Integrated Performance Report

Worcestershire Acute Hospitals NHS Trust

Committee Assurance Reports

Trust Board

9th September 2021

Finance & Performance Committee Assurance Report – 28th July 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 July 2021. Our focus was on the approach to developing our mid term plan, the financial forecast, operational performance (COVID, A&E, discharges and restoration) and Best People Programme.

Budget Update 2021/22: Given the positive YTD M2 variance across the system, CFOs agreed to offset beneficial YTD M2 variances against the unmitigated system risk in H1 (£6.4m). For us this was £1.8m. A further assessment of ERF achievement was performed following a re-submission of activity. This resulted in a further benefit to our position of £1m. Our H1 revised plan, inclusive of EFR is a £1.1m surplus. Excluding ERF this would be a £(1.1)m deficit. We are concerned about our ability to achieve our PEP target. We particularly wish to inform the Board that given the current restrictions on theatre capacity, social distancing rules (particularly for outpatients) we will not achieve the required 95% activity level to received ERF. If we incurred additional resources to strive to achieve the 95% it is consider too great a risk to do this and still not achieve the target.

Approach to Development of the Mid Term Plan: We welcomed this approach that will deliver a 3 year plan (both operational and financial) and starts with Directorates assessing themselves (with support) where they are now versus where we need to be in 2024/25 in order to be clinically and financially sustainable going forward, and how the sustainability agenda and the current Strategic Programmes will support that move towards sustainability. There are currently 48 priorities which need to be further refined for those with the biggest wins and where we have the necessary data to take decisions. The ICS is to be involved in the early stages to inform them of our plans to reduce the financial deficit and to get their buy in. Service Line Reporting is not embedded throughout the organisation but is considered to be in a position to reliably inform decisions.

The approach needs to be owned throughout the organisation. We recognise that staff are tired from dealing with COVID and other major improvement schemes. The language and timing to engage staff will be crucial. The OD & Comms teams will support Departments and Directorates in the hearts and minds changes required to embed the approach. We have added hearts and minds to the risk register with mitigations being developed. There is a commitment from the Divisional teams to deliver on the planning work.

We consider that to ensure delivery we need a better balance between the bottom-up and a top down approach. We recommended to define high-level objectives and more detailed guidance to divisions/specialties to steer the development of the plans and avoid wasting time. We share the concern about resourcing the plan, both from the divisions and corporate side. We suggested the next step would be to develop a detailed plan, based on the approach discussed and agreed. This plan should include detailed activities, accountabilities, milestones and resourcing requirements and a risk management mechanism. TME should assist in fulfilling the resourcing requirements as well as in prioritising this work, amidst the current crisis and other large programmes. We will receive an update at our next meeting in September 2021.

Finance & Performance Committee Assurance Report – 28th July 2021

Executive Summary (cont.)

Digital Care Record Business Intelligence and Reporting Requirements - PAS: At our last meeting we were unable to approve the recommendations associated with additional staffing resource and required further assurance on how these requests could be afforded. There is an immediate requirement to support the PAS Re-implementation programme and we received assurance on the financial resource associated with the PAS data quality elements only. This represents £131k only of the £4.5m additional resources identified and represents PAS costs for 2021/22 only. In the light of this we approved the additional staffing resource and will await the outcome of the benefits realisation exercise regarding the remainder of the additional resources identified within the DCR Programme Review.

Digitisation of Cellular Pathology – Benefits Realisation: We received details of the benefits noting that the KPIs will track both operational and financial performance. There is assurance that the benefits will cover the Trust's contribution to the project. The tracker has been developed specifically for this project and we have asked whether its use can be adapted for other benefits realisation projects.

Programme for Divisional Attendance: We have noted a programme for each of the five Division to attend once during the remainder of the current financial year. We will focus on the PRM activity and how the available data is being used to improve productivity and transformation.

Integrated Performance Report: We received an update on the current COVID position. We noted that the main challenges are Emergency and Urgent Care demand, patient flow and capacity, recovery and restoration of the elective programme including Outpatients and Diagnostics, Quality and Safety (Infection Prevention and Control, Sepsis and Maternity) and People and Culture. We noted that conveyances and type 1 attendances are significantly above 2019 activity levels. Following discussions with the Health and Care Trust there are early indications that increasing numbers of patients are being seen in MIUs.

