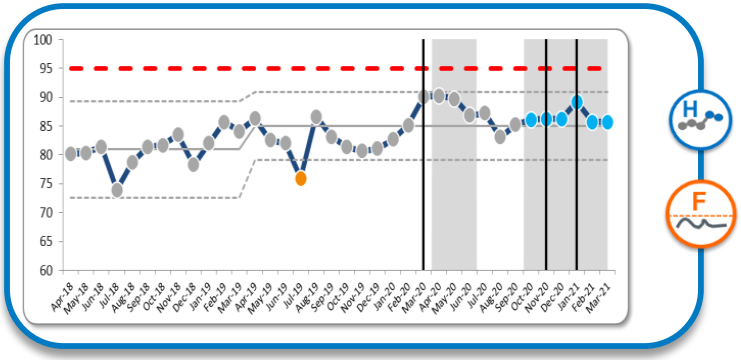
Month 12 [March] | 2020-21 Quality & Safety - Care that is Positive Experience

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated March 21 as at 12th April 2021

NHS Worcestershire Acute Hospitals NHS Trust

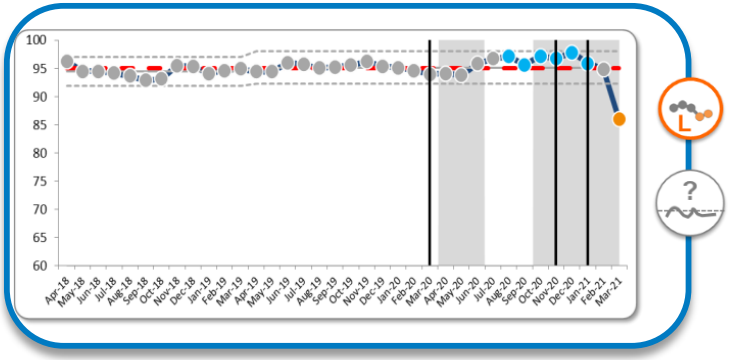
Accident & Emergency Recommended Rate Friends & Family Test (%)

85.71



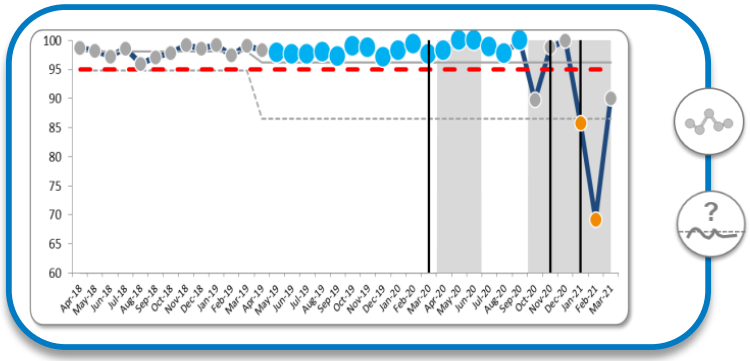
Inpatient Recommended Rate Friends & Family Test (%)

85.94



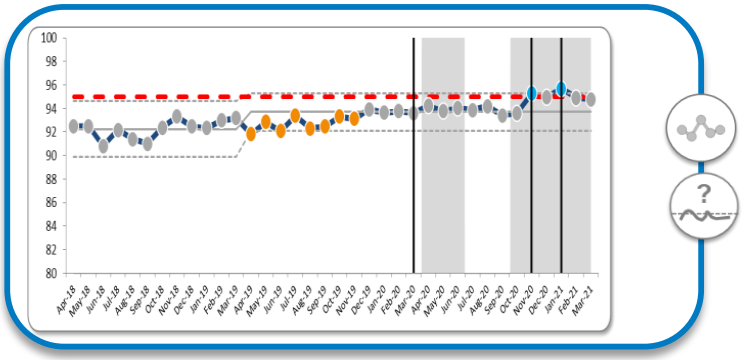
Maternity Recommended Rate Friends & Family Test (%)

90.00



Outpatients Recommended Rate Friends & Family Test (%)

94.77



Lockdown Period

COVID Wave

Maternity

Maternity Month 11: - What does the data tell us?

% admission of full-tern babies to neonatal care	Neonatal Deaths	Stillbirths	Maternal Deaths	% Pre-term births	% Home births	Booked before 12+6 weeks	Births
3.0%	2	2	0	7.1%	5.0%	88.5%	322

What does the data tell us?

- Births in Feb-21 are showing significant change, even in comparison to Feb-20 when there were 391 births.
- For the second consecutive month, there were 2 neonatal deaths.
- Modes of birth are all within normal variation, showing no significant change.
- We are below the national average for term admissions and we are not an outlier for neonatal or maternal deaths. We have one of the lowest stillbirth rates in the West Midlands.
- For the second consecutive month, at a rate above the expected range, for homebirth.
- Improved rate of women booked by 12+6 weeks of pregnancy

What have we been doing?

- Completed and submitted requested Ockenden assurance tool
- Further midwifery recruitment event planned for April with 26 applications received.
- Completed a number of key actions outlined in the CQC action plan to address all of the 'must do's' . Process for monitoring actions agreed within the Division.
- Completed scoping work with BR Plus around procurement of acuity tools and audit
- Incident reporting culture has increased for 2 consecutive months
- Review of IOL pathway

What are we doing next?

- Work ongoing to identify what resource is available to ensure a robust and supportive preceptorship package is available for newly qualified midwives.
- Preparing evidence for Ockenden submission
- Gathering evidence for CNST Q4 report.

Current Assurance Level: 5 (Mar-21)
Approved at QGC – 29th April 2021

When expected to move to next level of assurance:
Following evidence submission to NHSEI for Ockenden and feedback received.
No midwifery vacancies

Previous Assurance Level: 6 (Feb-21)

SRO: Paula Gardner (CNO)

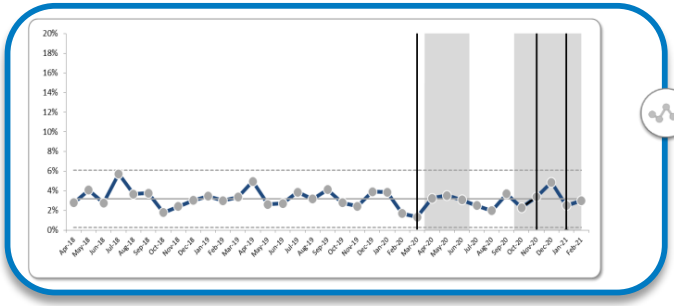
Month 11 [February] 2020-21 Maternity Summary

Responsible Director: Chief Nursing Officer| Validated for Feb-20 as 07th April 2021

NHS Worcestershire Acute Hospitals NHS Trust

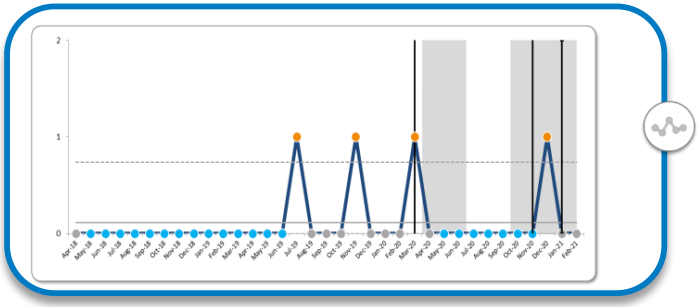
% admission of full-tern babies to neonatal care

3.0%



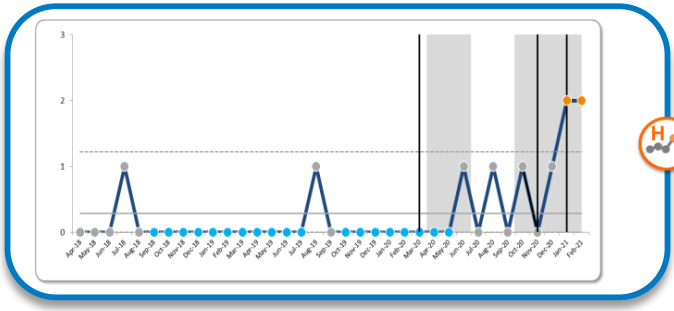
Maternal Deaths

0



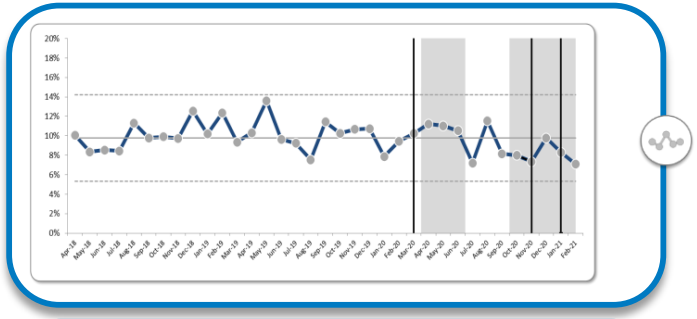
Neonatal Deaths

2



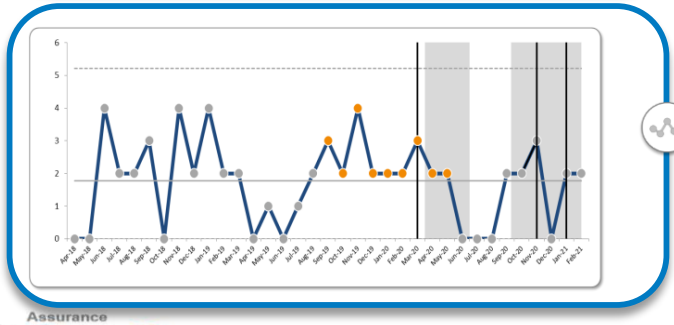
% Pre term births

7.1%



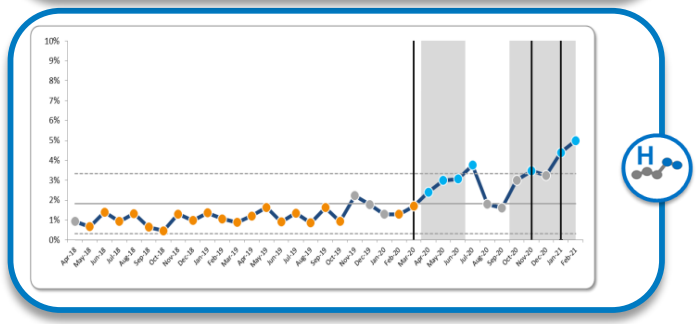
Stillbirths

2



% Home births

5.0%



Lockdown Period

COVID Wave

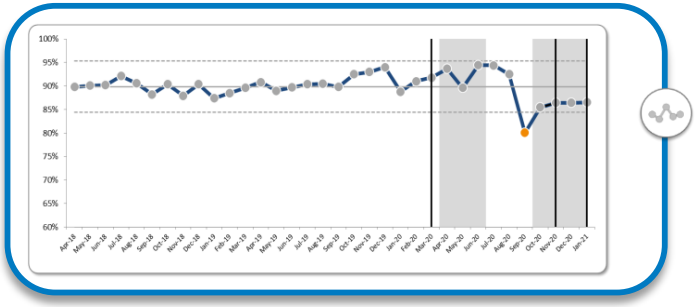
Month 11 [February] 2020-21 Maternity Summary

Responsible Director: Chief Nursing Officer| Validated for Feb-20 as 07th April 2021

NHS Worcestershire Acute Hospitals NHS Trust

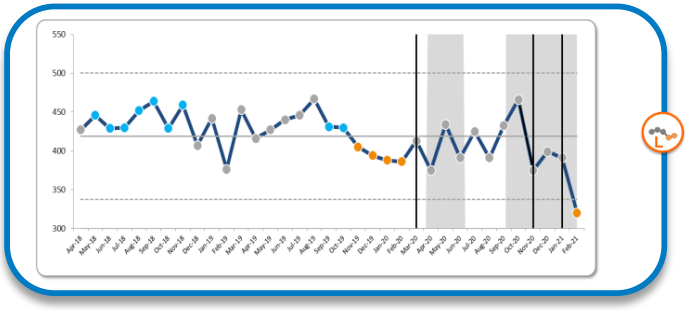
Booked before 12+6 weeks

88.5%



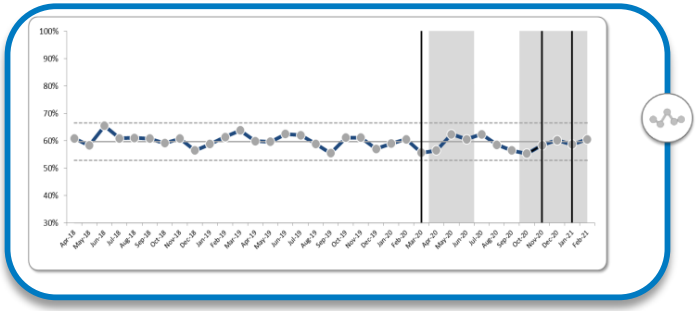
Births

322



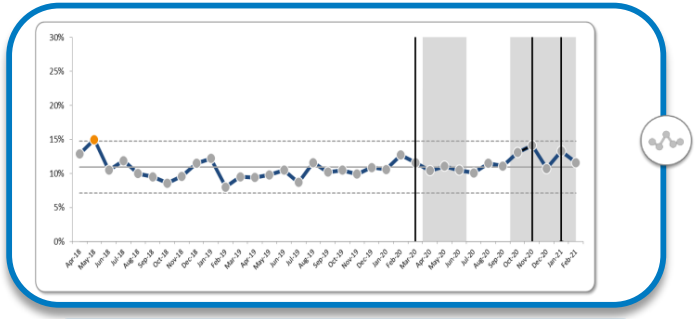
Vaginal Births

60.6%



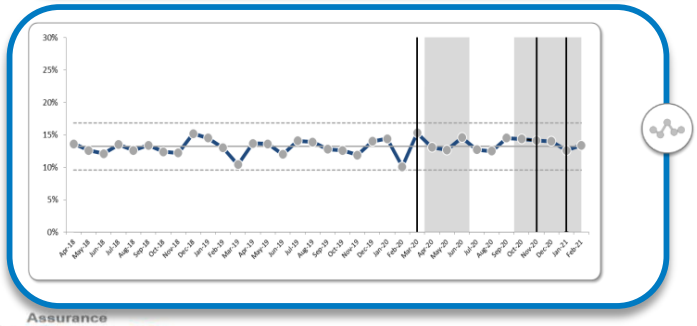
Instrumental rate

11.6%



Elective Caesarean

13.4%



Emergency Caesarean

14.4%

Variation

Assurance

Lockdown Period

COVID Wave

Workforce

People and Culture Performance Report Month 12 - Headlines

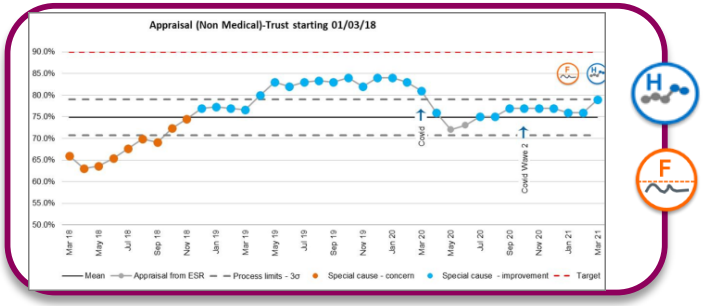
People & Culture	Comments
Getting the basics right (appraisal, mandatory training, job plans)	• Mandatory training compliance has improved by 1% and now meets Target at 90% • Medical appraisal compliance has improved by 2% to 83% • Non-medical appraisal rate has improved by 3% to 79% • Urgent Care continue to be the only division to have achieved 100% in consultant job plans • Surgery continues to be an outlier in terms of job planning compliance with only 17% • Appointment to dedicated Job Planning Officer will push use of e-job plan following the step down of Covid response level. • Based on the current position, if no job plan reviews are undertaken in April the position will drop to 39% next month
Absence due to Stress and Anxiety (S10)	• Sickness due to S10 (stress and anxiety) has reduced by 0.09% to 1.23%. This equates to 27% of all sickness. • Our staff health and wellbeing offer has been refreshed and continues to be communicated to staff at every opportunity through a summary infographic and an updated Wellbeing Pinwheel on the intranet. Wellbeing Wednesday is focussing on staff health and wellbeing
Monthly Sickness Absence Rate	• Monthly Sickness has improved by 0.04% to 4.51% which is 0.21% better than the same period last year ** • Cumulative sickness has reduced to 4.96% ** • Cumulative sickness is 0.51% higher than March 2020 which only had a part-month effect of covid absence ** • Covid absence (both sickness and self isolation) have reduced again this month in line with community prevalence rates *** NB - Sickness data is to be validated due to failure of an interface file for Nursing Absence which was escalated to IBM, Allocate and SBS but is not yet resolved on ESR. Data has been provided this month from Absence recorded on HeathRoster v Hours Available on ESR. This affects Nursing Rosters only.*
Vacancy Rate	• Vacancy rates have continued to improve despite the pandemic with a 27 wte increase in staff in post this month • Our vacancy rate of 7.29% continues to be better than the ONS national average of 8.1% and the Model Hospital average or 7.37%.
Staff Turnover	• Staff turnover has remained broadly unchanged this month at 9.5% which is 1.62% better than the same period last year • We have improved to Quartile 2 on Model Hospital with 0.86% monthly turnover against a national average of 0.93% (January 2021 data)

