	RM day fill	MSW day fill	RM night fill	MSW night fill
Antenatal Ward	92%	86%	93%	89%
Post-natal Ward	97%	74%	86%	86%
Delivery Suite	74%	66%	82%	92%
Birth Centre	80%	74%	77%	85%

Daily staff safety huddle

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

It is planned that the Maternity Unit Bleep holder will join the Site Team huddle daily and the maternity on-call manager will join the night huddle daily from June 2021.

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

As planned the Divisional Management team have reduced the frequency of the COVID huddle to weekly. The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels. Staffing is also discussed weekly at the Quality and Safety meeting.

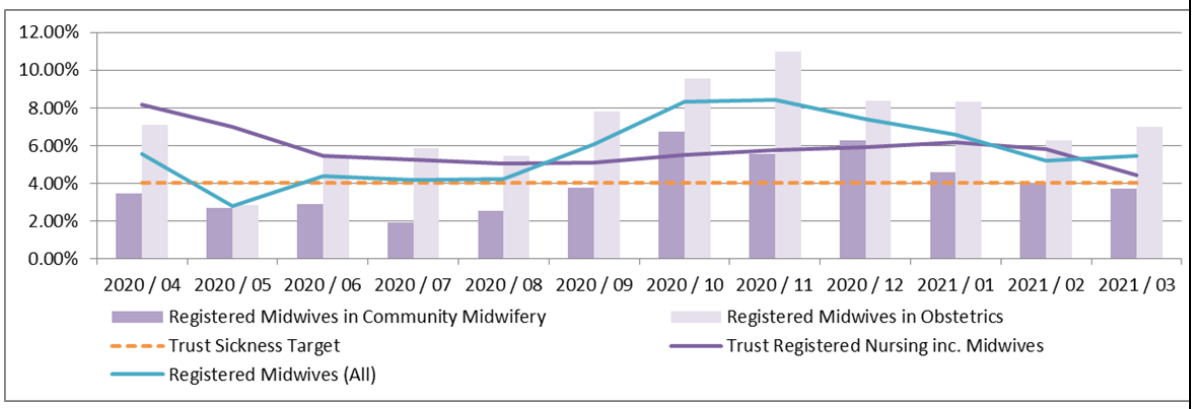
Sickness

The Division continues to work with our HR partners to obtain accurate sickness absence rates for midwives. The graph below provide some historic context and reports that for 2020/21 non COVID related sickness in the midwifery inpatient team has been above the Trust target.

Sickness absence rates were reported at 8% in May which represents a significant decrease in sickness absence within the inpatient areas. The reason reported for the majority of absence is recorded as 'mental health' or 'other'.

The following actions remain in place:

- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- A review of the health and wellbeing offer for staff in maternity services



Actions that continue throughout this period:

- Await a further 6 WTE midwives to join our community midwifery teams.
- Monitor recruitment process of 15 WTE midwives to ensure timely commencement at the Trust.
- Daily safe staffing huddles continued to monitor and plan mitigations and prepare to join site meetings.

- There was only one reported delay in the induction of labour process in May: each delay was managed through continuous risk assessment with the multi-professional team.
- All non-essential training and non - clinical working days were cancelled; ward managers were deployed to the clinical areas to support safer staffing levels as required throughout this period.
- Continue to work with HR to ensure that midwifery workforce data is correct and available.
- Maintain focus on managing sickness absence effectively.
- Continue to progress the development of the MSW programme.
- Identify further availability of agency midwives.
- Progress work with Birthrate Plus to complete staffing audit and implementation of acuity tools.

Conclusion

The additional new starters supported improved staffing levels throughout May. Additional actions taken did provide appropriate mitigation to maintain safe staffing levels and fewer reports of delays in care were noted. The availability of an agency midwife provided additional support to all areas of the service. There was an overall decrease in reported staffing incidents reflecting the improving rota fill rates.

A decrease in the reliance of support from the community midwifery and Continuity of Carer teams to maintain safe staffing levels was noted in May.

Sickness absence rates have reduced but remain above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively. Workforce data is now available for this group of staff and will support future workforce planning.

The prolonged reduction in available staff has resulted in increased stress and anxiety for the team and staff have reported reduced job satisfaction and increasing concern about staffing levels, burnout and staff health and well – being; this will be addressed in the work planned in the maternity improvement plan.

The ongoing and completed actions have supported the provision of safe staffing levels and an assurance level of 4 is suggested for May. This is the same assurance level from the previous month because although there has been an improvement in fill rates and sickness absence, a reduction in staffing incidents, a reduction in delays in care and a reduction in vacancies this is not yet sustained.

A higher level of assurance will be offered when the current position is sustained and there are no midwifery vacancies and the sickness absence rate is at the Trust target. It is anticipated that this will be achieved in September 2021.

Recommendations

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

Appendices

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F2

Maternity Services - Continuity of Carer Position 2021

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

Accountable Director	Paula Gardner, Chief Nursing Officer & Board Safety champion		
Presented by	Justine Jeffery Director of Midwifery	**Author /s**	Caitlin Wilson Consultant Midwife

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	June	Noted
QGC	1 July 2021	Noted

Recommendations	Trust Board are asked to note the current position at WAHT and agree with the recommended actions to support the roll out of CoC to improve health outcomes for women and babies and meet the national ambition in 2023.