Despite the increasing activity levels, our performance for delays over 4 hours, over 12 hours and ambulances handover delays has improved since 2019. Subject to coding clarification, we are on track to receive ERF for June 2021. We anticipate to achieve 93% performance for breast 2ww by September 2021 with the backlog addressed and maintaining referrals. The Chief Medical Officer is working with the Chief Digital Officer to improve VTE recording as snapshot audits of ward areas have shown that performance is better than that which is recorded. Timelines for moving to the next assurance level is to be addressed in future reports. During the forthcoming months an ICS scorecard is to be developed with each partner aligning key metrics. There is system agreement to improve pathway 1, 2 and 3 patient discharges before midday with patients moving to the Discharge Lounge before midday. However, there is a nervousness on our part in that some patients are not discharged as a result of partner issues and have to be returned to a ward late in the afternoon or early evening which presents particular challenges. We need to focus on our simple discharges before midday. The system now are increasingly recognising the urgency of improving patient flow.

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

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Executive Summary (cont.)

Financial Performance Report Month 12: We noted that the month 3 in plan reflects the system agreement to offset YTD beneficial variances reported in M2 distorting the in month variance position. At the end of Q1 we report a small adverse variance to plan of £0.2m. The guidance for H2 is not expected until September 2021.

We received the operational forecast for H1. We noted that the additional nursing home beds are being funded from the Better Care Fund. The maternity service plan is being funded from Ockenden/CNST monies. There is confidence that the forecast will be met at Q2 but further work is required for the year end position. The current work in progress version of the Year-end forecast shows a significant deficit, caused largely by COVID costs and lack of ERF funding. We agreed this is not acceptable and being mindful of the likely increase in the national efficiency requirement for H2 up to 3%, a full assessment of the current PEP schemes in terms of maturity and forecast delivery needs to be completed for the next meeting. Discussions are taking place within the system on our financial position and the mitigations in place to reduce our forecast. We are looking at the approaches used by other Trust's who have significantly reduced (and in one case completely) the use of bank and agency staff to see what can be learnt for our Trust. The assurance levels remain unchanged with 4 for income and expenditure, 5 for capital and 6 cash.

Best People Programme: We were disappointed with this programme for reducing our reliance on the temporary workforce and thereby reducing premium staffing costs. This Programme is in its early stages of development and hasn't matured into a tangible plan. We require better analysis to understand the drivers which cause the use of bank and agency staff. We also need to ensure that we have the right establishment in place at the outset. Our comments are being referred to the People and Culture Committee for a deep-dive into the approach/plan.

Contract Award: Oncotype DX Breast Recurrence Score: We approved a two year contract for this testing equipment subject to clarification of the impact on price if we do not meet the minimum commitment to the number of tests.

Standing Financial Instructions/Scheme of Delegation: We are recommending approval to these documents which have been approved by the Audit and Assurance Committee and TME. They appear as a separate item on the agenda.

Estates Strategy: The Non-Executive Directors received a briefing on the draft Estates Strategy recognising that it had yet to be presented to TME. We suggested that the draft should be amended to contribute to financial sustainability and demonstrate Return on Investment and linked to support our Clinical Services Strategy; a longer term view in linking with the ICS Estates Strategy; the helipad to be a definite part of the strategy; further carbon reduction and energy efficient measures and other aspects of sustainability; linking to our new ways of working and future proofing. Benchmarking should help us ground the strategy and cost metrics should enable us to measure progress. A separate strategy for Facilities is to be prepared.

Recommendation(s)

The Board is requested to receive this report for assurance.

Quality Governance Committee Assurance Report – 29th July 2021

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom Associate Non-Executive Director	Richard Oosterom Associate 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 July and the key points raised included:

Infection, Prevention and Control update: Committee noted continued progress in antimicrobial stewardship, however there had been an increase in outbreaks and incidents over the last month. The Trust had met its trajectory limit for MSSA , all 3 cases have been reviewed. The lab analyser for C-diff was being replaced and is currently double running to ensure validation. **Assurance level 4 (non-COVID) overall was approved.**

Integrated Performance Report: Committee discussed ED flow and discharges which has seen significant pressures, alongside an increase in Covid patients. Diagnostics, stroke and 52 week waits were discussed. Concern was expressed regarding the extent of assurances provided at the stroke programme board. Assurances were provided as to the improvement in data quality regarding maternity neonatal deaths **Assurance level overall was agreed at level 4.**

Maternity Improvement Plan – Committee received the plan noting the progress made and updates already provided to Trust Board. Committee debated the increasing impact of Covid on pregnant women and the consequential impact this may have on delivery of the plan, however this will progress as fast as possible. **Assurance level 4.**

LMNS Update – Committee received an update on the new role of the LMNS who will now have an oversight an monitoring role. They will be hosted within the CCG as part of the ICS developments and will attend Trust divisional governance meetings.