Month 12 [March] 2020-21 Workforce Compliance Summary

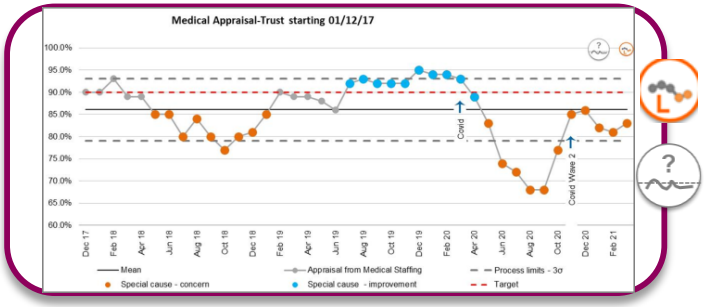
Responsible Director: Director of People and Culture | Validated for March -21 as 14th April 2021

NHS Worcestershire Acute Hospitals NHS Trust

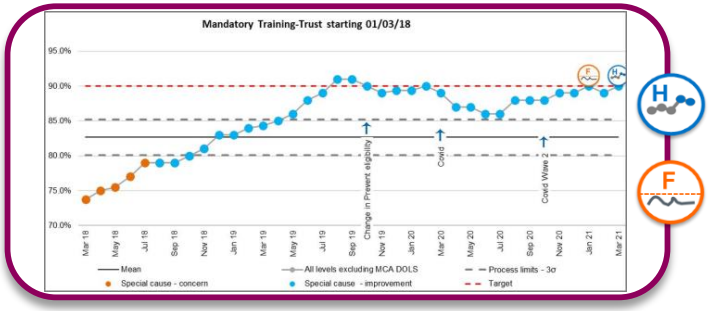
Appraisal (Non-Medical) — 79%



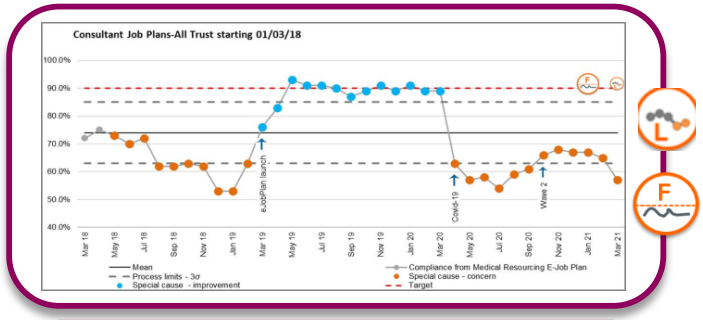
Medical Appraisal — 83%



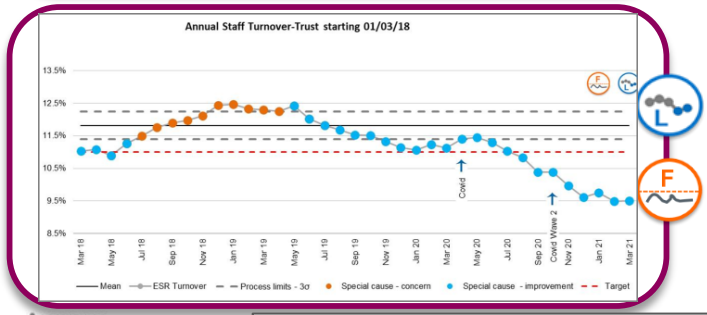
Mandatory Training — 90%



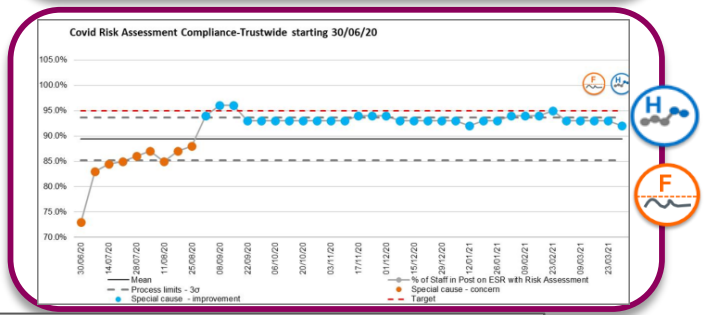
Consultant Job Plans — 57%



Staff Turnover — 9.5%



Covid Risk Assessment Compliance — 92%



Variation: Special Cause Concern High / Special Cause Concern Low / Special Cause Note/Investigate High / Special Cause Note/Investigate Low / Common Cause

Assurance: Consistently hit target / Hit and miss target subject to random / Consistently fail target

Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

Workforce Compliance Month 12: - What does the data tell us?

Appraisal and Medical Appraisal	Mandatory Training and Core Essential to Role Training	Consultant Job Planning	Staff Turnover	Covid Risk Assessment Compliance
79% and 83%	90% and 81%	57%	9.5%	92%

What does the data tell us?

- **Appraisal** – Compliance has improved by 3% to 79% which is 2% lower than the same period last year. From April 2021 pay progression will be dependant on managers conducting appraisals which should improve compliance.
- **Medical Appraisal –** Medical appraisal has improved by 2% to 83% this month but is 10% lower than the same period last year
- **Mandatory Training** – Mandatory Training compliance has improved by 1% to 90% this month which is better than the same period last year.
- **Essential to Role Training** – We have a 3% improvement in Essential to Role training this month. Frailty compliance has increased by 8% to 74%. Sepsis has increased by 4% and Dementia by 2%. The only topic that has seen a slight decrease is MCA and DoLS level 2.
- **Consultant Job Plans** – Consultant job planning compliance has reduced by 8% to 57%. Urgent Care remain 100% but have dropped in their SAS doctor compliance to 88%. SCSD have declined again to 59% and Surgery remains an outlier with only 17% compliance. Appointment to a dedicated Job Planning Officer role will push compliance with divisions. If no reviews are undertaken in April compliance will drop to 39% next month.
- **Staff Turnover** – Staff annual turnover has broadly remained the same this month at 9.5% which is well within target and 1.62% better than the same period last year. All divisions have easily met the new target of 11%.
- **Covid Risk Assessment Compliance –** Compliance dropped to 92% due to turnover of staff and staff returning from sick leave or shielding who were previously excluded

National Benchmarking (April 2021)
Model Hospital Benchmark for Mandatory Training compliance is 90% and a peer group average of 88% so the Trust is not an outlier. Performance is below Model Hospital average of 85% for Non-Medical and Medical appraisal and job planning.

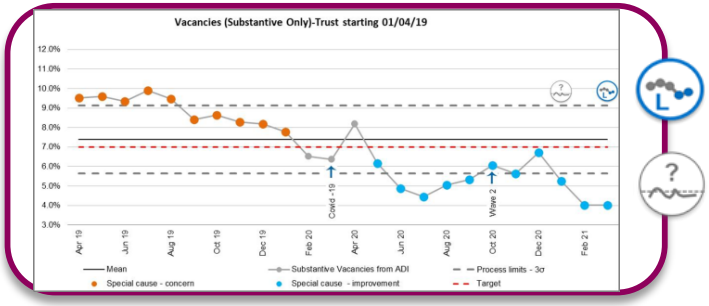
Month 12 [March] 2020-21 Workforce Performance Summary

Responsible Director: Director of People and Culture | Validated for March -21 as 14th April 2021

Worcestershire Acute Hospitals NHS Trust

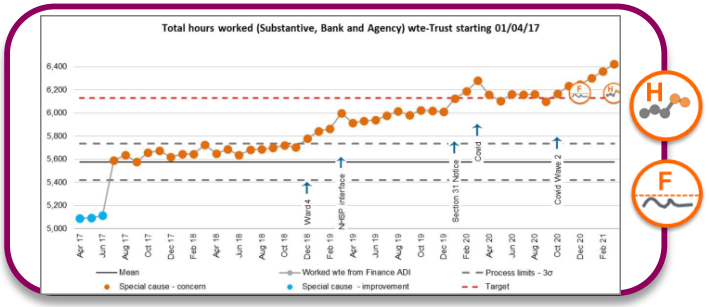
Substantive Vacancy Rate

4.01%



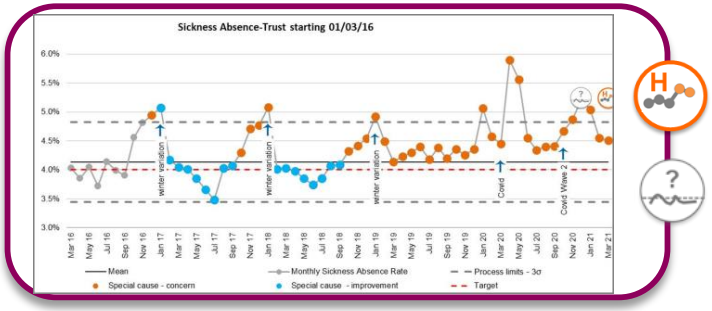
Total Hours Worked

6422 wte



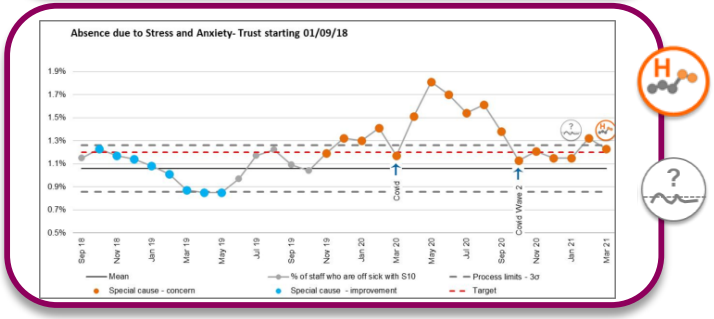
Monthly Staff Sickness Absence

4.51%



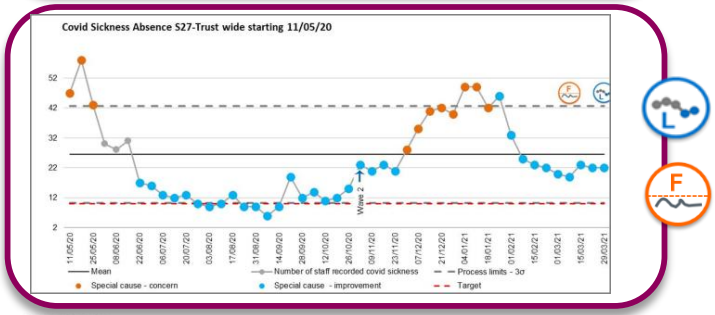
% Staff absent due to Stress and Anxiety (S10)

1.23%



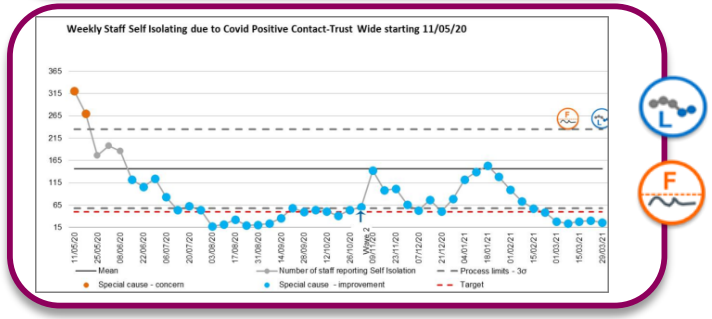
Number Covid Sickness (S27)

22



Number Self Isolating

26



Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

Workforce Performance Month 12 - What does the data tell us?

Vacancy Rate	Total Hours worked (including substantive bank and agency)	Monthly Sickness Absence Rate and cumulative sickness rate for 12 months	% Staff absent due to Stress and Anxiety (S10)	Number of staff off with Covid Sickness (S27) on the last Monday of month	Number of Staff self isolating due to Covid+ contact on the last Monday
4.01%	6,422 wte	4.51% and 4.96%**	1.23% **	22	28

What does the data tell us?

- **Vacancy Rate** – Substantive vacancy rates are at 4.01% due to 27 wte increase in staff in post. This is despite a 28 wte increase in our funded establishment this month. Our contracted staff in post is 248 wte higher than the same period last year, and establishment is 111 wte higher than March last year
- **Total Hours Worked** – The total hours worked for substantive, bank and agency staff increased from 6360 wte to 6422 which is higher than the agreed funded establishment of 6,348 (including bank and agency). The primary booking reasons via NHSP are vacancy (404 wte - 65k hours), Covid-19 Additional Staff (14k hours), Additional Beds (12k hours), and Sickness (10k hours). There is also an increase in annual leave taken in March. A triangulation exercise is being undertaken of the booking reasons v vacancies/sickness for hotspot areas.
- **Monthly Sickness Absence Rate** – The monthly sickness absence rate has reduced from 4.55% to 4.51% **which is 0.21% better than the same period last year. Cumulative sickness has reduced to 4.96%**
- **Absence due to Stress and Anxiety (S10)** – Absence due to stress and anxiety has reduced by 0.09% to 1.3%** this month which is 0.21% better than the same period last year. Pre-covid S10 sickness averaged at 1.03%.
- **Absence due to Covid Sickness (S27) –** 22 staff were Absent due to Covid. This did peak at 49 at the beginning of January but is now reducing in line with national pandemic trends. This figure includes those staff who have reported sick due to effects of the Covid vaccine.
- **Absence due to Self Isolation –** Absence due to self isolation (including shielding, and Test and Trace) had reduced dramatically from the peak of 244 in mid January to 28.

*** NB - Sickness data is to be validated due to failure of an interface file for Nursing Absence which was escalated to IBM, Allocate and SBS but is not yet resolved on ESR. Data has been provided this month from Absence recorded on HeathRoster v Hours Available on ESR. This affects Nursing Rosters only.*

National Benchmarking (April 2021)
We are Quartile 3 on Model Hospital for sickness with 5.25% compared to 5.17% national average (December 2020 data). Monthly turnover has improved to Quartile 2 with 0.86% compared to 0.93% national average (January 2021 data)

Annual Plan Strategic Objectives: Workforce

Strategic Workforce Plan		BAME Workforce	Organisational Development
Introduce new roles and staffing models to support the delivery of our clinical services strategy	Accelerate new ways of working from the Covid-19 experience	Undertake Covid-19 Risk Assessments for all BAME staff	Implement new operational management structure
		90%	

Annual Plan: Strategic Objectives | Best people

Ensure all our staff have annual appraisal and are suitably trained with up to date job plans. Ensure we have adequate staff to meet patient needs within financial envelope, and that this is a good place to work so that we can retain our substantive staff and reduce reliance on bank and agency staff.