Executive summary	Continuity of Carer (CoC) has shown to improve clinical outcomes for women on the pathway to date. The Cochrane review (2016) indicated a number of improved outcomes through continuity of carer: -decrease in premature births -decrease in interventions -increase in access to birth outside of obstetric units -decrease in use of regional analgesia -increase in satisfaction with experience of maternity services Continuity of Carer is a national ambition and following local reviews as recommended continuity of carer is to be implemented across the system in line with NHSE/I objectives for the majority of women by March 2023. Currently there are 6 CoC teams at WHAT providing care to 27.8% against the recommended national target of 35% by March 2021. The following actions must be completed prior to further implementation of this model: 1. Create a dedicated CoC work stream as part of the maternity improvement plan

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	2. Review of current staffing position with BR+, and staff modelling 3. Increase Band 3 capacity across the system including CoC teams/PN wards and AN clinics 4. Dedicated Band 7 level CoC implementation lead as well as project support (admin) 5. Dedicated support structures for CoC including estates, administrative support and coaching 6. Evaluation of Continuity of Carer impact across the service which includes MVP feedback 7. Move towards Continuity of Carer being the default model within by March 2023 with a phased approach. The Directorate will need to determine whether it will be beneficial to engage in formal consultation prior to launching more teams 8. Engagement and development of Band 7 leaders and consultant obstetricians as these groups are central to delivery success.

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

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**March 2022**					

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Introduction/Background

Introduction

Continuity of carer is a relational based model of care which has demonstrated better clinical outcomes for women and babies by increasing safety and through personalised care and choice throughout the maternity journey. There is an increase in satisfaction amongst women cared for in this model. The National Maternity Review (2016) sets out the ambition for maternity services to provide a known carer that the woman knows and trusts across all elements of the childbirth continuum including antenatal care, intrapartum care regardless of setting and postnatal care. Teams will organise care as an autonomous team providing antenatal, intrapartum and postnatal care throughout the childbirth continuum. The team will cover 24/7 care with an availability system for unplanned/unsocial care shared across the team. This model will continue to be the template for future team development.

The Cochrane review (2016) indicated a number of improved outcomes through continuity of carer:

-decrease in premature births
-decrease in interventions
-increase in access to birth outside of obstetric units
-decrease in use of regional analgesia
-increase in satisfaction with experience of maternity services

Generally, midwives working in a continuity of carer model report improved job satisfaction and a reduction in sickness and absence (Templeton Report 2018).

Issues and options

Continuity of Carer Implementation

In 2018, Worcestershire Acute Hospitals NHS Trust reported 0% continuity of carer rate. The Birthrate Plus Audit was carried out prior to the development of continuity of carer teams to determine the staffing and acuity baseline. WAHT won a bid to participate in a Health Education England Staffing Model Pilot in January 2018-April 2018. Both BirthRate Plus and HEE data showed that WAHT was funded and in position to fully implement continuity of carer teams.

The service had piloted a continuity of carer team (Cherry and Blossom) as part of the Meadow Birth Centre in 2018, which was withdrawn in March 2020 due to Covid-19 with the change of MBC into a Covid secure location. The model will not be re-deployed following Covid-19 as the lessons learned demonstrate that this model is not sustainable within the county of Worcestershire due to travel, estates and attrition rates. It would also not meet NHSE/I criteria for continuity of carer.

WAHT has commissioned a repeat Birth Rate Plus audit which will take place in June 2021 and will include an analysis of staffing levels required to implement continuity of carer at scale.

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Continuity of Carer Model at WAHT

WAHT currently has 6 continuity of carer teams. These teams are geographically based with a mixed risk caseload. All teams are within areas designated as the lowest 10% LSOA Deprivation Scores at Electoral Ward Level and Population Demographics by the Worcestershire County Council. Women are identified at booking for Continuity of Carer teams and are booked onto the pathway.

Each team has 7-8 headcount with a ***minimum*** of 6.2 WTE. Each WTE midwife has a caseload ratio of 1:35 with this reducing pro rata to match contracted hours. This model will continue to be the template for future team development and is supported by NHSEI.

The total caseload for each team will vary dependent on the individual members of the team. On average, a team of 6.2 WTE (8 midwives) will carry a team caseload of 215. This accounts for Newly Qualified Midwives (NQM) who are supported to join the teams on a bespoke preceptorship programme which includes a reduced caseload in year 1.

Each CoC team has a named consultant obstetrician who can be accessed for support, advice and referrals. While this has been in place since the inception of CoC teams, the overall process needs to be refined to ensure there is effective communication and defined role expectation. This work is in progress.

Teams will organise care as an autonomous team providing antenatal, intrapartum and postnatal care throughout the childbirth continuum. The team will cover 24/7 care with an availability system for unplanned/unsocial care shared across the team.
All staff within maternity services contributes to the ambition of continuity of carer. This is inclusive of CoC teams, the wider MDT, obstetricians and core maternity staff throughout community and acute settings.

Additional factors which impact CoC are travel, as more remote teams from the obstetric unit will have increased travel to provide labour care, as well as estates as dedicated, open access clinical space is not available for all teams due to capacity in maternity Hubs and access in Children's' Centres.

Position at WAHT as of March 31st 2021

WAHT has implemented 6 continuity of care teams since March 2019. Continuity of carer teams support 27.8% of women planning to birth at WAHT. This is an increase from 0% position in February 2019. In March 2020 the trajectory for continuity of carer was revised due to the Covid 19 pandemic. The target of 35% of women placed onto a CoC pathway was moved to March 2021.

There is a total of 37.4 WTE working in CoC teams across the county. In 2020/21 the number of births at WAHT was 4850. All of the midwives working within these teams either self-selected or were recruited on the basis that they would join a COC team.