Board Assurance Framework deep dive – Committee undertook its first deep dive into BAF 17 risk regarding staff engagement in delivering transformation. Committee had a broad discussion reviewing the control measures in place, actions required to progress and the level of assurance surrounding the risk. A number of updates to controls were agreed and further updates would be received. **Assurance level 3 (for BAF risk 17) with an agreed plan to move to level 4 assurance.**

Harm Review Panel Update – Committee received an update on a proposal to provide a more robust way to identify harms using the Datix system. The process will be reviewed in six months. **Assurance level 6.**

Complaints and PALS Annual Report – The report was welcomed by Committee with the patient facing link back to our values and behaviours noted. The Trust has been selected as an early adopter of the Ombudsman standards process. Healthwatch offered to support the production of an easy read summary of the report. **Assurance level 6 for PALS and level 5 complaints.**

Committee work plan – to be reviewed in September.

Recommendation(s)

The Board is requested to receive this report for assurance.

People and Culture Committee Assurance Report – 3rd August 2021

Accountable Non-Executive Director	Presented by	Author
Dame Julie Moore Non-Executive Director	Colin Horwath Associate Non-Executive Director	Martin Wood Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Number (s)	9, 10, 11 and 12

Executive Summary

The Committee met virtually on 3 August 2021. Below is a summary of our discussion.

- **Guardian of Safe Working:** We received the exception reporting data indicating that Junior Doctors are working in compliance with their terms and conditions of service. We are concerned over the lack of direct junior doctor engagement with our Trust on issues of concern. We welcome the anonymised feedback from the external organisations to whom junior doctors approach but this does not address our underlying concern. This is to considered as part of our 4ward and Equality, Diversity and Inclusion culture programmes with an update being presented in the next quarterly report. We noted that this issue is not particular to our Trust.

- **Integrated People and Culture Reports:** We received a comprehensive report providing us with assurance on the key people and culture issues impacting on our Trust. This included an ICS update through a people and culture lens; equality diversity and inclusion; half year 1 workforce plan; new ways of working and delivering care; workforce skills and how we will benchmark and quarter 1 performance. We asked for further work to be undertaken on the Equality, Diversity and Inclusion High Level Action Plan to make it more outcome based.

- **4ward Phase 2:** We noted the three options upon which feedback is to be sought in order to develop the next stage of 4Ward. We are pleased that there is a drive to improve 4ward as part of our cultural journey. We are keen that 4ward aligns to our Mid Term Plan in terms of people, performance and quality. The outcome of the engagement exercise is to be presented to our meeting in October 2021.

- **Recruitment and Retention Update:** We received an update on the vacancy and retention rates within our Trust; actions already taken to date to 'turn the dial' in some areas, and a forward look of proposed actions for the remainder of this year. Recognising that recruitment is a competitive process, we were informed that we are in line with the pack compared to other Trusts recognising that further work is required and time to fill is to form an early project for the Single Improvement Methodology. We are concerned over the high number of leavers within the first 12 months of appointment and noted that the Director of People and Culture is to prepare a balanced scorecard to ensure value for money. We recognise the importance of a work life balance and this is to be taken forward in our Flexible Working Forum which Mr Azmi has offered to assist.

- **Fit and Proper Persons Test Annual Audit:** We have noted that the voting and non-voting Executive and Non-Executive Directors of the Trust Board plus the Company Secretary and the four deputies included are compliant with the Fit and Proper Persons Test requirements.

People and Culture Committee Assurance Report – 3rd August 2021

Executive Summary (Cont)

- **Responsible Officer Report Medical Appraisal and Revalidation:** We were assured that work is continuing to improve compliance and engagement in relation to Medical Appraisals and Revalidation. Four divisions are above the Trust board tolerance level of 90% compliance for all medical staff in their division. There is a risk around the potential number of appraisers. We have invited the Acting Chief Medical Officer to see if data can be captured to show any themes around consultant retention.

- **Maternity Service Transformation Plan:** This report had already been presented to Trust Board. We focused on the cultural elements of the Plan noting the plans to improve engagement and the way in which continuity of carer is delivered. We noted that the governance resources have been approved by TME.

- **Safest Staffing Report – Adult Nurse and Maternity Staffing:** We received an assurance that adult nursing and maternity staffing for June 2021 was considered safest with mitigations in place. We noted the considerable challenges being faced during operating at alert level 4 and the actions being taken to ensure safest staffing. There is a focus to support staff. We are keen to ensure that all eligible staff are taking up the health and wellbeing offer and details of take up are to be presented to our next meeting. Wellbeing conversations are to commence in September to reinforce the health and wellbeing support available in time for the winter pressures. There have been improvements in maternity staffing with efforts continuing to make further improvement. We agreed the overall assurance level 5.