How have we been doing?

Included below are business as usual updates.

- Medical Appraisal rates have improved by 2% this month
- Vacancy rate is significantly better than same period last year despite 111 wte increase in funded establishment
- Staff turnover has reduced and is 1.62% better than last year
- Mandatory training compliance has improved to 90% which meets target and model hospital benchmark
- Covid vaccination has been offered to all staff with 85% uptake at the end of March
- Covid Risk Assessment compliance has fallen to 92% due to starters, leavers and returners from Long Term Sickness or Maternity Leave.
- We have rolled out HealthRoster and Employee on Line (EOL) /Loop self service functionality to Allied Health Professionals and other groups
- We have transferred all annual and other leave booking and approvals to HealthRoster with a monthly payroll upload to ESR from 1st April

What improvements will we make?

- Continue to work with divisions to ensure that OH risk assessments are kept up to date and compliance maintained for new starters
- Work with divisions to ensure 95% of patient facing staff are encouraged to take up the Covid vaccine
- To work with divisions to reduce their reliance on bank and agency staff
- To continue to roll out new Competencies on the Essential to Role matrix. End of Life Care Fundamentals of Care to be launched in April, followed by Donning and Doffing in May for all staff.
- To work with NHSP to tighten up booking of additional hours and triangulate to vacancies and sickness within the department

Overarching Workforce Performance Level – 5 – February 2021 **Previous Assurance Level - 5 – January 2021**	**To work towards improvement to next assurance level**

Finance

Finance | Headlines

Worcestershire Acute Hospitals NHS Trust

Delivery of the Internal Financial Plan £(78.9)m and NHSI Framework

Month 12 – March Position

Income & Expenditure	March 21 (Month 12)				
	NHSI Framework £000s	Budget £000s	Actual £000s	Variance to NHSI Framework £000s	Variance to Budget £000s
Income (Excluding top up)	36,787	39,958	47,379	10,593	7,421
Pay	(29,149)	(26,526)	(45,164)	(16,015)	(18,637)
Non Pay	(16,137)	(15,606)	(23,638)	(7,501)	(8,031)
Financing Costs	(2,397)	(2,571)	(9,466)	(7,069)	(6,896)
Other	6	0	5,319	5,313	5,319
Surplus / (Deficit)	(10,890)	(4,746)	(25,569)	(14,679)	(20,824)
Income - TOP UP	8,903	0	26,182	17,279	26,182
Adjusted Surplus / (Deficit)	(1,987)	(4,746)	613	2,600	5,358
Sub Table - Financial Position Excluding pre COVID-19					
Surplus / Deficit BEFORE TOPUP	(10,890)	(4,746)	(25,569)	(14,679)	(20,824)
COVID-19 Incremental Expenditure Included Above			8,428	8,428	8,428
Surplus / Deficit EXCLUDING COVID-19	(10,890)	(4,746)	(17,142)	(6,251)	(12,396)

YTD Month 12 – March Position

Income & Expenditure	Year to Date				
	NHSI Framework £000s	Budget £000s	Actual £000s	Variance to NHSI Framework £000s	Variance to Budget £000s
Income (Excluding top up)	436,652	455,416	449,318	12,667	(6,097)
Pay	(324,628)	(318,045)	(336,025)	(11,397)	(17,980)
Non Pay	(181,606)	(185,456)	(186,147)	(4,541)	(691)
Financing Costs	(28,749)	(30,849)	(35,564)	(6,815)	(4,715)
Other	72	70	5,385	5,313	5,315
Surplus / (Deficit)	(98,259)	(78,864)	(103,033)	(4,773)	(24,168)
Income - TOP UP	90,987	0	109,686	18,699	109,686
Adjusted Surplus / (Deficit)	(7,272)	(78,864)	6,653	13,926	85,518
Sub Table - Financial Position Excluding pre COVID-19					
Surplus / Deficit BEFORE TOPUP	(98,259)	(78,864)	(103,033)	(4,773)	(24,168)
COVID-19 Incremental Expenditure Included Above			24,394	24,394	24,394
Surplus / Deficit EXCLUDING COVID-19	(98,259)	(78,864)	(78,638)	19,621	226

BUDGET / INTERNAL PLAN - Against the internal **£(78.9)m** operational plan, the month 12 (March 2021) plan £(4.7)m deficit actual surplus of **£0.6m**. **Positive variance of £5.4m**. This is against a very different activity, income and resource plan. The combined **pay and non pay expenditure variance** against our **internal budget** is **£(26.6)m adverse**. This position includes **£8.4m** of incremental COVID-19 costs (of which £6.4m relates to a notional adjustment for centrally procured PPE). The combined income position was **£33.6m** favourable to budget **in month** recognising the interim funding regime.

Against the Financial Framework NHSI the Trusts Income & Expenditure position **was £2.6m** better.

The Month 12 surplus/ deficit position includes a number of material reporting items required for final accounts. These items either inflate income and expenditure lines (notional I&E for additional employers pension paid centrally (£12.1m) and centrally procured PPE stock items (£6.4m), or are removed from the surplus/deficit positon to generate the adjusted financial performance against which we are measured externally. (Impairment losses (£6.6m) and the impact of donated assets).

Overall our pre Audited adjusted financial performance position is a YTD surplus of £6.7m. This final position is better than forecast following receipt of income to match our provision for un-taken annual leave and removal of system risk as this has been managed locally.

I&E Delivery Assurance Level: **Level 4**

Rationale:

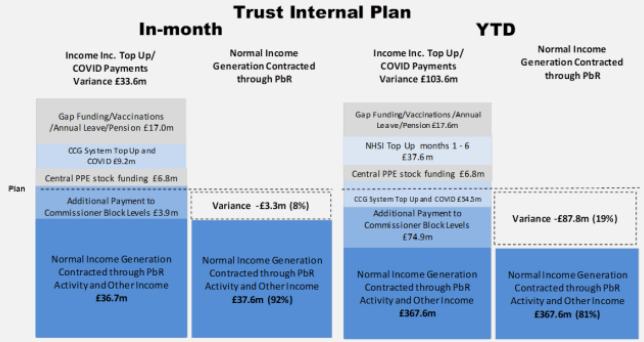
Positive FOT variance (L6 assurance in year). Medium term underlying deficit, PEP & Temp Staffing remain challenged (L4 assurance for sustainability)

Finance | Headlines

PERFORMANCE AGAINST Original Internal Operational Trust plan

Income

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was **£33.6m** above the Trust's Internal operational plan in March (deficit of £(78.9)m 2020/21). Income measured under normal PbR was **£(3.3)m below plan in month.**



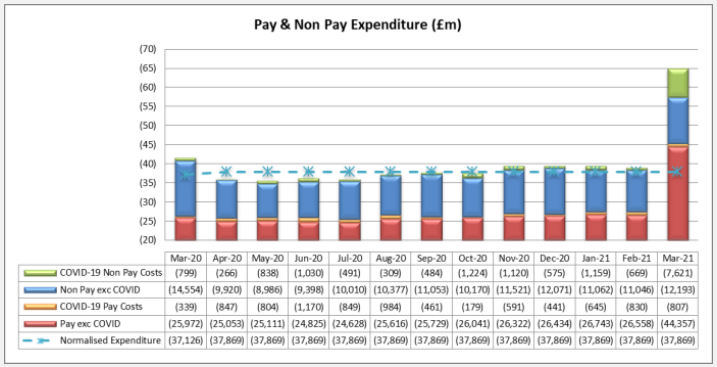
£9.2m additional System COVID/top up payment (Phase 3 regime). **Commissioner block payments were £3.9m** over the Trust's actual performance and **additional income £17.0m which has been offset in expenditure;** Pension uplift £12.1m, Annual Leave Support £3.4m Centrally funded Overtime £0.5m, Independent Sector Support £0.6m and Vaccinations/GAP funding £0.4m.
Without these adjustments **income measured under normal PbR was £(3.3)m below plan in month (February was £(5.0)m below):**

- Daycase/Elective activity **£(3.0)m** and A&E **£(0.5)m**
- Emergencies **breakeven –** activity has increased in March but acuity of patients remain high**. Maternity £1.0m** (catch up recording and coding)
- Outpatients **£(1.7)m** and Other Income **£0.4m (**Cancer funding/other)
- Other Operating income **£(2.1)m**; Other income including loss of car parking income

NHSE&I have advised the **Elective Incentive Scheme** has been suspended for 2020/21 with no adjustments being applied to the STP.

Expenditure

The combined pay and non pay expenditure variance against our internal budget is **£(33.6)m adverse**, against the Trust's Internal operational plan in March (deficit of £(78.9)m 2020/21).



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
COVID-19 Non Pay Costs	(799)	(266)	(838)	(1,030)	(491)	(309)	(484)	(1,224)	(1,120)	(575)	(1,159)	(669)	(7,621)
Non Pay exc COVID	(14,554)	(9,920)	(8,986)	(9,398)	(10,010)	(10,377)	(11,053)	(10,170)	(11,521)	(12,071)	(11,062)	(11,046)	(12,193)
COVID-19 Pay Costs	(339)	(847)	(804)	(1,170)	(849)	(984)	(461)	(179)	(591)	(441)	(645)	(830)	(807)
Pay exc COVID	(25,972)	(25,053)	(25,111)	(24,825)	(24,628)	(25,616)	(25,729)	(26,041)	(26,322)	(26,434)	(26,743)	(26,558)	(44,357)
Normalised Expenditure	(37,126)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)	(37,869)

Pay expenditure overall is £17.8m higher than February driven by an increase in:

- 6.3% notional pension adjustment which is funded nationally (£12.1m)
- Provisions for unused annual leave (£3.4m)
- Additional pay costs as a result of updates required to Consultant job plans (£0.7m)
- Overtime pay entitlements in respect of holiday pay following the settlement of the Flowers legal claim (£0.5m)
- YTD correction on Temporary Medics following further validation work undertaken on the NHSP data (£0.4m)
- Other provisions (£0.2m)
- Payment of NHSP winter initiative (£0.2m).

Note: The annual leave and Flowers provisions are externally funded.

Non pay expenditure overall increased from £18.1m in February to £33.1m in March. This increase is mainly driven by:

- Central PPE stock adjustment (£6.4m)
- Impairment losses (£6.6m)

Finance | Headlines

Capital

Capital expenditure for the financial year 2020/21 is £26.5m. This is £0.3m lower than originally planned. Despite an initial underspend in Capital, this has been offset overall by additional expenditure on IFRIC 12 of £0.9m. The overall overspend on the Trust's Core Programme is mainly due to the extent of works to be completed by the Estates team this financial year. We incurred capital spend on COVID related assets over and above the level reimbursed by NHSEI.

Capital Assurance Level: **Level 5**

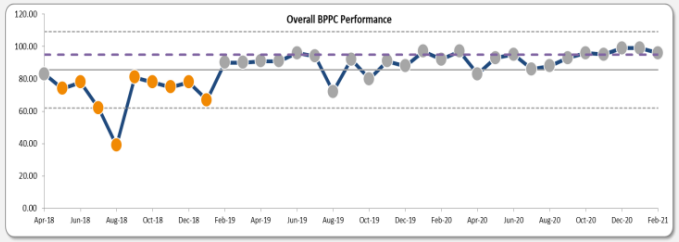
Reason: Revised forecast met. Significant capital schemes continue into 2021/22 and will require robust programme management to ensure delivery. **Assurance level proposed to increase to 5, reflecting in year outcome in line with action plan, but risk remaining in medium term.**

Cash Balance

Under the interim COVID-19 financial arrangements, sufficient cash is currently being received each month to meet obligations. At the end of Mar 2021 the cash balance was £41.5m. The high cash balance is the result of the timing of receipts from the CCG's and NHSE under the COVID arrangement as well as the timing of supplier invoices.

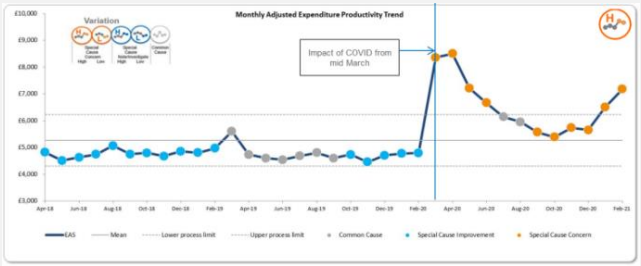
Cash Assurance Level: **Level 6**

Reason: Good cash balances, historic loans converted to PDC, rolling CF forecasting well established, achieving BPPC target, positive SPC trends on aged debtors and cash. Risks remain around sustainability given unknown regime for 2021/22.



Productivity & Efficiency

Although Financial Efficiencies are not being monitored under the COVID-19 Financial Framework operating this financial year, our internal operational plan is inclusive of £14.5m of plans, and as such we continue to assess current performance and impact of COVID-19 on the programme whether that be slippage or identification of further opportunities as a result of new ways of working. Notwithstanding all of the focus being on COVID-19, the Productivity and Efficiency Programme has delivered £10.9m of actuals at Month 12 against an Annual Plan figure of £14.6m. The key over-performing schemes are: Energy Rate Decrease: over-performing by £898k YTD; Evergreen Closure: over-performing by £459k YTD and Procurement Spec Med by £397k.



Adjusted Expenditure Productivity Trend:

COVID significantly impacts our spend against weighted activity. This local metric allows us to follow productivity changes through COVID recovery and to track against forecasted activity going forward.