A collaborative evaluation of CoC with the University of Worcester, the Maternity Voice Partnership (MVP) and the Maternity Directorate Management Team is vital to review the implementation processes. This evaluation will take place during the pauses between roll outs in 2021 and 2022. Specific, local audits will be carried out as required to review outcomes and practice.

The initial plan for roll out is outline in Table 2 however due to recent staffing challenges and feedback from staff re engagement the programme is currently paused and until the current staffing challenges have been addressed, the Birth rate Plus Audit is completed and the evaluation as described above there will be no further roll out until 2022.

Delivery of Continuity of Carer at Scale

The national expectation requires WAHT will be required to demonstrate that CoC is in place for women who may have poorer outcomes including women from BAME communities and those with increased social vulnerabilities (75% of BAME) by March 2022. By March 2023, CoC will become the default model for women receiving complete care pathway at WHAT. Please see ***Table 2*** below which outlines the roll out plan for CoC

Team Requirement to deliver CoC at 6.2 WTE per team minimum therefore 70.67 WTE midwives will be required to deliver 51% continuity of carer. This equates to 12 CoC teams at 6.2 WTE. To deliver 70% continuity of carer 97.0 WTE midwives will be required; this equates to 16 CoC teams at 6.2 WTE

Teams have previously been staffed with those who self- selected or were employed to join CoC teams, future planning may have to consider wider scale formal consultation with staff, especially if a more rapid roll out is favoured.

A dedicated and well trained core team will be required across the service including community, wards, and labour ward. These areas, like CoC teams, are all part of continuity of carer by supporting a safe and smooth care pathway for women both on and off the model.

Challenges with Continuity of Carer

Transition and Sustainability

Self-organisation and daily organisation of workload is a deviation from traditional shift pattern approaches. This requires transition time and while there is no evidence of the timeframes for this, anecdotal evidence suggests that this could take between 6-9 months.

Some staff may find the movement across pathways complex and outside of their current available skill set i.e. between LW and community. External coaching model needs to be applied to support the transition. Attention to the team transition is central to sustainability of teams. Intensive support is required until there is a full implementation and students/NQM are educated in this model.

Cultural issues within the maternity services around continuity of carer, in particular the role expectations and the shift away from a centralised model of care coordination have presented some additional challenges during implementation of the teams launched in late 2020. This has been exacerbated by the reduction in availability of core midwifery staffing due to COVID and non COVID sickness absence, vacancies and some of our vulnerable staff shielding during the second lockdown. Unfortunately this resulted in variation in workload in the Consultant Led unit as previous static staffing numbers were reduce as more CoC teams were implemented.

Mitigation

New teams members are provided with two days of full days of orientation with an additional day with the National Lead for Continuity of Carer. The teams are also given 2-3 weeks of adjustment time where they are working together to build caseload and spend time in key clinical areas where learning needs identified. There are no 'on calls' or intrapartum care provision during this time. Six monthly 'away days' are planned to support teams.

A dedicated Band 7 CoC Project Lead was funded by the LMNS for 2021/22 (22.5 hours/wk ending Jan 2022) and it is anticipated that the maternity service will fund this role in the future. 11.5 hours /wk supports the transition and embedding of philosophy with the current operational teams. 11.5 hours/wk are dedicated to unit transition to the model.

Newly qualified midwives work with a reduced caseload for a period of 4-6 months. Shifts are arranged in key learning areas and rostered each week in the area identified e.g. delivery suite.

Evidence shows that staff engagement events improve understanding the model and relationships. Engagement will re-commence once the teams have embedded and following the development of the maternity improvement plan a dedicated work stream has been identified to progress this work and plan for any future roll out. This work stream will be led by the Consultant Midwife and a representative from all professional groups and clinical areas will take part in future planning and engagement events.

Estates

Buildings are often dual use with traditional community teams and office space that is separate from clinical space is limited. There are 2 Maternity Hubs; these are utilised by 2 teams but clinical space remains a premium and limited access for the teams to support their way of working. Access to office and clinical space is required 7 days a week.

There is a high number of home-based visits occurring in CoC due to estates issues and also more recently challenges presented by COVID. A time and motion study is reviewing the impact of this on time demands and costs.

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Mitigation

This has been escalated to the STP as an ongoing issue

Outcomes

Table 1: High Level Outcomes of Continuity of Carer 2019/20

Outcome	CoC Teams	Trust
SVB	64.5%	59.4%
Instrumental	7.4%	10.5%
Elective C-section	12.2%	13.2%
Emergency C-section	15.9%	16.7%
TOTAL C-section	28.7%	29.9%
Homebirth	7.7%	1.4%
Birth Centre	14.9%	13.6%
Waterbirths (of SVB)	25.1%	11.1%
Continuity	94.6%	No full pathway

Year End data for x 3 teams for 20/21 available at beginning of June-awaiting comparison Trust data.