- **People and Culture Risk Register** We have approved the Risk Register with two risks increasing (PC28 & PC29) due to the increase prevalence of Covid-19 in the community impacting on staff absence. In addition we are seeing a month on month increase in non-COVID sickness absence due to workforce fatigue. The rating for COVID vaccinations (PC 31) has been reduced to 8 from 12 due to the increase in take up of all staff groups including ethnic minority colleagues. The Committee's BAF risks are to be further considered at a meeting later in the month.

- **Other reports noted:**
    - **Divisional Compliance Dashboard as at 30 June 2021**
    - **JNCC Notes**
    - **MMC Notes**
    - **Workplan**

Recommendation

The Board is requested to note this report for assurance.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
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Nurse staffing report – July 2021

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	18 August 2021	Assured

Recommendations	The Trust Board are asked to note: • Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout July 2021 has been achieved, this was supported when required through the booking of temporary workforce for short notice absences. • There were no staffing related patient moderate or significant harms reported for July. Although there was a slight decrease in incident reporting of 30 related to nurse staffing. • An increase in staff absences was experienced at the beginning of July due to an increased in the volume of staff reporting in needing to isolate from the Track and Trace national system due to a Covid contact. This position improved with the change in national guidance for NHS workers on 19th July with staff following a risk assessment can in certain situations return.

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

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

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Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A	
Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position and short term sickness.																	

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

Introduction/Background

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

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

Issues and options

The provision of safe care and treatment
Staff support ongoing

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

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

The provision of staff support will continue to be a priority for the teams. It has been and will remain essential that the Trust to continue support through:

- Health and well-being support through telephone helplines and various counselling services.
- Re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements.
- The Trust is supporting a pilot for introducing Professional Advocate (PA) model known as A-EQUIP. This model will aim to provide opportunities for development of reflection and builds resilience through the provision of restorative supervision, empowering the development of personal action to improve quality of care as an intrinsic part of their role. A strategy will be provided in September 2021. Funding has been secured through NHSEI to train a further 12 nurses on the Professional Advocate course, and also with the use of

CPD funding a further 6 places will be allocated. The first group of Professional advocates have completed and passed their course.

Harms

There were 30 minor and insignificant patient harms reported for July 2021 over a variety of areas due to confused patients there have been no escalation of concerns through the wards daily safety huddles.

Good Governance

With the step down in command and control Covid 19 procedures the Senior Nursing, Midwifery and AHP team have moved to monthly meetings. There is a daily staffing escalation call to cover last minute sickness and the divisions work together to cover the staffing gaps with last resort escalation to off framework agencies. Demand for short term sickness absence has increased in month with also the additional Covid beds being created across the trust. There remains an assurance weekend staffing meeting held each week with the CNO and the monthly NWAG meeting.

Safe Staffing

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

An increase in staff absences was experienced at the beginning of July due to an increased in the volume of staff reporting in needing to isolate from the Track and Trace national system due to a Covid contact. This position improved with the change in national guidance for NHS workers on 19th July. Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where staff to do so.

Current Trust Position			What needs to happen to get us there	Current level of assurance
	Day % fill	Night % fill	All establishments reviewed 7/05/21 actions for July/August will be for final rotas to be updated by finance and sign off by CNO. Rotas due for Signoff at NWAG 17/08/21	**5**
RN	93%	98%		
HCA	97%	106%		

FROM THIS POINT ON THE DATA REMAINS IS AS June 2021

Vacancy trust target is 7% June position is 8.67%

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

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Division	RN/RM WTE	HCA WTE		
Speciality Medicine	27	-3	Increased RN and RM recruitment to reduce vacancies. Rolling adverts for specialities have been ongoing and recruitment of the student nurses since paid deployment has reduced the vacancy factor. Ensure HCA recruitment continues following the recruitment drive with HEE. International nurse recruitment – this will re commence from the end of August 2021.	4
Urgent Care	55	14		
Surgery	40	19		
SCSD	9	29		
Women'sand Children's	19RN 11RM	15		

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

- Inpatient wards have deployed staff and employed use of bank and agency workers.
  Vacancies numbers has led to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
  Urgent Care are currently carrying the majority of the RN vacancies but with active recruitment this will improve by September 2021.
  With the ongoing realignment of surgical services, a targeted recruitment campaign will be launched to support trauma and orthopaedics.

Recruitment International nurse (IN) recruitment pipeline

The first 25 nurses from the 20/21 business case arrived in Through March and April 21. International nurse recruitment was paused nationally due to the COVID 19 pandemic in India. This scheme of work has been restarted with the first arrivals due 16th August and will isolate now in trust accommodation. Below is the recruitment pipeline for the divisions with a September start date.