The improvement trend that we saw earlier in the year has subsequently slowed and then deteriorated from November. **Productivity (pending final coding) has remained at this worsened position over the final quarter as COVID 19 has continued to impact.**

Appendices

Operational Performance Table | Month 12 [March] 2020-21

NHS Worcestershire Acute Hospitals NHS Trust

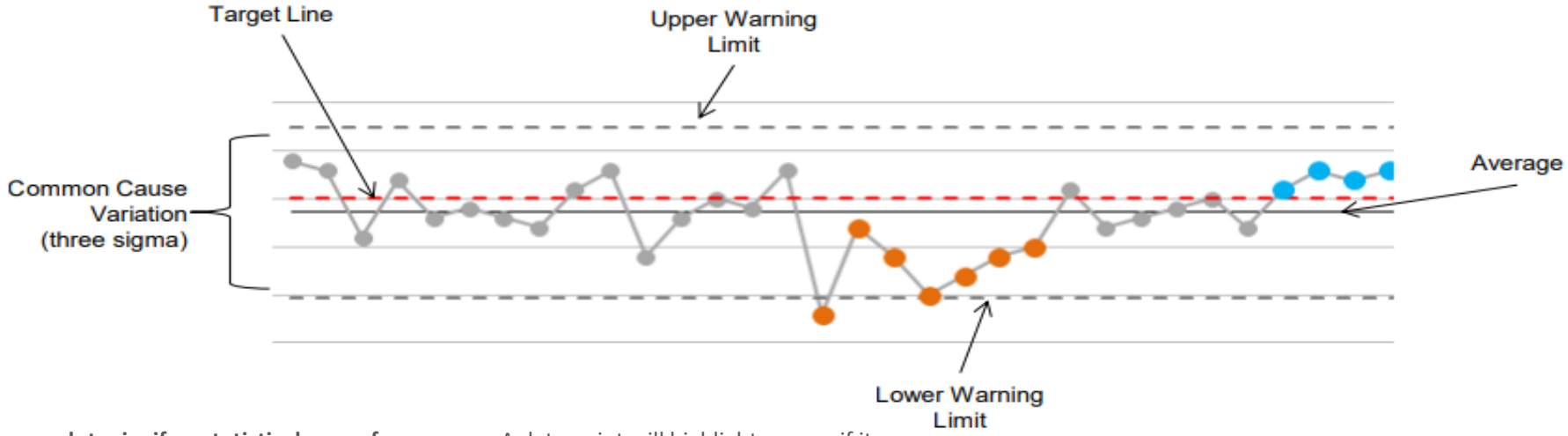
	Performance Metrics	Operational Standard		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
EAS	4 Hours (all)	95%	Actual	77.90% ✗	88.92%	91.33%	88.73%	92.60%	88.05%	83.47%	83.56%	82.09%	76.18%	75.34%	75.99%	80.94%
			Trajectory	86.00%												
	15-30 minute Amb. Delays	-	Actual	1992 ✗	1,443	1,148	1,119	818	933	979	986	893	908	1073	817	791
			Trajectory	470												
	30-60 minute Amb. Delays	-	Actual	413 ✓	145	82	150	97	172	188	213	178	327	279	251	169
			Trajectory	470												
	60+ minutes Amb. Delays	0	Actual	88 ✗	2	3	25	13	28	67	58	63	365	192	170	100
			Trajectory	0												
RTT	Incomplete (<18 wks)	92%	Actual	78.75% ✗	69.92%	59.89%	49.95%	42.70%	47.84%	53.03%	55.58%	57.47%	56.68%	55.18%	53.27%	52.89%
			Trajectory	82.43%												
	52+ WW	0	Actual	1 ✗	7	52	178	483	873	1,403 ✗	2,007 ✗	2,457 ✗	3,131 ✗	4,290 ✗	5,608 ✗	6,515 ✗
			Trajectory	0						1,269	1,533	1,532	1725	2030	2174	2134
CANCER	2WW All	93%	Actual	93.83% ✓	90.30%	94.59%	88.11%	88.89%	81.00%	85.62%	72.27%	77.20%	80.51%	73.60%	85.98%	79.16%
			Trajectory	93.10%												
	2WW Breast Symptomatic	93%	Actual	83.94% ✗	100.00%	100.00%	70.42%	91.95%	78.65%	82.95%	25.00%	13.59%	10.00%	10.89%	38.46%	9.09%
			Trajectory	84.80%												
	62 Day All	85%	Actual	75.82% ✗	60.81%	64.57%	72.39%	74.83%	69.42%	70.80%	74.03%	72.73%	70.11%	71.70%	61.41%	64.38%
			Trajectory	86.04%												
	104 day waits	0	Actual	68 ✗	50	71	186	189	118	52	44	45	57	100	93	97
			Trajectory	0												
	31 Day First Treatment	96%	Actual	97.65% ✓	97.67%	92.86%	95.41%	97.22%	97.07%	97.84%	97.05%	96.17%	95.10%	89.52%	94.71%	93.71%
			Trajectory	97.22%												
	31 Day Surgery	94%	Actual	90.9 % ✗	100.00%	-	-	-	0.00%	-	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Trajectory	95.83%												
	31 Day Drugs	98%	Actual	97.8 % ✗	100.00%	97.78%	99.20%	98.08%	95.56%	94.74%	100.00%	96.08%	97.87%	98.18%	100.00%	100.00%
			Trajectory	100%												
	31 Day Radiotherapy	94%	Actual	100.0 % ✓	96.43%	97.18%	95.60%	98.99%	100.00%	100.00%	100.00%	98.53%	98.82%	98.84%	100.00%	100.00%
			Trajectory	100%												
	62 Day Screening	90%	Actual	73.9 % ✗	70.6 %	88.2 %	0.0 %	15.4 %	0.0 %	66.7 %	84.2 %	97.6 %	80.4 %	81.8 %	81.3 %	71.8 %
			Trajectory	81.25%												
	62 Day Upgrade	-	Actual	92.4 % ✓	95.5 %	89.5 %	91.8 %	86.8 %	81.8 %	92.6 %	100.0 %	100.0 %	100.0 %	97.5 %	100.0 %	95.1 %
			Trajectory	65.38%												
	Diagnostics (DM01 only)	99%	Actual	94.29% ✗	33.37%	27.52%	31.85%	34.56%	37.20%	42.89%	45.72%	61.32%	63.87%	47.63%	47.65%	49.33%
			Trajectory	99.03%												
STROKE	CT Scan within 60 minutes	-	Actual	59.38% ✗	53.85%	49.21%	48.10%	59.52%	40.79%	47.69%	50.00%	43.64%	72.12%	47.54%	37.50%	-
			Trajectory	80.00%												
	Seen in TIA clinic within 24hrs	-	Actual	86.84% ✓	91.94%	94.52%	92.31%	89.36%	87.72%	89.23%	72.09%	96.23%	90.90%	93.33%	100.00%	-
			Trajectory	70.00%												
	Direct Admission	-	Actual	56.25% ✗	46.15%	65.08%	63.29%	65.48%	50.00%	55.38%	43.75%	36.36%	20.34%	50.82%	50.00%	-
			Trajectory	90.00%												
	90% time on a Stroke Ward	-	Actual	75.00% ✗	71.15%	81.54%	79.75%	85.54%	76.92%	73.38%	68.75%	74.55%	76.27%	83.61%	83.93%	-
			Trajectory	80.00%												

Quality & Safety Performance Table Month 12 [March] 2020-21

NHS Worcestershire Acute Hospitals NHS Trust

Performance Metrics			Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-20
Cdiff	0	Actual	5 ✗	3 ✓	2 ✓	3 ✓	6 ✗	5 ✓	6 ✗	9 ✗	6 ✗	3 ✓	6 ✗	6 ✗	6 ✗
		Trajectory	4	5	4	4	5	5	4	4	5	4	4	4	4
Ecoli	0	Actual	2 ✗	2 ✓	3 ✓	3 ✓	1 ✓	4 ✓	2 ✓	3 ✓	3 ✓	4 ✓	2 ✓	3 ✓	4 ✓
		Trajectory	5	4	4	4	4	4	4	4	5	4	4	4	4
MSSA	0	Actual	2 ✗	0 ✓	1 ✓	1 ✗	5 ✗	2 ✗	4 ✗	3 ✗	5 ✗	1 ✓	1 ✓	1 ✗	0 ✓
		Trajectory	0	3	1	0	1	1	1	0	1	1	1	0	0
MRSA		Actual	1 ✗	0 ✓	0 ✓	0 ✓	0 ✓	0 ✓	0 ✓	0 ✓	1 ✗	0 ✓	0 ✓	0 ✓	1 ✗
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Acquired Pressure Ulcers: Serious Incidents	0	Actual	0 -	0 -	1 -	0 -	1 -	0 -	0 -	0 -	0 -	0 -	0 -	1	0
		Trajectory	-	-	-	-	-	-	-	-	-	-	-	-	-
Falls per 1,000 bed days causing harm	0	Actual	0.08 ✗	0.00	0.14	0.07	0.00	0.17	0.00	0.19	0.05	0.00	0.00	0.05	0.09
		Trajectory	0.04	-	-	-	-	-	-	-	-	-	-	0.04	0.04
% medicine incidents causing harm	0%	Actual	8.24% ✓	6.45%	5.71%	2.65%	1.15%	3.41%	1.12%	2.08%	4.39%	2.73%	3.28%	2.47%	2.75%
		Trajectory	11.71%	-	-	-	-	-	-	-	-	-	-	11.71%	11.71%
Hand Hygiene Audit Participation	100%	Actual	78.76% ✗	95.65%	89.25%	93.88%	91.18%	86.24%	89.09%	91.89%	90.99%	93.69%	85.85%	88.68%	90.74%
		Trajectory	100%	-	-	-	-	-	-	-	-	-	-	100%	100%
Hand Hygiene Compliance to practice	97%	Actual	99.35% ✓	99.17%	99.38%	99.73%	99.28%	99.49%	99.53%	99.66%	99.64%	99.75%	99.56%	99.37%	99.46%
		Trajectory	97%	-	-	-	-	-	-	-	-	-	-	98%	98%
VTE Assessment Rate	95%	Actual	96.76% ✓	96.91%	95.49%	96.03%	96.45%	95.99%	96.47%	96.82%	97.65%	97.23%	97.10%	96.98%	96.77%
		Trajectory	95%	-	-	-	-	-	95%	95%	95%	95%	95%	95%	95%
Sepsis Screening compliance	90%	Actual	82.99% ✗	63.25%	81.30%	82.59%	87.86%	86.08%	83.38%	85.54%	83.16%	83.72%	71.13%	73.91%	-
		Trajectory	90%	-	-	-	-	-	95%	95%	95%	95%	95%	95%	95%
Sepsis 6 bundle compliance	100%	Actual	64.94% ✗	43.37%	57.58%	55.07%	50.70%	32.14%	34.91%	34.31%	39.02%	45.20%	40.40%	50.34%	-
		Trajectory	90%	-	-	-	-	-	95%	95%	95%	95%	95%	95%	95%
#NOF time to theatre <=36 hrs	95%	Actual	87.30%	76.10%	68.42%	64.79%	80.65%	75.95%	72.73%	72.73%	77.19%	71.59%	80.72%	-	-
		Trajectory	85%	-	-	-	-	-	85%	85%	85%	85%	85%	85%	85%
Mortality Reviews completed <=30 days	100%	Actual	22.94% -	18.95%	19.25%	21.32%	29.46%	52.46%	55.13%	48.73%	35.50%	-	-		
		Trajectory	-	-	-	-	-	-	-	-	-	-	-	-	-
HSMR 12 month rolling average	100	Actual	101.39 -	104.34	103.93	101.78	101.16	98.83	98.03	97.68	99.58	98.04	99.08	-	-
		Trajectory	-	-	-	-	-	-	-	-	-	-	-	-	-
Complaints responses <=25 days	85%	Actual	86.49% ✓	43.33% ✗	84.62% ✓	22.22% ✗	58.06% ✗	58.54% ✗	51.61% ✗	83.33% ✓	73.13% ✗	90.70% ✓	64.29%	83.87%	79.25%
		Trajectory	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
ICE viewed reports [pathology]	100%	Actual	95.77% -	97.06%	97.19%	90.76%	96.41%	96.42%	96.05%	96.44%	96.05%	96.29%	96.95%	97.24%	-
		Trajectory	-	-	-	-	-	-	-	-	-	-	-	-	-
ICE viewed reports [radiology]	100%	Actual	81.22% -	84.46%	80.56%	83.42%	84.38%	82.99%	83.20%	83.85%	83.35%	80.61%	83.45%	82.80%	-
		Trajectory	-	-	-	-	-	-	-	-	-	-	-	-	-

Statistical Process Charts (SPC) Guidance



Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

Blue dots signify a statistical improvement. A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Levels of Assurance

RAG Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of the desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of the desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of the desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

MARCH 2021 IN NUMBERS

Worcestershire Acute Hospitals NHS Trust

6,113
Walk-in patients (A&E)

4,783
Patients arriving by ambulance

10,974
Inpatients

23,089
Face to Face outpatients

14,938
Telephone consultations

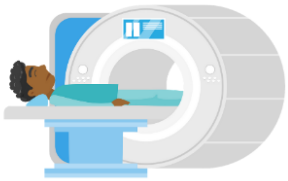
466
Babies

1048
Elective operations

151
Trauma Operations

278
Emergency Operations

6.3
Average length of stay



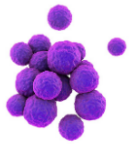
13,659
Diagnostics

Putting Patients First 4ward

QUALITY AND SAFETY IN NUMBERS

March 2021

NHS Worcestershire Acute Hospitals NHS Trust

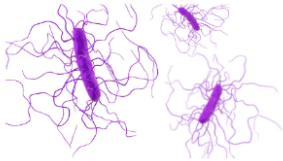


MRSA

1

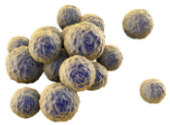
ECOLI

4



CDIFF

6



MSSA

0

Hand Hygiene

Participation	**90.74**
Compliance	**99.46**

SEPSIS

Sepsis

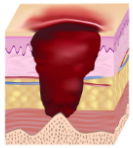
Screening Compliance	**73.91**
Sepsis 6 bundle compliance	**50.34**

ICE reports viewed

Radiology	**82.80**
Pathology	**97.24**

Falls per 1,000 bed days causing harm

1



Pressure Ulcers

All hospital acquired pressure ulcers	**9**
Serious incident pressure ulcers	**0**

Response Rate

A&E	**18.77**
Inpatients	**33.22**
Maternity	**3.53**
Outpatients	**12.55**

Recommended Rate

A&E	**85.70**
Inpatients	**85.94**
Maternity	**90.00**
Outpatients	**94.77**

HSMR 12 months rolling (Jan 21) **99.08**

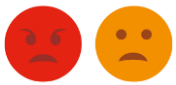
Mortality Reviews completed </=30 days (Nov-20) **35.50**

Risks overdue review **157**

Risks with overdue actions **178**

Discharged before midday

14.57



Complaints Responses </=25 days

79.25

Total Medicine incidents reported **109**

Medicine incidents causing harm (%) **2.75**

Putting Patients First 4ward

WORKFORCE COMPOSITION IN NUMBERS

NHS Worcestershire Acute Hospitals NHS Trust

March 2021

Employees

6748

BAME employees

17%

Part-time workers

44%

Female

82%

Registered nurses

2149 (32%)

HCAs, helpers and assistants

1304 (19%)

Doctors

713 (11%)

Other clinical and scientific staff

854 (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

9%

Integrated Performance Report

Worcestershire Acute Hospitals NHS Trust

Committee Assurance Reports

Trust Board

13th May 2021

Finance & Performance Committee Assurance Report – 28th April 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 28 April 2021. Our focus was on annual planning, single improvement methodology, the restoration and recovery elements of the Integrated Performance Report and the programme review of the Patient Administration System (PAS).

Annual Planning 2021/22: We received a presentation on the current position of the Annual Plan covering activity and intervention, workforce, finance, PEPs and progress of business cases. We noted the proposed activity levels and that further ways are being considered to increase activity both within our existing financial framework and with potential accelerator bid funding. We have said that a baseline needs to be established to monitor deliverability. Infection prevention and control requirements are the main blockers to increasing activity. Work is progressing to triangulate workforce to activity and finance to produce a baseline position. We noted the steps to preparing the budget which currently excludes PEPs. Again we have said that a baseline position needs to be established to enable monitoring of deliverability. Our proposed PEPs amount to 1% of our budget which is in line with planning guidance and much lower than historical percentages. The impact of PEPS are planned to be delivered in the second half of the year focusing on transformational changes. Work is ongoing on developing business cases. We expressed concern about the increasing cost without understanding productivity and we stressed again the need for the plan beyond the 1HY, which needs to be based on the operationalisation of the clinical services strategy and enabling strategies, which will then inform the midterm financial plan. We requested a timetable for this longer term planning process.

Single Improvement Methodology (SIM): We have endorsed the service specification, procurement process and revised timeline culminating in a business case being presented to the Trust Board in September 2021. The specification has taken on board our comments. The procurement process is being undertaken concurrently with the development of the business case which will include funding. The intention is to implement the methodology within our Trust before extending this to system partners to develop transformation projects. This alignment has been requested by the Provider Oversight Committee. We have asked that the business case clearly sets out our ROI ambition, executive ownership and governance and leadership arrangements to implement SIM noting that the introduction of the Guiding Board is to prepare for the leadership changes required for successful implementation.

Financial Performance Report Month 12: We note that overall our pre audited adjusted financial performance position is a YTD surplus of £6.7m. This is despite not achieving our planned activity levels and a reduction in beds. This final position is better than forecast following receipt of income to match our provision for un-taken annual leave and removal of a historic system contractual risk which has been managed locally. We have congratulated the Team on this positive outcome. Our cash position is healthy and our capital programme has been underspent by £0.3m. We have requested a report to our next meeting to provide assurance that the introduction of Allocate for recording temporary medical staff is working effectively to reduce our agency spend.