Table 2: Current WAHT Trajectory of Continuity of Carer Roll Out Plan

Recommendation	Action	Pathway/Team	Post Codes (LSOA 10%)	Caseload Size (births)	Timeline Predicted	Timeline Actual	NHSE/I Target of WAHT Births (20/21)	Total of births at WAHT (20/21)
Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions	**No more than 8 midwives (headcount) to deliver CoC through pregnancy continuum (AN/IP & PN). Variance in WTE in each team**	**WAHT has implemented full caseload model; each WTE midwife holds 1:35 caseload per annum with out of hours availability for IP/unplanned work**	**All teams in designated 10% LSOA**	**Numbers booked per annum**	**Predicted date of rollout (matching with student registration dates)**	**Dates of rollout**	**35% by March 2021-*target not met* Default pathway by March 2023 (70%) 75% of BAME and vulnerabilit**	**4850**

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							ies booked onto CoC pathways by March 2022	
		Ruby	WR4	220	March 2019	March 2019	4.5%	4.5%
		Sapphire	WR10	202	March 2019	March 2019	4.2%	8.7%
		Opal	WR6/DY13	210	March 2020	March 2020	4.3%	13.0%
		Emerald	B98/B60 3	210	March 2020 **DELAYED to** September 2020	Sept 2020	4.3%	17.3%
		Pearl	WR2	212	April 2020 **DELAYED** to Sept 2020	Sept 2020	4.3%	21.6%
		Amethyst	WR9	233	Nov 2020 **DELAYED** to Jan 2020 **DELAYED** to March 2020	March 2021	4.8%	26.4%
		Topaz	WR9	221	Nov 2020 **DELAYED** to Jan 2020 **DELAYED** to March 2020 *Not out due staff availability with no current plans to re-launch*	-	-	

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		Redditch City	B97/B80	215	Jan 2021 BAME **DELAYED**	TBC	4.4%	30.8%
		Bromsgrove	B60	215	March 2022 BAME	TBC	4.4%	35.2%
		Kidderminster City	DY10/DY 11	215	July 2022 Vulnerable	TBC	4.4%	39.6%
		Worcester City	WR1/WR 4	215	November 2022 BAME	TBC	4.4%	44.0%
		Worcester City	WR5	215	November 2022 Vulnerable	TBC	4.4%	48.4%
		Malvern	WR14	215	January 2023 Vulnerable	TBC	4.4%	52.8%
		Worcester City	WR4/3	215	March 2023 vulnerable	TBC	4.4%	57.2%
		Worcester City	WR2/WR 14	215	March 2023 vulnerable	TBC	4.4%	61.6%
		Evesham	WR11	215	March 2023	TBC	4.4%	66.%
		Droitwich	WR9	215	March 2023	TBC	4.4%	70.4%

Conclusion

Continuity of Carer has shown to improve clinical outcomes for women on the pathway to date. Continuity of Carer is a national ambition and following local reviews as recommended continuity of carer is to be implemented across the system in line with NHSE/I objectives for the majority of women by March 2023. Ongoing impact evaluation and adjustments are assessed via the governance reporting systems and engagement with teams.

The following actions must be completed prior to further implementation of this model:

1. Create a dedicated CoC work stream as part of the maternity improvement plan.
2. Review of current staffing position with BR+, and staff modelling.

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3. Increase Band 3 capacity across the system including CoC teams/PN wards and AN clinics.
4. Dedicated Band 7 level CoC implementation lead as well as project support (admin).
5. Dedicated support structures for CoC including estates, administrative support and coaching.
6. Evaluation of Continuity of Carer impact across the service which includes MVP feedback.
7. Move towards Continuity of Carer being the default model within by March 2022 with a phased approach. The Directorate will need to determine whether it will be beneficial to engage in formal consultation prior to launching more teams,
8. Engagement and development of Band 7 leaders and consultant obstetricians as these groups are central to delivery success.

Recommendations

Trust Board are asked to note the current position at WAHT and agree with the recommended actions to support the roll out of CoC to improve health outcomes for women and babies and meet the national ambition in 2023.

Appendices

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Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F3

Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme

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

Accountable Director	Paula Gardener: Chief Nursing Officer		
Presented by	Justine Jeffery : Director of Midwifery	**Author /s**	Nicola Robinson: Divisional Governance Lead. Justine Jeffery : Director of Midwifery

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	23.6.21	Endorsed
QGC	01.07.21	Endorsed

Recommendations	Trust Board are asked to review the evidence submitted against the ten safety actions and accept this report to demonstrate compliance.

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 in the template provided. This is further subject to external peer review and will then require final sign off by the Trust Board ahead of the Trust Declaration on July 22nd 2021

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	√	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		N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

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Introduction/Background

The NHS Resolution Clinical Negligence Scheme for Trusts Maternity Incentive 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 update outlines progress to date and reports on the required evidence to demonstrate compliance against the ten safety actions to support the Board to confidently complete the Board declaration to NHS Resolution.

This year (year 3 of the scheme) was paused due to the recognised challenges of the coronavirus pandemic. The maternity incentive scheme has been revised to include additional elements that ensure key learning from important emerging Covid-19 themes have been considered and implemented by NHS maternity services.

The Scheme was relaunched in October 2020 and underwent a second revision in January and a further revision in March 2021.

In order to be eligible for payment under the scheme, it was previously expected that Trusts would submit their completed Board declaration fro to NHS Resolutions by 12 noon on Thursday 15th July 2021 however due to an error on the declaration form Trusts have been provided with an extension and the revised submission date is now by 12 noon on 22nd July 2021.

This report details compliance, progress and actions required for all of the CNST safety standards. The 10 required standards are detailed within the template and evidence embedded to support the declaration.

Issues and options

Following a review of the evidence available, there remain some additional elements required to demonstrate compliance with all 10 standards. These are as follows

Safety Action 4:

- Awaiting evidence to confirm attendance of the duty anaesthetist for obstetrics should participate in labour ward rounds.

- Action Plan for Neonatal Medical & Nursing staff action Plan for sign off by Trust Board & submission to the RCN (enclosed).

Safety Action 5 :

- Audit in May regarding supernumerary status of shift coordinator (enclosed within staffing report)
- 1 to 1 care of women in active labour information captured on BadgerNet, however

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data cleansing required (enclosed in staffing report).