Division	International Nurses	Domestic Pipeline
Speciality Med	5	18
Urgent Care	2	19
Surgery	2	17
SCSD	1	18
Women's and children's	0	18

Domestic nursing and midwifery pipeline

7 RNA's have passed their academic interviews and will commence with Birmingham City University in September 2021, there may be a second cohort of RNA top ups in January 2022.
19 Nurse Associate Apprentices are due to commence a University of Worcester in September 2021.

Bank and Agency Usage

Trust target is 7%- Currently monthly 8.2% agency 6.82% bank

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

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Division	Bank	Agency		
Speciality Medicine	51WTE	40	Sign up to the TWS11 workforce solutions – adhere to agency cap rates in line with NHSI cap rates. Reduce agency % and in short term increase bank % until recruitment of substantive staff at 97%. HR to support divisions in retention work stream bespoke for N&M workforce flexible working strategies.	**4**
Urgent Care	64WTE	45		
Surgery	44WTE	32		
SCSD	44WTE	46		
Women's and Children's	26TE	11		

Sickness –

The Trust Target for Sickness is 4%, June position is 4.59%

Current Trust Position			What needs to happen to get us there	Current Level of Assurance
	Monthly	Stress related	Divisions to ensure Sickness reviews in place staff signposted to Health and wellbeing package of support. Sickness has increased in Divisions in month with an increase in stress related reports. Discussion in NWAG given increased risk and reports at clinical/divisional level for a request HR to provide weekly data to provide real time focus for hotspot clinical areas. Revisit to Communications of support services available.	**4**
Spec Med	4.61%	0.89%		
Urgent care	3.47%	0.85%		
Surgery	4.13%	0.65%		
SCSD	4.82%	1.43%		
W & C's	6.11%	2.50%		

Turnover

Trust target for turnover 11%. June is RN/RM 9.11% HCA 12.09%

Current Trust Position			What needs to happen to get us to there	Current level of Assurance
Division	RN/RM	HCA	HR to update retention policy – staff development in house for all staff groups Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3 – level 7 are available through the apprenticeship Levy.	**5**
Speciality Medicine	8.06%	13.03%		
Urgent Care	8.9%	11.3%		
Surgery	8.42%	9.27%		
SCSD	10.58%	12.33%		
Women's and Children's	6.8%	11.04%		

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

Recommendations

The Trust Board are asked to note:

- Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout July 2021 has been achieved, this was supported when required through the booking of temporary workforce for short notice absences.
- There were no staffing related patient moderate or significant harms reported for July. Although there was a slight decrease in incident reporting of 30 related to nurse staffing.
- An increase in staff absences was experienced at the beginning of July due to an increased in the volume of staff reporting in needing to isolate from the Track and Trace national system due to a Covid contact. This position improved with the change in national guidance for NHS workers on 19th July with staff following a risk assessment can in certain situations return.

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Midwifery Safe Staffing Report July 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	July 2021	
TME	18 August 2021	

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

Executive summary	This report provides a breakdown of the monitoring of maternity staffing in July 2021. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Unify data • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) • Sickness absence rates Throughout July it has remained challenging to maintain safe staffing levels due to sickness absence, COVID related absence and vacancies. Agency staff have been used when available and the team continue to provide additional shifts via NHSP. Incident reporting reduced this month with 23 red flag events reported in maternity resulting in no harm. There were no reports of women not receiving 1:1 care in labour. The escalation policy was enacted to maintain safe staffing levels. The

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	deployment of staff and the cancelling of non- clinical working days provided additional staff to maintain safe levels and provided appropriate mitigation. No role specific mandatory training was cancelled in month to support the clinical areas. Acuity was reported to be higher than the actual staffing levels in 61% of occasions throughout this period. This is a reduction in compliance on previous months and is due to the noticeable increase in COVID absence in month. A continuous recruitment programme remains in place for staffing in both inpatient and community. The 17 WTE midwives expected in September is being monitored closely to ensure that there are no avoidable delays in providing start dates. Start dates have been provided for a small number to commence in August which is ahead of the expected start date. Sickness absence rates continue to be higher than the Trusts target at 7.08% across all areas; this represents a sustained decrease in rates within the midwifery workforce. The directorate continue to work with the HR team to ensure that the excellent progress made to date continues. The level of assurance provided for safe maternity staffing is reduced to 4. The decrease in the level of assurance is based on increasing COVID related absence rates and a decrease in the ability to meet acuity in the intrapartum area. A higher level of assurance will be offered when the COVID related absence reduces, there are no vacancies recorded and the sickness absence rate is at the Trust target.