The assurance levels for income and expenditure and cash remain unchanged at 4 and 6 respectively and capital has been increased from 4 to 5.

Finance & Performance Committee Assurance Report – 28th April 2021

Executive Summary (cont.)

Contract Awards – ProLab Reagents: We are recommending the Trust Board approve this contract, the details of which are in a separate report on the Private Trust Board agenda.

Integrated Performance Report: The three areas of concern highlighted were the Impact of COVID-19 | activity and waiting times | a year on and NHS Planning 2021/22; Quality and Safety relating to infection prevention and control and Sepsis; and People and Culture. The increase in the number of long waiting patients is a concern and the proposed activity levels in the Annual Plan do not prevent the backlog from increasing. Interventions are planned to prevent an increasing backlog. A detailed report is to be presented to our next meeting. From the changes in the ways of working during COVID we noted that we wish to maintain the increased risk threshold for admissions and a decreased threshold for discharges, increasing non face to face outpatient appointments and an extension to other specialities of the elective triage for 2ww. We received an assurance that the 90% mandatory training performance is being achieved with automated reminders sent to both staff and managers with monthly Divisional reports prepared. The 90% target was reduced from 95% during COVID and is to be reviewed next year. The essential to role training was introduced last year and the current low compliance is expected to increase once firmly embedded.

Assurance levels remain unchanged for urgent care and patient flow including HomeFirst Worcestershire 5, cancer 5 except 62 days which is 4, Outpatients and planned admissions 4, diagnostics 4 and stroke 5. RTT has been reduced from level 4 to 3 and a plan to address is to be presented to our next meeting. The overall assurance level is 4.

Programme Review of PAS Implementation: We received a presentation on the Patient Administration System (PAS) review focussing on 14 areas to both inform and enhance the Programme. Whilst the PAS upgrade has taken 4 years to get to this point, the current programme has robust project plans, assurances, and governance; testing and training strategies; infrastructure approach and limited additional funding requirements. The Programme Plan and go-live has been agreed by the Trust's commercial partners. With the introduction of new experienced Programme Managers there is confidence that the system can be re-implemented to the benefit of Trust staff and patients to achieve a successful Go-live on 24 January 2022. We are to receive quarterly reports to monitor progress.

BAF Risks – Finance and Performance Committee Section: The small Group established to consider the Committee's risks has identified further work to update risks and a detailed report is to be presented to our next meeting.

Workplan: We noted the workplan. The workplan is to be revisited together with a review of the format of our agendas to give a greater focus for our deliberations.

Recommendation(s)

The Board is requested to receive this report for assurance.

Quality Governance Committee Assurance Report – 29th April 2021

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore Non-Executive Director	Dame Julie Moore Non-Executive Director	Rebecca O'Connor Company Secretary

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

The Committee met virtually on 29 April and the key points raised included:

Infection, Prevention and Control update:

Committee noted continued improvement in respect of MSSA and antimicrobial stewardship. It is expected that assurance levels for antimicrobial stewardship will increase next month. Good progress re Covid swabbing and VTE compliance was reported and welcomed by Committee. **Assurance level 4 overall was approved, all levels remained as per last month.**

Integrated Performance Report:

Committee discussed focus on non Covid IPC measures including cannula and wound care. ED flow and discharges were discussed in detail with a report due back in respect of a greater understanding of the drivers of demand, discharges and reinstating of command structures. In respect of cancer 62 days, expect the trajectory will improve as the expansion of the Alex as the elective base increases, but also expecting an increase in cancer referrals coming in. Good progress was noted regarding VTE and actions are underway to improve the administration and reporting **Assurance level overall was agreed at level 4.**

Local Maternity & Neonates System:

Committee received the presentation from the LMNS Network on their activity. It discussed the impact of Continuity of Carer model and noted that roll out of the seventh team had been paused. However, also noted the challenges faced by this and other Trusts in the roll out of this new model of working. Committee noted the importance of acting upon learning from the change management process and also in socialising the evidence base behind the model, as improving the experience of mothers and babies.

Maternity Action Plan Update

Committee reviewed the combined action plan against both the CQC and engagement event actions. Good progress is being made in closing the actions and the NHSE/I support programme is underway. **Assurance level 5 approved.**

Ophthalmology Failsafe Reporting:

Committee noted very few significant harms had been identified and the review is underway. Committee to received an update report following completion of the review. . **Assurance level 6 approved.**

Quality Governance Committee Assurance Report – 29th April 2021

Executive Summary (cont.)

Mortality/Learning from Deaths Report:
Committee was advised that both measures of mortality were with expected ranges and there is an improvement overall. It was positive to see the reviews by Medical Examiners and a discussion followed regarding the availability of data to support care for frail patients across the system. **Assurance level 5 approved.**

Sepsis Deep Dive:
Committee undertook a deep dive into Sepsis 6 Bundle with divisions each presenting their position and actions to improve overall performance and reporting. Committee welcomed the work of the divisions and commended Dr Packer for her work in driving the Sepsis 6 working group, recommending the same for onwards reporting to the Board. The Sepsis 6 presentation is appended **Assurance level 6 approved.**

Provider License Conditions:
The paper was noted for assurance

Maternity Funding Bid:
Total bid of £795k was approved to be put forward for sign off by the LMNS against the Ockendon monies

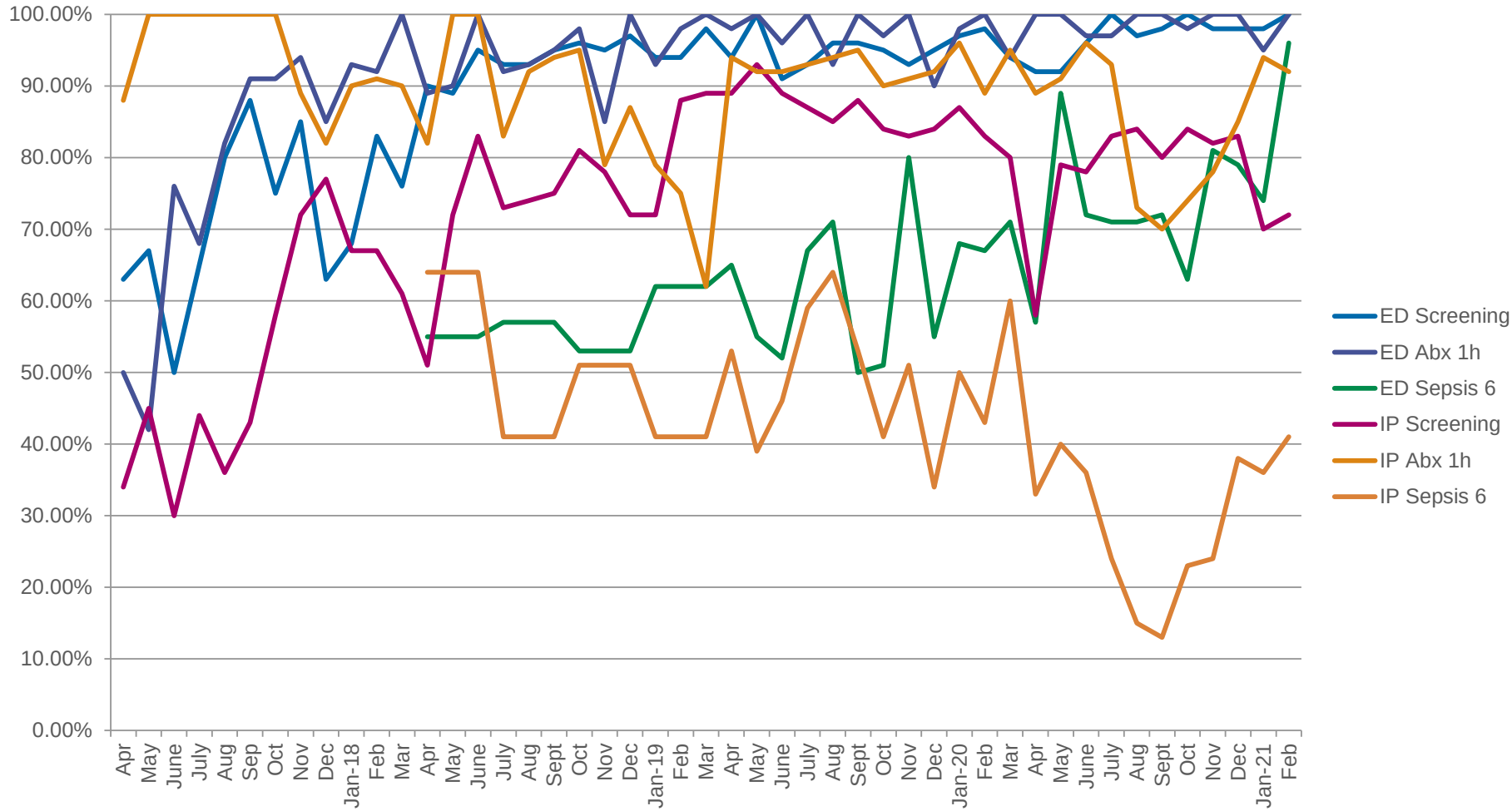
Committee Escalations
Key issues to Trust Board via this reports; there was cross attendance at both People and Culture and Finance and Performance Committees. There were no risk escalations for the BAF. Highlight for noting by the Trust Board include progress in mortality and Sepsis, recruitment of the Medial Examiner and sharing the positivity of divisional staff presenting their work to Committee.

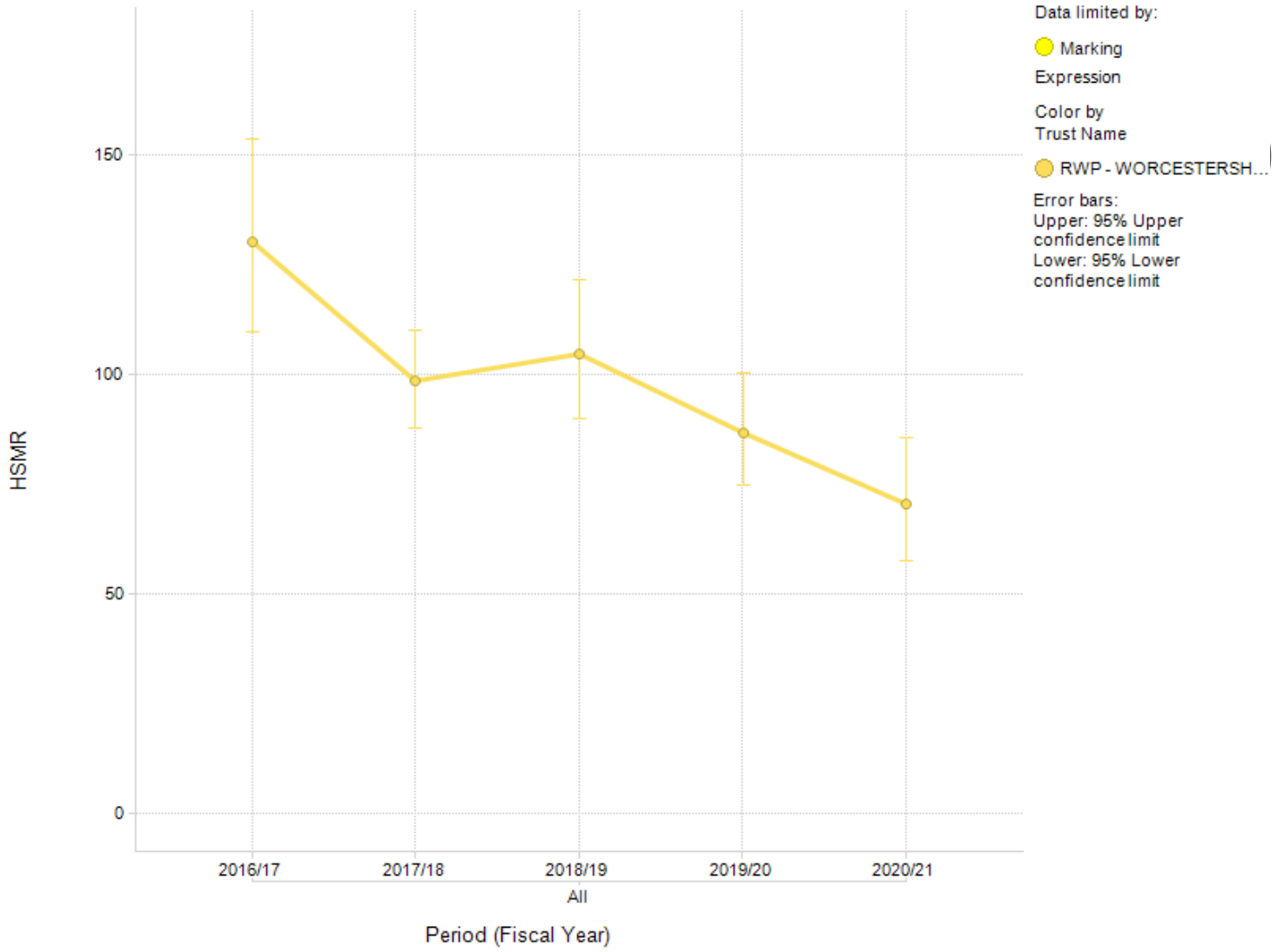
Recommendation(s)

The Board is requested to receive this report for assurance.