Safety Action 5 :

- Awaiting Action plan regarding plan to achieve 95% compliance for smoking cessation (enclosed).

Safety Action 9:

- COC Action plan to achieve 35% compliance (enclosed)

Now the above is available a peer review of selected actions has been confirmed, the declaration will then be prepared no later than the 19th July for submission by the Board ahead of the July deadline.

Conclusion

The maternity and neonatal services were able to demonstrate compliance with all 10 safety actions in 2019 a full rebate was received in 2019. In 2020 all Trusts received a full rebate as the scheme was suspended due to the pandemic. Compliance in 2021 has been extremely challenging as the information outlined within the scheme has undergone a number of revisions, the pandemic has interrupted some committees where the evidence would be reported and discussed, and staff have been deployed to critical areas of the wider hospital to deliver care which will impact on training compliance and the roll out of continuity of carer.

Regular updates have been provided to ensure that the Board are sighted on the on-going position and compliance with each safety action and whilst the Division have been able to provide evidence against all of the safety actions there is some variation in the quality of the evidence due to some of the challenges outlined within the report.

Recommendations

The Trust Board are asked to review the evidence submitted against the ten safety actions and accept this report to demonstrate compliance.

In order to be eligible for payment under the scheme, WHAT Trust must submit the completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 22nd July 2021 and must comply with the conditions stated within the guidance.

Appendices

1. CNS Evidence Template
2. Neonatal Workforce Information / Action Plan.

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Meeting	Trust Board
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Paper number	Enc F4

KP Sepsis & PMRT Assurance Report

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

Accountable Director	Angus Thomson – Divisional Director Women and Children's		
Presented by	Paula Gardner Chief Nursing Officer	**Author /s**	Lara Greenway, Neonatal Matron Amrat Mahal - DDN

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

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	1 July 2021	Noted

Recommendations	The Board is asked to: • Note the content of the paper and the progress against the implementation of the Kaiser Permanente Sepsis Risk Calculator (KP-SRC) and the Perinatal Mortality Review Tool (PMRT) process. • To provide the West Midlands Neonatal Operational Delivery Network (WMMODN) assurance that WAHT is implementing the KP Sepsis calculator. • To provide the WMNODN assurance that WAHT has adequately resourced clinicians time to deliver the PMRT incentive and have an outside of the Trust member present during the reviews.

Executive summary	This report provides a background and progress update to the implementation of the KP Sepsis Risk Calculator and the process embedded for PMRT reviews. The KP Sepsis guideline was approved at the: • Paediatric governance meeting on 15.07.2020 • Medicines Safety Committee Meeting on 14.04.2021 • Maternity Governance on the 18.06.2021 The KP Sepsis tool is now live on Badgernet and training commences 21.06.2021 **PMRT** 1. Clinicians are adequately resourced to deliver the PMRT incentive at WAHT. 2. There is an external member present at each meeting. This is

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	usually the Chair of the Maternity Voices Partnership (MVP) who is also a retired professor of Midwifery. In her absence a member from another Trust is invited such as the Quality & Safety Matron from Wye Valley NHS Trust.

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	7	X	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		N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Introduction/Background

Kaiser Permanente Sepsis Risk Calculator

The West Midlands Neonatal Operational Delivery Neonatal (WMNODN) began work on the implementation of the "Kaiser Permanente Sepsis Risk Calculator" (KP-SRC) to aid clinical management of infants at risk of early onset sepsis across the whole of the neonatal network in 2019.

The proposal was led by a Neonatologist at University Hospital's Birmingham (UHB). In order to commence the development work on KP-SRC the network liaised with and sought agreement from a range of stakeholders:

- First, the WMNODN Governance group who agreed in principle with the approach – each Provider Trust is represented by their Neonatal Clinical Leads in this forum and whilst not all Clinical leads have chosen to move forward with the project, all have been aware of the proposal for some time.
- Secondly, Specialised Commissioners are supportive of this approach and its continued implementation. In order to meet NHSE/I clinical oversight requirements Dr Surana presented the project to the Regional Clinical Senate in January 2020. Whilst the Senate do not authorise work programmes, they were keen to see the development of the approach and expected outcomes. Please note that NICE have now referred to the acceptability of the use of KP-SRC as an alternative to the NICE framework for babies >34 weeks of gestation. The final version of guideline is due for publication in April 21, which gives additional assurance for the adoption of the proposal at all units across the Network.

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Perinatal Mortality Review Tool (PMRT)
As part of the NHS Resolution Maternity Incentive Scheme year 3, https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf the use of the Perinatal Mortality review tool (PMRT) is one of the ten required actions. It is also a required recommendation within the National Neonatal Critical Care review.

Within the guidance for using the Perinatal Mortality Review tool https://www.npeu.ox.ac.uk/pmrt/implementation-support a multi-disciplinary team is required to review all deaths and this includes input from a member external to the Trust. This means a clinician from another Trust/Health Board is invited to be a member of the review group.

The Mortality within the West Midlands Neonatal Network is highest in England. Peer review involving independent members are essential in helping to reduce the morbidity and mortality within the region.

The West Midlands Neonatal Operational Delivery Network (WMNODN) wrote to all Trusts in December 2020 (attached) requesting assurance from Trust Board that:

1. The KP-SRC proposal has been through the Trust governance structures? If yes, confirm relevant committees & dates.
2. Is the Trust in agreement with the proposal and seeking to implement KP-SRC?
3. If the Trust going to implement KP-SRC, please provide an indicative timeframe for commencement?
4. Clinicians will be adequately resourced to deliver the PMRT incentive.