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

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

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'
- Unify data
- Daily staff safety huddle
- COVID SitRep (re -introduced during COVID 19 wave 2)
- Sickness absence rates

In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The next complete full Birthrate plus audit will take place in Autumn 2021; this has been delayed due to the company's capacity to meet demand following the recent introduction of the Ockenden recommendations. The six monthly report will be available to this committee in September 2021.

Issues and options

Completion of the Birthrate plus acuity tool (4 hourly)

Acuity of women is recorded in the tool every 4 hours (6 times per day). Acuity was reported to be higher than the actual staffing levels in 61% of occasions throughout this period. This is higher than June.

In the minority of cases (36%) a shortfall of 2 midwives (red) was reported in the intrapartum area and in 25% of cases a shortfall of one member (amber) of staff was recoded due to staff sickness and/or a midwife scrubbing in theatre. Staff were redeployed from other clinical areas to mitigate the risk. In 39% of the periods staffing either met or exceeded required staffing.

Following procurement of the new acuity tools it is anticipated that the tools will be available to staff by the end of quarter 2 and will report on staffing in all areas of the service.

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 July was 1:25 (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'

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Shift leader supernummary

All red flags continue to be reported via Datix until the implementation of the new and updated acuity tools are embedded. There were no reports that indicated that the shift leader was not supernummary in July.

One to one care in labour

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

Staffing incidents

There were 18 staffing incidents reported in July. No harm was recorded. The themes reported this month are:

- Availability of CoC midwives – ongoing work to improve reporting of availability.
- CMW on call availability and impact on workload
- In escalation and requirement to reduce antenatal ward and Triage to agreed minimum staffing levels to deploy staff to delivery suite to ensure that 1:1 care is provided and the shift leader remains supernummary.

Staffing levels were maintained at or above minimum agreed levels with the support of the on call community midwife and the continuity team midwives were also requested to provide cover due to the increase in COVID related absence. No harm was reported in this period however some reports were initially scored as minimal harm – further training is planned with the team to ensure that harm levels are appropriately recorded.

It continues to be acknowledged that any reduction in available staff can result in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and concern about staffing levels, burnout and staff health and well – being. A Trust psychologist is now working with the team to support staff wellbeing and initial feedback from the team has been very positive.

Medication Incidents

There were 5 medication incidents and no harm was reported.
The three incidents were due to:

- Additional doses of medication given before the appropriate interval
- No TTOs provided on discharge
- Omission in prescribing aspirin in the antenatal period
- Non administration of prophylactic Anti D

The remaining clinical red flags (as listed in the NICE Safe staffing guidance) can be reported on Safecare.

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Unify data

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

Whilst many of these rates fall below the 95% national target there is an additional six Continuity of Carer teams who provide care to 1200 women annually across the entire maternity pathway. This availability is captured on ERoster retrospectively and is not presented in the information provided below.

	RM Day	MCA Day	RM Night	MCA Night
Antenatal Ward	90%	90%	90%	92%
Postnatal Ward	76%	63%	89%	89%
Delivery Suite	88%	84%	84%	95%
Meadow Birth Centre	64%	90%	74%	92%

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This huddle is attended by the multi professional team and includes the unit bleep holder, Midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Director of Midwifery. Additional huddles were called with the senior team during this time period.

The maternity Unit Bleep Holder and the on call manger continue to join the Trust site meeting twice per day. This has facilitated escalation of any concerns and a greater understanding of the pressures within maternity services. The maternity team have also gained an insight into the challenges currently faced across our hospital services. The directorate team are now exploring the development of a daily SitRep for maternity services to ensure that information shared at the bed meetings is recorded.

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

The Divisional Management team have recommenced the COVID huddles due to the increasing community prevalence and admissions to hospital. The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels.

Sickness

The Division continues to work with our HR partners to obtain accurate sickness absence rates for midwives.

Sickness absence rates were reported at 7.08% in July which represents a significant decrease in sickness absence within the inpatient areas. The reason reported for the majority of absence continues to be recorded as 'mental health' or 'other'.

The following actions remain in place:

- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- A Trust psychologist is working with the team
- Signposting staff to Trust wellbeing offer
- Daily walk arounds by members/member of the DMT

Actions throughout this period:

- Monitor recruitment process to ensure timely commencement of newly appointed 17 WTE midwives at the Trust.
- Daily safe staffing huddles continued to monitor and plan mitigations and prepare to join site meetings.
- Work with the psychologist to provide staff support to improve health and wellbeing
- Develop service improvement plan and agree at Board
- All non-essential training and non - clinical working days were cancelled; ward managers were deployed to the clinical areas to support safer staffing levels as required throughout this period.
- Continue to work with HR to ensure that midwifery workforce data is correct and available.
- Maintain focus on managing sickness absence effectively.
- Continue to progress the development of the MSW programme.
- Identify further availability of agency midwives.
- Work with Birthrate Plus to expedite the completion of the staffing audit and implementation of acuity tools.