Appendix 1 - SEPSIS

Sepsis Performance

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Trust Name
RWP - WORCESTERSH...
Error bars:
Upper: 95% Upper confidence limit
Lower: 95% Lower confidence limit
HSMR
150
100
50
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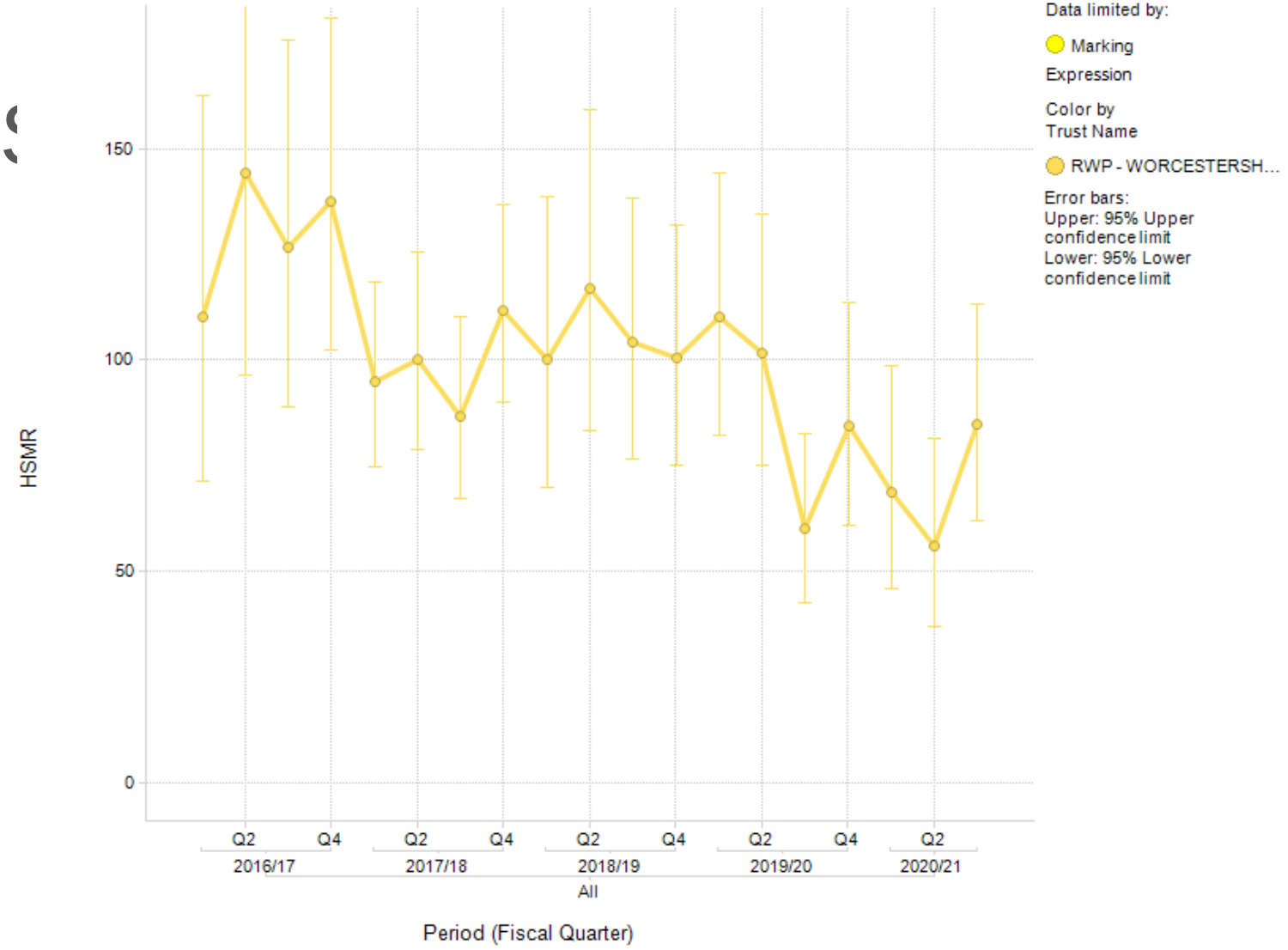
2016/17
2017/18
2018/19
2019/20
2020/21
All
Period (Fiscal Year)


HSMR
150
100
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Q2
Q4
Q2
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2016/17
2017/18
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2020/21
All
Period (Fiscal Quarter)
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Trust Name
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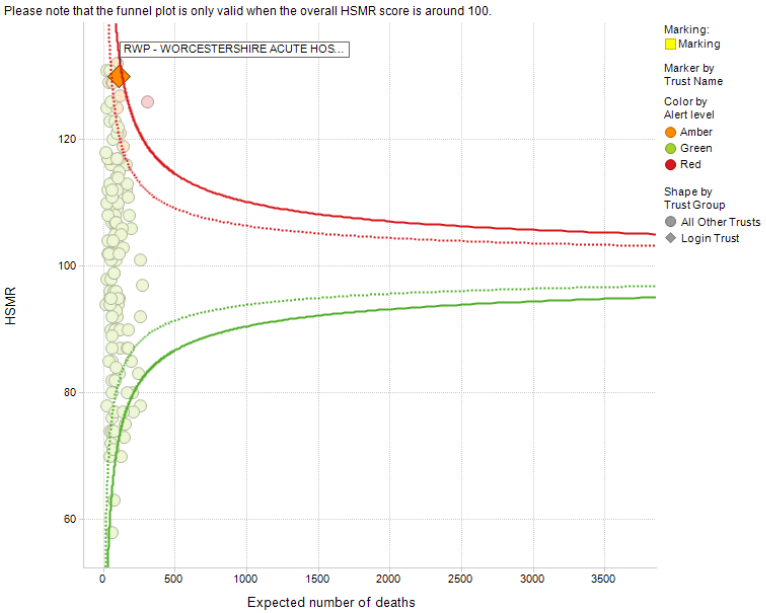
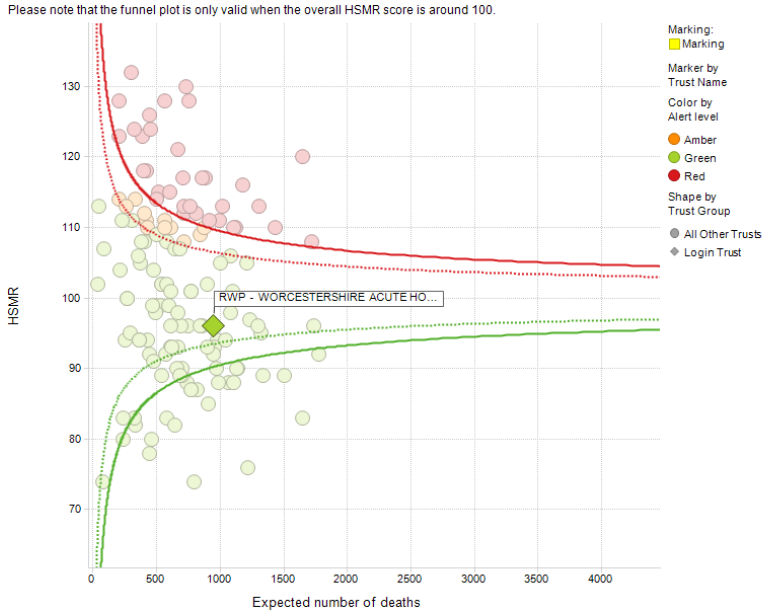
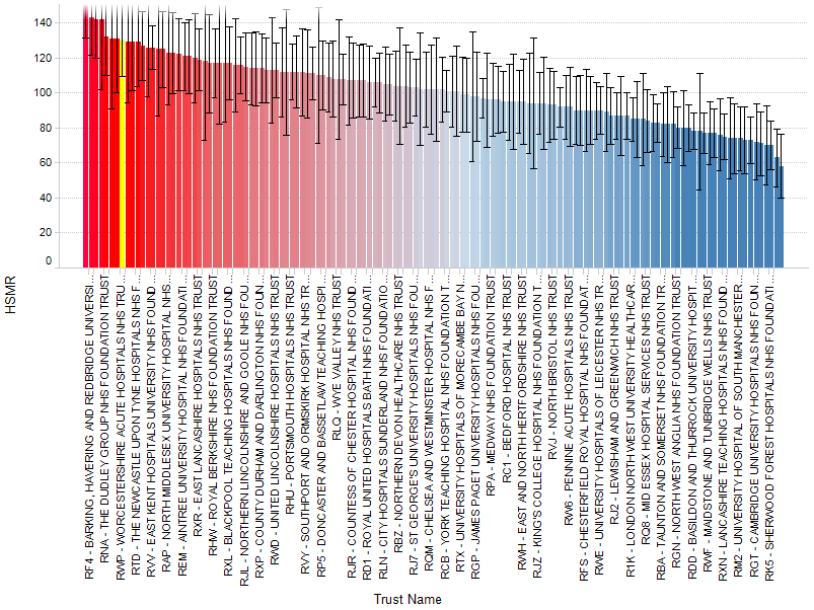
Error bars:
Upper: 95% Upper confidence limit
Lower: 95% Lower confidence limit

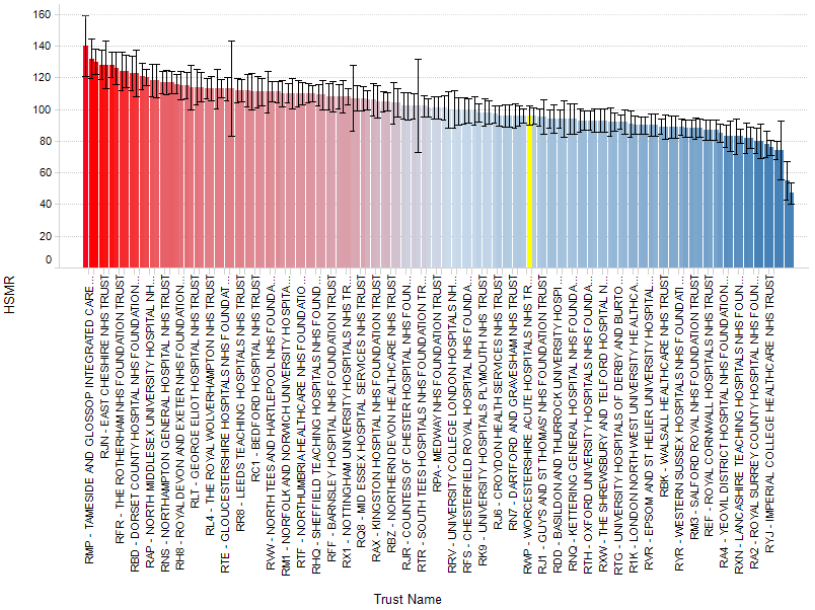
Sepsis HSMR National



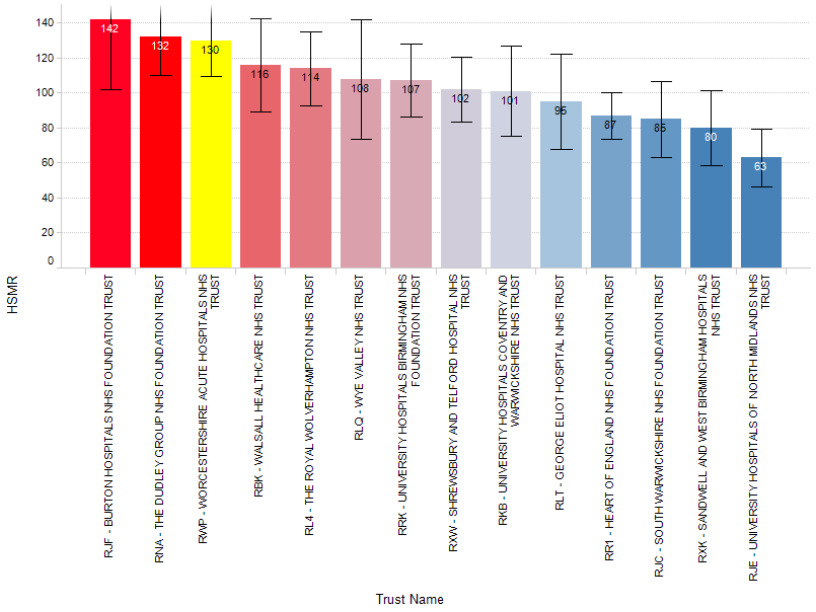


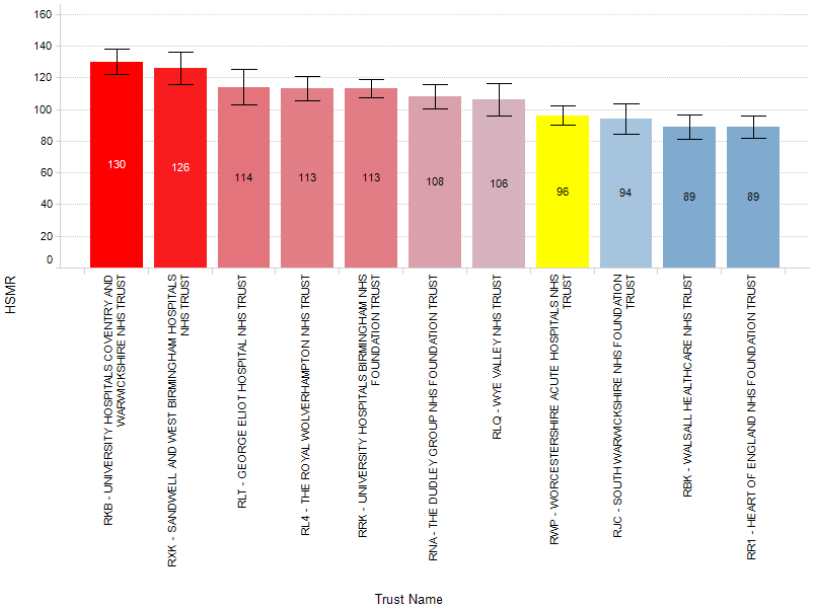
Sepsis HSMR National





Sepsis HSMR West Midlands





Sepsis screening

Location	Q4 16-17(Jan-Mar)	Q4 17-18(Jan-Mar)	Q4 18-19 (Jan-Mar)	Q4 19-20 (Jan-Mar)	Q1 20-21 (April)	Q1 20-21 (May)	Q1 20-21 (June)	Q2 20-21 (July)	Q2 20-21 (Aug)	Q2 20-21 (Sept)	Q3 20-21 (Oct)	Q3 20-21 (Nov)	Q3 20-21 (Dec)	Q4 20-21 (Jan)	Q4 20-21 (Feb)	Q4 20-21 (Mar)
ED Screening	53% (average)	Alex = 79% WRH = 75% Average =75%	Alex = 98% WRH = 94% Average = 96%	Alex = 97% WRH = 96% Average = 96%	Alex = 85% WRH = 100% Average = 92%	Alex = 85% WRH = 100% Average = 92%	Alex = 93% WRH = 100% Average = 96%	Alex = 100% WRH = 100% Average = 100%	Alex = 93% WRH = 100% Average =97%	Alex = 97% WRH = 100% Average = 98%	Alex = 100% WRH = 100% Average = 100%	Alex = 96% WRH = 100% Average = 98%	Alex = 96% WRH = 100% Average = 98%	Alex = 100% WRH = 94% Average = 98%	Alex = 100% WRH = 100% Average = 100%	Alex = % WRH = % Average =%
	N= 150	N= 129/171	N= 193/202	N= 154/160	N= 46/50	N= 47/51	N= 55/57	N= 26/26	N= 64/66	N= 55/56	N= 51/51	N= 44/45	N= 44/45	N= 40/41	N= 37/37	N=
IP Screening	35%	65 %	80%	84%	58%	79%	78%	83%	84%	80%	84%	82%	83%	70%	72%	%
	N= 150	N= 285/440	N= 522/653	N= 527/631	N= 145/252	N= 147/187	N= 174/223	N= 113/137	N= 239/286	N= 256/319	N= 363/433	N= 361/442	N= 424/514	N= 410/588	N= 337/469	N=

Sepsis treatment

Location	Q4 16-17(Jan-Mar)	Q4 17-18 (Jan-Mar)	Q4 18-19 (Jan-Mar)	Q4 19-20 (Jan-Mar)	Q1 20-21 (April)	Q1 20-21 (May)	Q1 20-21 (June)	Q2 20-21 (July)	Q2 20-21 (Aug)	Q2 20-21 (Sept)	Q3 20-21 (Oct)	Q3 20-21 (Nov)	Q3 20-21 (Dec)	Q4 20-21 (Jan)	Q4 20-21 (Feb)	Q4 20-21 (Mar)
ED Abx within 1h	60% (average)	Average = 96%	Average = 97%	Average = 97%	Average = 100 %	Average = 100 %	Average = 97%	Average = 97%	Average = 100 %	Average = 100 %	Average = 98%	Average = 100 %	Average = 100 %	Average = 95%	Average = 100 %	Average = %
	N= 74	N= 86/90	N=124/128	N= 109/112	N= 37/37	N= 28/28	N= 35/36	N= 34/35	N= 34/34	N= 39/39	N= 39/40	N= 32/32	N= 33/33	N= 18/19	N= 26/26	N=
ED full 'Sepsis 6'	Not measured	47%	62%	69%	57%	89%	72%	71%	71%	72%	63%	81%	79%	74%	96%	%
	-	N= 42/90	N= 72/117	N= 77/112	N= 21/37	N= 25/28	N= 26/36	N= 25/35	N= 24/34	N= 28/39	N= 25/40	N= 26/32	N= 26/33	N= 14/19	N= 25/26	N=
IP Abx within 1h	53%	90%	73%	94%	89%	91%	96%	93%	73%	70%	74%	78%	85%	94%	92%	%
	N= 9	N=57/63	N= 96/132	N= 115/122	N= 41/46	N= 32/35	N= 27/28	N= 27/29	N= 57/78	N= 48/69	N= 72/97	N= 71/91	N= 123/144	N=124/132	N= 111/121	N=
IP full 'Sepsis 6'	-	83%	41%	52%	33%	40%	36%	24%	15%	13%	23%	24%	38%	36%	41%	%