Issues and options

Kaiser Permanente Sepsis Risk Calculator
During the WMNODN Executive Board meeting held in November 2020, it was agreed that the ODN should seek individual Trust assurance that this proposal has been shared, discussed and understood through the Trusts overall governance process, prior to a final decision being taken by each Trust regarding the adoption of the proposal.

The WMNODN have requested confirmation of the following:

1. **Has this proposal been through your Trust governance structures? If yes, please confirm relevant committees & dates.**

   The guideline (attached) was approved at:
   - Paediatric Governance on the 15.07.2020
   - The Medicines Safety Committee on 14.04.2021
   - The Maternity Governance on 18.06.2021

2. **Is the Trust in agreement with the proposal and seeking to implement KP-SRC?**

   - Agreement to implement KP-SRC was made at the Medicines Safety Committee on 14th April 2021

3. If your Trust is going to implement KP-SRC, please provide an indicative timeframe for commencement?

- The KP sepsis calculator has been added to Maternity Badgernet (IT data system) that went live in June 2021
- Training for maternity staff starts week commencing 21.06.21 and is being delivered by Dr Watson and the digital midwife

PMRT

The WMNODN is looking to develop a reciprocal agreement to allow clinicians to offer the externality essential across the region to meet this requirement. There was a risk highlighted to the WMNODN that there is lack of clinical time in job plans, specifically for PMRT reviews and therefore externality at PMRT reviews does not happen in many Provider Trusts.

The WMNODN are seeking clarification and assurance from the Trust Board that this element will be included in SPA's and clinicians will be adequately resourced to deliver the PMRT incentive. WAHT has developed an SOP (attached) and implemented the following:

- Clinicians are adequately resourced to deliver the PMRT incentive at Worcestershire Acute NHS Trust.
- An external member is present at each meeting. This is usually the Chair of the Maternity Voices Partnership (MVP) who is a retired professor of Midwifery. In her absence a member from another Trust is invited such as the Quality & Safety Matron from Wye Valley NHS Trust.

Conclusion

In conclusion assurance can be provided to the WMNODN that:

The KP-SRC guideline was approved at:

1. Paediatric Governance on the 15.07.2020
2. The Medicines Safety Committee on 14.04.2021
3. The Maternity Governance on 18.06.2021
4. The KP sepsis calculator has been added to Maternity Badgernet (IT data system) that went live in June 2021
5. Training for maternity staff starts week commencing 21.06.21 and is being delivered by Dr Watson and the digital midwife
6. Clinicians are adequately resourced to deliver the PMRT incentive at Worcestershire Acute NHS Trust
7. An external member is present at each meeting. This is usually the Chair of the Maternity Voices Partnership (MVP) who is a retired professor of Midwifery. In her absence a member from another Trust is invited such as the Quality & Safety Matron from Wye Valley NHS Trust.

Recommendations

For the Trust Board to provide assurance to WMNODN that WHAT:

- Is implementing the KP Sepsis Risk Calculator

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- Has adequately resourced clinicians time to deliver the PMRT incentive and have an outside of the Trust member present during the reviews.

Appendices

Kaiser Permanante Sepsis Calculator.pdf

FINAL SOP for PMRT - July 2020 - v2.docx

Letter to MNSC re KP-Sepsis.pdf

Letter to MNSC for PMRT2.docx

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Date of meeting	15 July 2021
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Bewick Review Update

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

Accountable Director	Mr Mike Hallissey, Chief Medical Officer		
Presented by	Mr Mike Hallissey, Chief Medical Officer	**Author /s**	Kira Beasley, Business Manager to Chief Medical Officer Dr Stephen Graystone, Clinical Lead for Learning from Deaths

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	23.6.21	Noted
QGC	1.7.21	Noted

Recommendations	The Board are invited to note the content of this report and continue to support improvements based on the recommendations from the Bewick Report.

Executive summary	This report outlines the response to the recommendations that were received following the Bewick Report. All of the actions are either complete or are becoming business as usual to continue to improve our care. The Mortality Review Group, Divisional Governance Teams along with the ReSpect programme and End of Life Care Steering Group continue to develop strategies and improve communication between the clinical teams.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	Quality and Safety (4)

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None*																	

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

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Are the actions identified starting to or are delivering the desired outcomes?	Y		N		
If no has the action plan been revised/ enhanced	Y		N		
Timescales to achieve next level of assurance					

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Introduction/Background

This report outlines the response to the recommendations that were received following the Bewick Report.

All of the actions are either complete or are becoming business as usual to continue to improve our care. The Mortality Review Group, Divisional Governance Teams along with the ReSpect programme and End of Life Care Steering Group continue to develop strategies and improve communication between the clinical teams.