Conclusion

We have seen a decrease in the number of available staff throughout July alongside a lower than expected birth rate/activity. The primary reason for the decrease has been due to COVID related absence. Additional actions taken did provide appropriate mitigation to maintain safe staffing levels.

The availability of agency midwives has provided additional support to all areas of the service. There was a similar number of reported staffing incidents recorded in July and a decrease in reported medication errors.

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Redeployment of staff was required and requests to community colleagues to support the inpatient area. Continuity of Carer team support was also required in July.

Sickness absence rates have been reported at 7.08% which continues to demonstrate an improvement however it is noted that rates remain above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively. Workforce data is now routinely available for this group of staff and will support future workforce planning.

The prolonged reduction in available staff has resulted in increased stress and anxiety for the team and staff continue to report reduced job satisfaction and increasing concern about staffing levels, burnout and staff health and well – being; support is now available from the visible leadership team and a psychologist is now working alongside the team.

The level of assurance provided for safe maternity staffing in July is reduced to 4. The decrease in the level of assurance is based on increasing COVID related absence rates and a decrease in the ability to meet acuity in the intrapartum area. A higher level of assurance will be offered when the COVID related absence reduces, there are no vacancies recorded and the sickness absence rate is at the Trust target. It is anticipated that this will be achieved in September 2021.

Recommendations

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

Appendices

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Assurance levels March 2021

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc F2

Maternity Serious Incident Report Q1 2021/22

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

Accountable Director	Paula Gardner (Chief Nurse/ Maternity Safety Board Champion)		
Presented by	Justine Jeffery (Divisional Director of Midwifery & Nursing)	**Author /s**	Nicola Robinson (Divisional Governance Lead)

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
Divisional Governance	August 2021	

Recommendations	To note the Serious Incidents reported in Maternity in Q1 March – June 2021 contained within the report and the progress to date and learning from SIs that were reported in Q4. To share the findings with the LMNS as a minimum every 3 months as per the recommendations of the Ockenden report.

Executive summary	This report is to provide a summary of key issues & learning from all maternity Serious Incidents (SIs) reported during for Q1 April - July 2021. This is a national requirement following the publication of the Ockenden report in December 2020. During this period there were a total of 3 cases that met the criteria for reporting as a Serious Incident. All have been escalated and reported via the appropriate risk management process. One case has been referred to the Health Safety Investigation Branch (HSIB) and the remaining two cases will be investigated via the Trust SI process. Progress and learning from Sis reported in Q4 are also contained within the report.

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

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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						

Introduction/Background

In December 2020, the Ockenden Report was published and recommended the following:

- Trusts must work collaboratively to ensure local investigations into Serious incidents (SIs) have regional and local maternity system (LMNS) oversight. All maternity SI reports (and summary of the key issues) must be sent to the Trust Board and at the same time to the local LMNS for scrutiny, oversight and transparency. This is provided every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

This report provides a summary of all Serious Incidents (SIs) reported by the Maternity and Neonatal Directorates during April - June 2021. The Directorate will provide a report to the Trust Board every three months outlining all serious incidents, the progress of duty of candour and the report, themes (where identified) and any lessons learned.

The report will also include an update on progress of all Sis reported in the previous quarter.

There were three serious incidents reported in April – July 2021 which are outlined in this report.

Issues and options

- **Cases reported in Quarter 1**

Case 1

Web 155398 Incident date 12.04.21

Incident category – Unexpected maternal transfer to ITU

Not referred to HSIB as did not meet criteria reported as an SI 2021/7955

Case summary

A woman in her 3rd pregnancy appropriately booked for consultant led care at 11 weeks with a history of 2 previous Caesarean Sections (CS).

Diagnosed with gestational diabetes and commenced on metformin. Woman requested for a planned LSCS.

At 37 weeks admitted for sliding scale and steroids in preparation for planned CS. An uneventful CS was performed at 37+6 and baby born in good condition.

Admitted to the postnatal ward for routine care, maternal observations initially showed a low heart rate at 50bpm but were otherwise normal. Maternal heart rate increased on movement and by the evening, maternal heart rate was around 60-65bpm.