Issues

ED

- Good performance maintained
- Sepsis 6 compliance improving
- ‘business as usual’

Inpatients

- Poor sepsis 6 completion
  - Training compliance
  - COVID impact
- Changes in audit process/data sample
  - Sample from EZ notes using NEWS escalation sticker search
  - Best way to identifying patients with NEWS >/= 5 req. screening
  - Larger sample

Action plan (Trustwide)

- Paeds & Maternity sepsis data into WREN
  - Different pathways to adult population
- Case reviews
  - Gather themes regarding deviation from pathway
  - Medicine (in progress)
  - SCSD completed (Neutropaenic pts.)
- Survey of Drs at all grades on challenges to compliance with Sepsis patient pathway
- Sepsis FAQ sheet for wards
  - Troubleshoot issues/common themes
- Review training records
  - ESR Launched end of Oct
  - Push to complete training by Divisional Governance teams
- Audit of patients with +ve blood cultures and patient pathway
- Divisional ‘Sepsis Champions’

Focus: Medicine Division

- Excellent engagement from Medicine
- Local audit in progress
  - Real-time audit of NEWS >/= 5 patients by Nurse in charge of ward
  - Dynamic feedback and troubleshooting
  - Intermittent Peer review
  - Evidence of sepsis screening on ADT whiteboard
- Local QI work in progress
  - Blood gas processing training to improve lactate measurement
  - Aide memoir to Sepsis 6 in BC packs
  - 'Team approach' to Sepsis pathway
    - Dr/Nurse expected roles
- Monthly meetings with Medicine Divisional Governance team/Matron/Divisional Sepsis Nurse Lead
  - PDSA cycle

Focus: Women & Children's Division

- Excellent engagement from teams and receiving support from informatics
- All staff being encouraged to complete online training
- Paediatrics: Local PEWS audit continuing and Paediatric Sepsis Audit on GAP now set-up
  - Ad hoc audit of PEWS >/= 3 patients by nurse in charge of ward/ward manager with immediate feedback and troubleshooting in case of missed escalation
  - Sepsis data should be available from April 2021
  - Febrile Neutropenia Audit carried out annually: In 20/21 89% received antibiotics within 1 hour of arrival (cf 65% nationally)
- Neonates: Work to implement KP sepsis almost complete
  - Stratify risk of neonatal sepsis and reduce unnecessary antibiotic usage
- Maternity: Work with informatics ongoing with respect to pulling sepsis data from BadgerNet
  - Mandatory fields activated on BadgerNet
  - Awareness event took place on 29th March 2021 for the sepsis pathway in BadgerNet
  - Sepsis champions being recruited
  - Ongoing work to ensure maternity and neonatal pathways align
- Breast Services: Extremely low levels of de novo sepsis however data likely to be sitting within surgical directorate currently.
  - Working with informatics to link data to consultant rather than ward

Focus: SCSD Division

- There is good outcome assurance that patients are surviving as well, or better, than the national average both in the Trust as a whole and on Critical Care.
- There is poor compliance with all of the Sepsis 6 bundle, but good compliance with rapid administration of antibiotics, which is the most important factor in affecting mortality in severe sepsis. That is to say that the desired outcomes are being achieved, but this is without using the means which are promoted as the way to achieve this outcome.
- Further gains may be accrued by greater adherence to the Sepsis 6 pathway.

Actions to be taken:

- Work with the Trust Sepsis lead to relaunch Sepsis 6
- Work with Acute Oncology Service team to ensure that they implement the Sepsis 6 protocol, either through amendment of the neutropenic sepsis protocol, or through adoption of the Sepsis 6 screening tool.
- Survey of ward nurses and junior doctors to understand barriers to completion of Sepsis 6.

Focus: Surgical Division

- Ward visit 22/4/21 intelligence gathering: Ward level meetings TBA
- Problems identifying medical outlier teams-ward-based junior team system worked during Covid-why not for sepsis?
- Problems identifying responsible day doctor-bleep number written in notes every ward round
- Short staffing overnight-complex
- Sepsis six form redesign and data collection system revision

Sepsis Patient Pathway Update

- Engagement with Allscripts medical advisor to develop electronic Sepsis pathway
  - Launch date delayed
- Sepsis screening tool update in progress
  - Aim for launch Aug 21
  - Update to NEWS/Sepsis escalation sticker
  - Update to sepsis screening tool
    - Based on Dr survey feedback
    - Based on Feedback from SCSD and Medicine case reviews
    - Based on common themes from Trust-wide and local audit

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 May 2021
Paper number	Enc E1

Nursing and Midwifery staffing report – March 2021

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

Accountable Director	Paula Gardner Chief Nurse		
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	21/4/21	

Recommendations	The Trust Board is asked to note: • Staffing of the wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout March 2021 has been achieved through the deployment of staff ,3rd year student nurse paid deployment and booking of temporary workforce for short notice absences. • There were no patient harms reported for March. There has been an increase in incident reporting over this period of time for nursing and maternity. • Workforce plans have been instigated and remain in place to return staff from redeployment from critical care as Covid 19 infections reduce all staff deployed back from critical care.

Executive summary	This report provides an overview of the staffing safeguards for nursing and midwifery of wards and critical care units (CCU's) during March 2021 Staffing of the wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients being cared has been achieved through the deployment of staff, 3rd year student nurses on paid deployment and the booking of temporary workforce for short notice absences. Throughout March the trust has maintained the Covid and Non Covid Pathways for patients entering the system, thus continuing to escalate and de-escalate ward and critical care areas although this has greatly reduced over March with many wards regaining there original identity. The trust has been requested to maintain Critical care capacity at 15 Beds this still impacts the need for temporary staffing in this area and some substantive staff to be deployed to the area.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 May 2021
Paper number	Enc E1

	With the decrease in community prevalence from Covid 19 infections the trust saw a decrease nursing and midwifery staff absences although monthly sickness is remaining the same but with stress related sickness increasing. We have been acutely aware of the fact that staff absences and high acuity, bed occupancy has resulted in a two-fold impact: • potential impact on quality of care. There has been no harm reported at this time to patients from staffing incidents. • potential impact on staff morale, health and wellbeing: a number of actions taken to support health and wellbeing offers and a road map for deployment instigated.

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

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

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

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 May 2021
Paper number	Enc E1

Introduction/Background

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

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

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

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

During March this has seen the majority of deployed staff being returned to their substantive posts within the organisation.

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

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

April will see the phased return of shielding staff back into the workplace which will also have an emotional and physical impact on both staff returning and colleagues supporting in the workplace.

Issues and options

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

Staff support ongoing

Across the nursing, midwifery, health care scientists and Allied health professional, all line managers are aware of staff support available internally and externally to the trust, supporting colleagues to access the support they require to maintain health and wellbeing. The ongoing health and wellbeing of the workforce is paramount.

The workforce has taken a step down approach from the beginning of March to return all deployed staff to their substantive posts and to ensure that all necessary support has been put in place.

Divisions 'own' and maintain their staffing lists of staff returned so periodically can touch base with staff to ensure health and wellbeing of staff members
The provision of staff support has continued to be been pivotal in providing the safeguard for staffing. It has been essential to continue:

- A shift by shift, 7 days a week senior nursing leadership presence on hospital sites.
- Health and well-being support through telephone helplines and various counselling services, particularly for teams reporting ongoing challenges as COVID 19 pandemic continues. This has been revisited as the redeployment of staff through blended models of staffing from AHP /health scientists has required significant support both in terms of training/retraining and listening forums to anxieties and fears of working in a different practice setting.
- Re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements
- Reinstated use of the dynamic trigger tool in safety huddles with weekly auditing care provision.
- Introduction of the national red flags though the Allocate software
- The role out of Lateral flow testing kits have been reported as beneficial for staff and the role out of the Covid 19 vaccine through January has also supported anxieties.

Harms

There were no patient harms reported for March 2021. There has been an increase in datix reporting over March for both Nursing and Midwifery.

In March there were reported minor and insignificant harms for Nursing 10 harms in total 8 minor harms and 55 for Midwifery 22 being minor harm the rest being insignificant.

Good Governance

The Senior Nursing, Midwifery and AHP team have now moved to monthly meetings with the senior nurse meetings moving to monthly.

Safe Staffing

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

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	Review establishment for planned hours for all areas and ensure staffing rota is correct.	**4**
RN	88%	92%		
HCA	87%	95%		

The Challenges seen by the divisions have been specifically due to:

Staff having to re-shield due to the third national lockdown but still unable to return to the clinical activity they were undertaking previously, this has had an impact particularly in maternity services.

Vacancy trust target is 7%

Current Trust Position			What needs to happen to get us there	Current level of assurance
Registered Midwives	3.37%	7	Increased RN and RM Recruitment to reduce vacancies. Ensure HCA recruitment continues Continue International nurse recruitment	5
Registered Nurses	11.10%	215		
HCA's	2.88%	26		

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

- Maternity services have deployed staff from the community and the continuity of carer teams to cover identified shortfall where and when required.
- Inpatient wards have deployed staff and employed use of bank and agency workers.
- Vacancies numbers has been leading to constraints on staffing and a need for Bank or agency to keep staffing safe across all the wards.

Bank and Agency Usage

Trust target is 7%

Current Trust Position			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 inline with NHSI cap rates. Reduce agency % and in short term increase bank % until recruitment of substantive staff at 97%.	**5**
Speciality Medicine	10.46%	4.94%		
Urgent Care	32.5%	8.96%		
Surgery	7.26%	8.73%		
SCSD	9.55%	3.89%		
Women'sand Children's	4.93%	6.25%		

Recruitment

International nurse (IN) recruitment pipeline

The first 12 nurses from the 20/21 business case arrived in the country on the 15th February 2021 there are 7 nurses from the co-hort allocated to the Alexandra hospital and 5 allocated to the Royal site to support the reduction in vacancies.
A further cohort of 12 international nurses landed in March with a continued plan of 12 nurses a month.

Domestic nursing and midwifery pipeline

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

Sickness – Feb data only available at present due to IT issues March will be available next week for validation.
The Trust Target for Sickness is <4% - February Trust 4.55%

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

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

Turnover

Trust target for turnover 11% March turnover 9.5%

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Current Trust Position	What needs to happen to get us to level 6	Current level of Assurance
<table><tr><td>Division</td><td>RN/RM</td><td>HCA</td></tr><tr><td>Speciality Medicine</td><td>7.24%</td><td>13.47%</td></tr><tr><td>Urgent Care</td><td>8.37%</td><td>12.96%</td></tr><tr><td>Surgery</td><td>8.50%</td><td>11.59%</td></tr><tr><td>SCSD</td><td>10.68%</td><td>12.53%</td></tr><tr><td>Women'sand Children's</td><td>7.05%</td><td>13.52%</td></tr></table>	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	**5**

Recommendations

The Trust Board is asked to note:

- Staffing of the wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout March 2021 has been achieved through the deployment of staff ,3rd year student nurse paid deployment and booking of temporary workforce for short notice absences.
- There were no patient harms reported for March. There has been an increase in incident reporting over this period of time for nursing and maternity.
- Workforce plans have been instigated and remain in place to return staff from redeployment from critical care as Covid 19 infections reduce all staff deployed back from critical care.

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Midwifery Safe Staffing Report March 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	April 2021	
TME	21/4/21	

Recommendations	Trust Board 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 March 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' • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) • Sickness absence rates Throughout March it has remained extremely challenging to maintain safe staffing levels due to an increase in activity, non-Covid and Covid related sickness absence, vacancies and the number of clinically vulnerable staff who are required to shield. Staff have raised concerns with the Executive team and engagement events are planned. We continue to see a sustained increase in incident reporting culture during this period in response to engagement with staff facilitated by the governance team and also following feedback in the CQC report. All staffing incidents were reviewed and no harm was identified.

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	For large periods of the month the escalation policy was enacted to maintain safe staffing levels. The deployment of staff and the cancelling of study leave and non- clinical working days provided additional staff to maintain safe levels and provided appropriate mitigation. Despite these actions there were some significant delays in care for women undergoing induction of labour. A continuous recruitment programme remains in place for staffing in both inpatient and community recruitment and we are pleased to welcome 6 WTE inpatient midwives into post with a further 6 WTE expected at the beginning of April. The final 6 WTE employed for community are currently progressing through the approvals process and are expected in May. A further recruitment event is planned for early April when 21 applicants will be interviewed which will then fill any additional vacancies, planned maternity leave over the summer and additional funded posts. Sickness absence rates continue to be higher than the Trusts target at 8 - 14% across inpatient areas. The level of assurance provided for safe maternity staffing is 4. This is a decrease in assurance levels from the previous month as despite an action plan agreed to address staffing issues some of those actions are yet to demonstrate an improvement.

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.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**3 months**					

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Introduction/Background

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

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tool (4 hourly)
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Daily staff safety huddle
- COVID SitRep (re -introduced during COVID 19 wave 2)
- 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) and acuity was reported to be higher than the actual staffing levels in 65% of occasions throughout this period. In the majority of cases (39%) a shortfall of 2 midwives was reported in the intrapartum area due to staff sickness and/or a midwife scrubbing in theatre. Staff were redeployed from other clinical areas to mitigate the risk.

The purchase of an updated acuity tool is progressing and will enable recording of acuity throughout the entire inpatient pathway. It will also capture the impact of staff deployment. Training is planned for April.

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 March was 1:28 (in post) and 1:23 (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'

There were 57 staffing incidents reported in March. All of the reports record less than expected staffing numbers in triage, the antenatal ward, delivery suite and some reduced availability for on-call continuity midwife.

Staffing levels were maintained at or above minimum agreed levels and no harm occurred as a result of these incidents however staff have been deployed and the escalation policy has been enacted to maintain safe staffing levels which has resulted in delays in care. The

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 has been shared with the CNO.

There were 15 medication incidents; 2 reports of aspirin not being prescribed to women at risk of pre-eclampsia. This is a reduction in previous reported incidents.

There were two recorded delays in the completion of the newborn septic bundle and therefore the commencement of antibiotics was delayed. All other medication errors were reported as 'no harm' events and no themes were identified.

The remaining clinical red flags (as listed in the NICE Safe staffing guidance) can be reported on Safecare. It was expected that training would now be completed and the recording of red flags would have ceased via Datix and be captured within the Safecare system. Due to reduced staffing numbers training has been delayed and therefore all red flags will continue to be reported via Datix until all team members have access and are trained to use this reporting system.

Daily staff safety huddle

Daily staffing huddles have been completed each morning within the maternity department and the Chief Nursing Officer has joined the morning huddle. 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. One additional huddle was called with the senior team during this time period and a contingency plan was agreed to mitigate the risk of lower than expected staffing levels on the night shift.

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

The Divisional Management team continue to complete a daily COVID huddle with all directorates to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels. These meetings reduced to three times a week during March as the alert level reduced to *4.* It is likely that these may be reduced further in April 2021.

Sickness

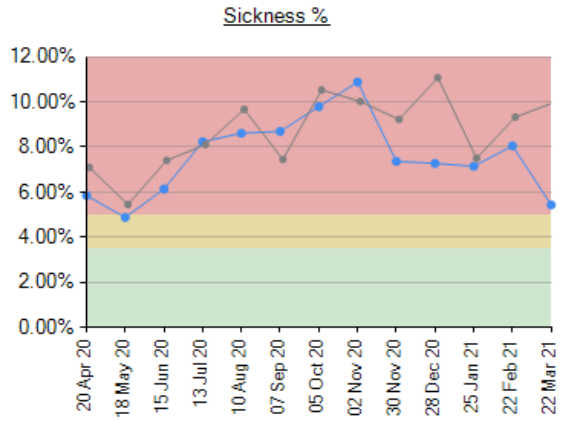
The Division continues to work with our HR partners to obtain accurate sickness absence rates for midwifery only groups. The data below has been taken from the E- Roster for inpatient staff only**.** The information provided is for the previous and current financial year and demonstrates that the sickness levels are consistently above the Trusts target. Please note that this data was completed before the end of the financial year and therefore the March data is incomplete for 2021.