Issues and options

Bewick Report

General recommendations	Commentary	Update – May 2021
5.2.1 CQC improvements need to be fed back to staff in a consistent manner	All CQC improvement requirements relating to mortality are discussed at Mortality Review Group (MRG) Actions & learning are identified and communicated back to divisions through their governance communications processes. Communicated to Trust Board via corporate governance route. Any issues affecting all staff are communicated via weekly Mortality Review Group staff briefings.	Mortality meetings back up and running with single reporting template into Divisional Governance meetings and then to Mortality Review Group (MRG). Reporting covers what went well as well as improvement activity
5.2.2 The CMO and CNO should develop a system of cross reference between the mortality judgement reviews and CQC findings, especially about safe care and learning from serious incidents. This should help further to develop professional curiosity when undertaking any future SJRs and increase learning.	CMO or deputy CMO in attendance at Mortality Review Group (MRG) whose role is to ensure mortality review programme is in alignment with corporate strategy which will, in part, be shaped by CQC findings. Quarterly reports to the Trust board monitor Aggregate CuSum >3 to identify repeat triggers and allow for action to be taken in preventing the triggers. Mortality outlier alerts from Dr Foster/CQC, findings from internal review and actions resulting are reported monthly to Mortality Review Group (MRG)	Refinement of this process continues with work being undertaken t link incidents and mortality reviews as part of the Trusts refreshing of its patient safety strategy

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5.2.3 The Trust should develop the learning from deaths process through the use of the structured judgement review tool, an expansion in the capacity to do so is required. This is especially so for a trust with continuing mortality issues.	The introduction of the new 'bereavement app' in April 2020 allows quantitative and qualitative analysis of the results of the SJRs. Quality assurance work ongoing and the app will continue to be refined to make it serve the needs of the organisation.	Bereavement App in routine use with work being undertaken to improve the usefulness of reports from the app for Divisions and for corporate needs (e.g. FOI requests). As the Bereavement App is newly rolled out and is still being implemented across divisions there has not been an opportunity to develop learning from the outcomes.
5.2.4 The backlog of as yet unevaluated deaths (800+) should be processed and adequate resource allocated to do so.	Backlog greatly reduced by end of 2019/20. Ongoing reviews of backlogs via Mortality Review Group (MRG)	Backlog issues monitored through Mortality Review Group (MRG) – Medical Examiner service starting to apply filters to backlog to ensure appropriate focus.
5.2.5 There should be a regular forum to share learning from all specialities investigating deaths in the Trust. The current mortality review group only partially fulfils this role.	Re-established following on from suspension due to Covid-19 pandemic.	Mortality review group now rebranded as Learning from Deaths group to move focus from process mechanics to quality improvement and truly developing the learning to share across the trust and the system
5.2.6 The newly appointed medical director must be given high level Board support in seeking to improve engagement with clinicians, and to deal with resistance where it is occurs, in implementing new ways of working. A review of the current divisional clinical leadership is advised.	CMO has reviewed divisional medical management structure, process and responsibilities with the Divisional Directors. Divisional directors have overall responsibility for clinical governance within their Division. Each Division has a designated individual who takes a lead on Governance.	Work is continuing to improve the clinical governance within the divisions and implementing the National Patient safety strategy. There is clear challenge at CGG and QGC of the Divisional leads and their approach which is then reflected up to the Board

5.2.7 Safeguarding training compliance has improved but it was very low to begin with and most of it still does not meet the 90% compliance standard (only level 1 children). Medical and dental statistics show that most improvement is still well below the target. We recommend that this continues to be on the risk register and the board scrutinise rigorously. Many of the cases that we reviewed showed elderly vulnerable patients receiving sub-optimal care.	Continues as a high priority for mandatory training. Compliance has recently been disrupted by the pandemic. There is a focus at Divisional level of Compliance which is monitored monthly.	Continued high priority for the Trust and routinely monitored and challenged
5.2.8 The Trust must ensure all staff receive and complete their required mandatory training, including safeguarding and Mental Capacity Act 2005 training and this should be completed in a timely fashion	Changes in delivery of safeguarding and Mental capacity act mandatory training during COVID period to on-line resource so this element can continue despite pressures on clinician's time and limitations in meeting to undertake training.	Continues to be a high priority for the Trust and routinely monitored.
5.2.9 The Trust must ensure all medical staff are trained to the required level of safeguarding for both children and adults.	As above – monthly focus and performance management across organisation.	Continues as a high priority and reviewed through appraisal and divisional structures.

Recommendations	Commentary	
8.2.1 That the Trust Board improves its oversight of the mortality review processes. This is described more fully in part 1 of our report.	Quarterly Reporting on Mortality and Learning from deaths are reviewed by Trust Board.	Regular updates to the Trust executive team regarding Mortality & Learning from Deaths to ensure clarity on the process, impact of changes made and progression of learning from deaths
8.2.2 An expansion of the medical examiner role with recruitment of a broader skill base reflecting the Trust's range of expertise	Increased recruitment occurring from Consultant physicians – as of the end of Feb 2021.	Current Medical Examiner profile – • 4 Anaesthetists, • 1 Intensivist, • 2 Physicians, • 1 Gynaecologist. Medical Examiner Officer appointments made, one experienced MEO from another Trust, one band

		6 nurse, 1 bereavement officer. To allow further support to the medical examiners.
8.2.3 The newly appointed medical director should review the current reporting across the Trust of the various mortality review processes, unifying the process of reporting lessons learned.	Trust-level reporting reviewed by CMO and changes implemented during 2019/20. Reporting to recommence following suspension due to Covid-19.	Learning from Deaths reports have been standardised across all divisions and feed in to the Learning form deaths group
8.2.4 Develop closer working relationships between the SJR and serious incident reporting, again to refine the reporting of lessons learned.	As part of policy review (ongoing at the moment) any element of care graded poor or inadequate will be reported as an incident. Current example of improved linking of mortality review and incident reporting is potentially Healthcare Associated COVID infections resulting in death.	Being addressed as part of the review of the Trusts patient safety strategy. The bereavement app will be updated to include reasons for SJR.
8.2.5 A review of the current understanding of clinical engagement in the medical division and how improvements can be achieved in supporting the acute pathway and reducing admission waiting times and timely medical opinion.	• Daily in reach to ED/AMU by all the major medical specialities • Specialty Medicine hot clinics set up to support early discharge • Medical Junior Doctor rota has been adjusted to ensure there is adequate capacity within the emergency departments • Physicians associates have been employed to help support Acute care and Medical Wards • Successful implementation of an Acute Medical Unit with new patient pathways in April 2020. • Learning from this to be utilised to drive changes at WRH. • Plans in place in the context of UEC project to develop AMU model at WRH, delivery August 2022	Continued support for the Acute Pathway from the Specialty Medicine Division. KPI's introduced for specialty reviews of patients in the Emergency Department Continued development of physicians associate role across the Trust

8.2.6 Additionally practise which delays either decision to discharge or to implement an 'end of life' pathway needs to be challenged by the new clinical leadership.	New End of Life Steering Group implemented with the Deputy CMO as Chair. ReSPECT and Amber Pathways have been rolled out across the Trust to allow for recognition of end of life or uncertain recovery.	End of life steering group has developed a strategy for improving end of life care and recognition of 'outcome uncertain' for patients that will be implemented across the Trust. EOLC steering group reports to the Clinical Governance Group regularly.
8.2.7 A review of the documentation of do not resuscitate for consistency and completeness.	Part of ReSPECT implementation and sustainability project.	Audit of position within acute Trust in planning phase – due to report by end July. ReSPECT to move to version 3 and be digital as part of ICWR project.
8.2.8 An improved care plan to focus on basic support including hydration and nutrition.	Care plans have been improved as part of the ReSPECT implementation and audits continue to monitor progress.	Nutrition and hydration group have modified fluid balance and nutrition record charts to improve focus on key elements.
8.2.9 When visualised electronically the current notes are often illegible and disorganised. In the acute situation, those seeking information quickly, will often be frustrated at the time taken to retrieve often critical information. The IT system needs radical upgrading or replacement in the medium term	Digital Care Record programme in place –where possible all data will be direct digital entry to remove issues relating to poor handwriting and errors in filing into current scanned system. This will also result in better identification of those planning and delivering all aspects of care.	DCR programme continues.

Next steps	Commentary	
8.3.1 To comment on and discuss the findings of our report prior to the Trust Board meeting on the 12th September.	Complete.	
8.3.2 To develop a plan to improve medical engagement and to agree new working practices in the acute medical pathways. Consensus is preferred but not absolute as the current situation isn't unsustainable.	ReSPECT & End of life care group are overseeing improvements in pathways and engagement. The MAU/MSSU model at the Alex and Length of Stay has	Continues to be a high priority for the Trust and training figures are routinely monitored. ReSPECT Mandatory Training Compliance

	fallen, diving better patient through put and quality of care. There has also been a reduction in long length of stay across the Trust.	(April 2021) 86% (Improved from 40% compliance on last year)
8.3.3 Our review only surveyed 10% of recent deaths; the Trust requires assurance that any avoidable factors in deaths are fully appreciated. The medical examiner role needs urgent expansion and support. The backlog of mortality reviews, currently over 800, needs to be assessed clearing the way for a more sustainable process in the future.	Recruitment of Medical Examiner Officers and healthcare assistants is taking place to support the Medical Examiners. Once the medical examiner officers commence in post we will have the nationally expected levels of support.	Currently at 9PA's per week of ME time with recent appointment of 2.3 WTE MEO's to commence with Trust by end of June.
8.3.4 Discussion with stakeholders to establish priorities for end of life care and how the new Respect initiative will reduce inappropriate deaths in hospital.	Hereford & Worcestershire Mortality group and STP wide End of Life Steering Group and ReSPECT steering groups established with a reporting structure.	STP focus on EOL and ReSPECT continues. Meetings were paused during the COVID pandemic, however are expected to be reinstated to ensure a renewed focus on EOL. Early discussion taking place regarding including community deaths in ME service. Regional ME office has confirmed funding is available to include community deaths in ME scrutiny process.

Conclusion

In conclusion, a great deal of work has ensured that there has been continuous improvement following the Bewick Report with improvements in communication and engagement of the clinical teams.

Recommendations

Trust Board are invited to note the content of this report and continue to support improvements based on the recommendations from the Bewick Report.

Appendices

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Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F6

Audit and Assurance Committee Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 9 June 2021. Committee was focused on the Annual Accounts and Annual Report as follows. Committee: • Noted the Head of Internal Audit Opinion • Received the Auditor's opinion on the audit of the 2020/21 Accounts and noted: a) Section 30 Letter to the Secretary of State b) Auditor's Annual Report Letter • Received and signed off Trust's letter of representation. • Agreed the adoption the 2020/21 Annual Accounts and sign off of the appropriate certificate • Received and signed off the Trust's Annual Governance Statement • Approved the draft Annual Report to be received by the Board. Committee expressed its thanks to the Trust finance teams and to the auditors for their hard work and diligence.

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

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

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Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc F7

Remuneration Committee Report

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

Accountable Director	Sir David Nicholson, Remuneration Committee Chair		
Presented by	Sir David Nicholson, Committee Chair	**Author /s**	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Executive summary	This report summarises the business of the Remuneration Committee at its meeting held on 24 June 2021 The following key points are escalated to the Board's attention: **1. Secondment of Interim Chief Finance Officer** Committee discussed and approved the secondment of an interim Chief Finance Officer from 5 July to 10 September 2021 due to planned sick leave. Committee further noted the associated delegation arrangements within the finance team.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*9 and 10*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A		
Financial Risk	*None directly arising as a result of this report*																		

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