To address the historic high levels of sickness the team have commenced the following actions:

- Workshops provided by HR for all ward managers and matrons to refresh and update

on the management in line with Trust Policy.

- Review of flexible working agreements (noted at 45% in some areas) and may be having an impact on the wider team health and wellbeing.
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the correct support and guidance.



The Division will continue to work with the Human Resource team to ensure that ongoing monitoring of sickness rates, turnover and bank fill are available visible to the Directorate management team.

Actions that continue throughout this period:

- Arrival of 10 WTE midwives, induction completed and joined rota throughout March.
- Daily safe staffing huddles continued to monitor and plan mitigations.
- The delays in Induction of Labour continued in this period: each delay was managed through continuous risk assessment with the multi-professional team.
- No adverse clinical incidents were reported which related to staffing or delays in care however it is acknowledged that some women had a poor experience and staff have been under additional pressure. Daily discussions with the Consultant / midwife in charge were undertaken.
- All non-essential training and non - clinical working days were cancelled and all of the matrons, ward managers and specialist midwives were deployed to the clinical areas to support safer staffing levels as required throughout this period.
- Further recruitment events planned
- Continue to work with HR to improve midwifery workforce data availability to support planning and ensure that midwifery staff in post documentation is accurate.
- The roll out of one continuity teams was discontinued due to withdrawal of a number of staff following ongoing delays with roll-out. No further teams planned.
- MSW scoping work completed and plan for recruitment to training programme agreed and provider identified.
- Additional support to the postnatal ward was also provided by neonatal nurses, nursery nurses and nursing staff from the gynaecology service

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

- Awaiting start dates for 5 WTE to commence in community services.
- Reduction in Covid and non Covid related absence
- Return of CEV staff
- Further recruitment expected in April – this will allow over – recruitment to ensure that any further turnover throughout the next 3 - 9months does not negatively impact on staffing levels.

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

Conclusion

Whilst the arrival of a number of new starters across the month was welcomed it remained a challenging time to maintain safe staffing levels. Actions taken did provide appropriate mitigation to maintain safety however delays in care were noted. There was an increase in reporting staffing incidents demonstrating an improved reporting culture in response to local and regulatory feedback.

The 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 has been shared with the CNO and engagement events planned throughout April.

We saw an increase in the reliance of support from the community midwifery and Continuity of Carer teams to maintain safe staffing levels. It is recognised that whilst these teams have provided additional support, due to the flexible way in which they are able to work, this has a negative impact on their job satisfaction and the Divisional Management team is extremely thankful for their commitment.

Further recruitment events have been arranged and a Health and Wellbeing Group is being led by a new maternity matron in partnership with our HR partner.

Recommendations

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

Appendices

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Review of Provider Licence Condition FT4 and G6

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

Accountable Director	Matthew Hopkins, Chief Executive		
Presented by	Rebecca O'Connor, Company Secretary	**Author /s**	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	21/4/21	Assured
QGC	29/4/21	Assured
Audit & Assurance	20/4/21	Assured

Recommendations	1. Trust Board are requested to approve the self-certification for publication.

Executive summary	Each year, the Trust has to declare against two provider licence provisions, FT4 and G6. The declaration has to be placed on the Trust website by 31 May. There is no requirement for the declaration to be returned to the centre. The Trust was removed from quality special measures on 24 September 2020. On 9 December 2020, the CQC conducted an unannounced on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital. Following the inspection, the Maternity service's overall rating reduced from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good. The Trust is subject to Section 31 Conditions Notices for the Worcestershire Royal Hospital and Alexandra General Hospital Emergency Departments. The Trust has continued to satisfy the conditions, submitting fortnightly reporting to the CQC. In February 2021, the Trust applied for the Section 31 Conditions to be removed from the Emergency Departments and on 29th April received notice of decision to remove these conditions. The Trust has maintained its overall quality rating of "Requires

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	Improvement". The Trust continues to be rated positively "Good" in the "Effective" and "Caring" domains, and "Requires Improvement" in the "Safe", "Responsive" and "Well-Led" domains. This paper details the suggested compliance with the conditions of licence

Risk			
Which key red risks does this report address?	-	**What BAF risk does this report address?**	*BAF 4 and 7.*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this paper. However financial risks materially impact upon the assessment of non-compliance.*																	

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

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Introduction/Background

NHS Trusts are required to make the following self-certified declarations:

1. Condition G6(3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (being considered by the Audit and Assurance Committee)
2. Condition FT4(8): Providers must certify compliance with required governance standards and objectives.

Whilst NHS Trusts are exempt from holding a provider licence, NHS Trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate. This is then used as a basis for oversight. NHS trusts therefore are legally subject to the equivalent of certain licence conditions and now must self-certify.

There is no set process for assurance or how conditions are met which reflects the autonomy given to providers. Boards need to sign off on compliance and there are no returns or information submissions. Templates are provided to assist with the process but do not need to be returned.

Issues and options

The executive team have considered the conditions required for compliance with provider conditions FT4 and G6. The Trust Board needs to approve the compliance and the statements need to be placed on the website prior to 31 May 2020.

The Audit and Assurance Committee are considering the compliance statements at the meeting on 20 April 2021.

Condition FT4

	Corporate Governance Statement	**2021**
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Not confirmed**
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed**
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed** Confirmed Confirmed Confirmed
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee	**Not confirmed** Confirmed Confirmed Confirmed

	including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed Confirmed Confirmed Confirmed Confirmed
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**

Condition G6

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Proposed response: **Not compliant**

Evidence:
The Trust was removed from quality special measures on 24 September 2020. There are currently the following conditions in place on the registration with the CQC, however an

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application for removal has been made in February 2021 as detailed above:

- Section 31 Conditions Notices for the Emergency Departments at Worcestershire Royal Hospital and the Alexandra General Hospital

The Board Committees have met on a regular basis throughout the year and reported in to the Board. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework are reviewed by each Committee and changes approved by the Board at the following meeting. The Audit and Assurance Committee reviews the processes for the management of the BAF.

The Trust continues to have significant challenges in delivering key NHS Constitution targets including Emergency Access Target, 18-weeks referral to treatment – incomplete pathways, cancer waiting times, diagnostics waiting times and C-diff, MSSA and MRSA.

Conclusion

The suggested compliance for condition FT4 and G6 are shown above. The detail in relation to the compliance statements is appended and has been considered by the Audit and Assurance and Quality Governance Committees.

Recommendations

1. Trust Board are requested to approve the self-certification for publication.

Appendices

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	Corporate Governance Statement	2021	Evidence

1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Not confirmed	The Trust was removed from quality special measures on 24 September 2020.
			
			The Trust is subject to Section 31 Conditions Notices for the Worcestershire Royal Hospital and Alexandra General Hospital Emergency Departments:
			• Regulation 12 (2) (a) (b) (i)
			  ○ The trust must ensure that ambulance handovers are timely and effective.
			• Regulation 12 (2) (a) (b) (i)
			  ○ The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.
			• Regulation 12 (2) (a) (b) (i)
			  ○ The trust must ensure that patients receive medical and specialty reviews in a timely manner.
			• Regulation 12 (c)
			  ○ The trust must ensure that consultant and nurse cover in the department meets national guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota.
			• Regulation 12 (2) (a) (b) (i)
			  ○ Fully implement the trust wide actions to reduce overcrowding in the department.
			• Regulation 10 (1)
			  ○ The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times.
			
			In response to the notices, the Trust took a number of immediate actions and in partnership with NHSI/E, CCG and WMAS, safety, quality, risk assessment and assurance tools and processes have been implemented and embedded across the service. Oversight of the continuous improvement has been

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			monitored via the Trust's internal governance structure and the Homefirst Worcestershire Board. The Trust has continued to satisfy the conditions, submitting fortnightly reporting to the CQC. An application for removal was made in February 2021. The Trust is advised the NHSEI Provider Oversight Committee will not review its application to remove conditions, as the Trust will be assessed and rated alongside all other Trusts. On 9 December 2020, the CQC conducted an unannounced on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital. Following the inspection, the Maternity service's overall rating reduced from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Executive team regularly receive communications from NHSI. All guidance is reviewed by the executive team and where appropriate escalated to the Board. The Board have utilised the National NHSI team and Leadership for Improvement to support the Board development programme during 2020/21.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	a&b. There is an effective Board Committee Structure in place comprising of: • People and Culture Committee • Quality Governance Committee • Audit and Assurance Committee • Finance and Performance Committee • Remuneration Committee • Charitable Funds Committee The Board Committees meet and report back to the next Board meeting. All terms of reference are reviewed and revised as required and approved by the

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			Board each year or more frequently as required. The relevant risks within the Board Assurance Framework (BAF), are reviewed by each Committee and changes approved by the Board. The Trust has worked in year to develop and refine its approach to management of risk appetite and use of the seven levels of assurance by Committees and in its reports. The Audit and Assurance Committee reviews the processes for the management of the BAF. The Risk Management Group was revised during the year and meets monthly. c. There are robust reporting processes in place from a clinical/operational level through the Divisions and to Trust Management Executive and Board Committee/Board meetings with clear reporting lines and accountability at each level.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee	Not confirmed	a&b. The Trust Management Executive (TME) meets monthly to manage the operational business of the Trust. Board Committees meet monthly (Finance and Performance, Quality Governance) and People and Culture meets bimonthly. The Board meets monthly (not August) and has a forward plan for business. At each meeting the integrated performance report provides an update on quality, operational and financial performance and people management. c. The Quality Governance Committee meets monthly and holds the executive directors to account for quality standards and oversees the Trust's response to the conditions on licence. The Finance and Performance Committee meets monthly and holds the executive directors to account for performance standards. d. The Finance and Performance Committee meets monthly to scrutinise the operational and financial performance and reports to each Board meeting. In 2020/21 the Trust operated under the interim COVID-19 financial architecture and delivered a surplus out-turn position. The Trust was developing its

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	decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Medium Term Financial Plan as the COVID-19 pandemic hit and is now working to refresh this alongside the Clinical Services Strategy and other enabling strategies. In light of the Trust, and system underlying deficit, we are actively working with system partners to ensure effective financial management as a system as well as an Organisation. In year the Trust has not required interim financing (other than the April 2020 payment requested prior to the change in architecture) beyond the top-up mechanism. Through the STP capital envelopes and national PDC capital the Trust has had sufficient cash to support capital spend. The Trust remains compliant with NHSI spending approvals processes. There are robust processes in place for the management of Business Cases which require investment. Despite the pandemic, the Trust maintained effective financial controls and decision governance, and finance actively engaged with the divisional and directorate leads to monitor and discuss any variation of budgetary plans. The Performance Review Meetings are scheduled to re-start as part of the restoration phase. e. The Quality Governance Committee uses performance data to inform the decision making process. The F&P Committee scrutinise the performance dashboards and financial performance reports monthly and undertakes benefits realisation reviews following major investment. Both QGC and F&P Committees scrutinise the significant improvement plans such as the Home First Worcestershire Improvement Plan.. f. The Board Assurance Framework (BAF) was reviewed during the year in both Board meetings and Board development. A review into the use of risk appetite was led by the Governance Task and Finish Group. The relevant risks are considered by Board Committees at their meetings. g. The Trust's annual planning process is overseen by the Annual Planning Steering Group which is attended by corporate leads from Strategy & Planning, Informatics, HR and Finance as well as the Divisional Operational Directors. Assurance relating to the development, changes to and monitoring

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			of delivery of plans is achieved through reporting to CETM, TME, F&P Committee and Trust Board. Progress against delivery of plans is monitored during PRMs. The Trust is represented appropriately at system level to ensure our plans are cognisant with those of the system and are appropriately triangulated. h. The Trust was registered with the CQC during the year 2020/21.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	a. The Quality Governance Committee (QGC) oversees all aspects of quality and clinical governance within the Trust. This meets monthly and escalates via a written report to each Board meeting. The Chief Nurse and Chief Medical Officer are responsible for quality of care at Board level. The Trust has fully participated in QIRG (Quality Improvement Review Group) during the year and this has been replaced with the newly established system-wide System Improvement Board and a monthly NHSE/I led System Review Group. b&c. The Trust strategic objectives which were developed by the Trust Board provide the framework for the development of Trust annual priorities and plans and the structure of the Trust Board agenda. The Trust strategic objectives provide a balanced scorecard approach to Trust Board business including due focus on quality & patient experience, workforce, finance and operational performance d. QGC considers quality performance data at each of its meetings. This is then reported to the Board via the written report from QGC. The Board considers an integrated performance report at each meeting. e. The Board receives a patient story or equivalent at each Board meeting and receives updates via the QGC report on the Quality Improvement Strategy and associated plans. The three year Quality Improvement Strategy 2018-2021 has been extended: described as Year 3 + with the addition of 4 Quality Priorities: Hospital Acquired Functional Decline, Nutritional and Hydration, Dementia and End of Life. Year 3 + was in response to enable the new incoming Chief Nurse to proceed with a new Quality Strategy that aligns

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			to the National Patient Safety Incident Response Framework 2020. Board members will return to undertaking safety and leadership walk rounds in clinical areas, when safe to do so. Progression continues engaging staff and patient representatives in a range of forums, adapted to virtual meetings. Each ward/clinical department has Quality Improvement Plan and has good awareness and ownership of the high level and specific goals relevant to them. The impact of introducing Quality Service Improvement and Redesign (QSIR) education and training pre covid has informed (for some) the steps and tools used to improve in an agile way. QSIR training has been stood back up, with dates planned for virtual training and now joined up with the Clinical Audit Programme to improve junior doctors engagement in Quality Improvement Projects. Attending the training and delivery of an improvement project is a pre-requisite to support The Quality Improvement Strategy delivery and achievement of the ward accreditation programme known as "pathway to platinum".
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board has no vacancies. All Board members have undertaken the Fit and Proper Person Test.

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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 20 April 2021 The following key points are escalated to the Board's attention: **1. Value for Money** Committee noted changes regarding the scope of the Value for Money audit. The audit plan sets out a broader review and is required to identify significant areas of weakness. Risks included sustainability, development of a medium term financial plan, the ICS and benchmarking against other providers and outlying areas. A core team, fees and services have been identified. Further information regarding the changes are available at: Guidance and information for auditors - Code of Audit Practice (nao.org.uk) **2. External Audit Plan** As referenced above, Committee approved the external audit plan, noting it awaits guidance to be issued with regards to the review of the Trust's Quality Accounts. **3. Provider Licence Conditions** Committee reviewed the paper noting no matters of escalation; the position being consistent with the year prior and recommended the same for approval by the Board.

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Risk														
Which key red risks does this report address?		**What BAF risk does this report address?**	*N/A – the Committee reviews all strategic risks*											
Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this report*													
Action														
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X								
Are the actions identified starting to or are delivering the desired outcomes?	Y		N											
If no has the action plan been revised/ enhanced	Y		N											
Timescales to achieve next level of assurance														

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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 8 April 2021 The following key points are escalated to the Board's attention: **1. Recruitment of Chief Medical Officer** Committee discussed and commented upon the job description and person specification. It approved the timeline for recruitment and starting salary range, which was in line with NHS Improvement recommended payscales.

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						

NHS
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Trust Management Executive

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

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Martin Wood Deputy Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Executive summary	This report gives a summary of the items discussed at the Trust Management Executives (TME) held in March and April 2021. Members will see that there is a clear line of sight between the Board, Committees and TME.

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

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?					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						