On mobilising, the woman collapsed. She remained conscious and appropriate resuscitation measures were commenced – reported chest felt tight and oxygen saturations 82% in air, 15L O2 given by rebreathe mask. ITU Consultant attended. Transferred to radiology for urgent CT chest, abdomen and pelvis. This confirmed bilateral PE's and she was commenced on twice daily Clexane®.

A MDT discussion took place to ensure that the most appropriate plan was followed. The agreed plan was for IV heparin and transfer to ITU for ongoing care. The woman was transferred to ITU at QEHB.

Following transfer the woman developed intra-abdominal bleed and had a return to theatre. No cause for the bleeding was identified and she was later transferred back to WAHT for the remained of her postnatal care.

Issues: LMWH not prescribed and therefore not administered.

Immediate Learning:

The initial dose of LMWH was omitted however it is unlikely that this would have avoided the development of the bilateral PE. LMWH is normally prescribed by the anaesthetist to commence in the immediate postnatal period – staff have been reminded to ensure that LMWH has been prescribed prior to transfer to the ward.

Duty of Candour completed at the time followed by a further call 19.04.21 and letter sent.

Discussed at QSRM 14.04.21

Taken to SIRG 12.04.21 agreed to escalate as an SI

Investigation ongoing completion expected 07.08.21 (60 working days)

Case 2

Web 158342 - Incident date 03.06.21

Incident category – Stillbirth

Not reported to HSIB as did not meet criteria (pre term) reported as an SI 2021/11933

Case summary

A woman in her 3rd pregnancy booked at 6+3 weeks gestation and noted to be GBS positive. No other obstetric concerns noted

Dating USS at 11+6 confirmed MCDA twins and she was referred to multiples clinic where a plan was made for the recommended USS surveillance.

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At 19+6 weeks gestation twin 1 was noted to have no fetal movements seen on USS and was referred to fetal medicine unit (FMU).

At 20+4 weeks gestation reviewed in FMU, an USS performed confirmed polyhydramnios and twin-to-twin transfusion syndrome was noted. Referral to BWH was completed for laser ablation which was performed two days later.

Five days following procedure an USS was performed and identified that one twin had sadly died in utero (recognised risk of procedure). An USS was completed for the surviving twin & referral for MRI was completed. The MRI identified mild ventriculomegaly @ 27+6 weeks. Care continued in the Fetal Medicine Unit with regular USS & liquor volume all within normal range.

At 31+4 weeks gestation the woman called Triage reporting reduced fetal movements. A cardiotocograph (CTG) was performed and the Dawes Redman criteria was not met however the CTG was incorrectly discontinued and following review by an ST5 she was discharged home.

She returned the following day 31+5 weeks gestation again reporting reduced fetal movements and sadly an intra uterine death was confirmed.

Issues:
It was agreed that on admission to triage at 31+4 the expected plan of care, given the complex history, delivery of the baby should have been undertaken at this time.

Immediate learning:

Development and implementation of fetal monitoring guideline in the antenatal period.

Parents have met with Consultant Obstetrician and Bereavement midwife, investigation briefly discussed DOC delayed due to distress experienced by family and completed at a more appropriate time.

Discussed at QSRM 10.06.21

Escalated to SIRG 07.06.21 agreed to escalated as an SI

Investigation ongoing completion expected 01.09.21 (60 working days)

<u>Case 3</u> (reported in Q1 occurred during Q4)

A 32 year old woman in her 2nd pregnancy (previous miscarriage in 2016), booked at 12 weeks gestation, Smoker and a low BMI 15.7 and appropriately referred for Consultant led care and also to smoking cessation service. Stopped smoking by 16/ 40. Patient did not speak English as first language.

Seen regularly throughout the antenatal period for regular growth scans, baby was breech so an elective LSCS was booked for 8th March.

Attended triage with spontaneous rupture of membranes (SROM) prior to planned date for surgery so an uneventful emergency CS was performed and the baby was born in good condition.

Breastfeeding was established on the ward. NIPE examination was performed and referral for hip USS was indicated – nil else noted.
Discharged home the following day and visited by the CMW as planned and no concerns were noted (father noted to be a smoker). It was reported that dad fell asleep with baby following nappy change. Mum woke in the early hours and found baby unresponsive, ambulance called and basic life support provided on transfer to A & E. Continued on arrival with advanced life support however decision made to withdraw.

Case referred to coroner and referred to HSIB.

No omissions in care identified on the initial case review, HSIB investigation draft report received on 6th August 2021 and no safety recommendations made within the report. Post mortem results confirm a sudden unexpected early neonatal death (SUEND).

	Incident Category	SI Declared	Referred to HSIB	DoC completed
Case 1	Maternal admission to ITU	Yes	Did not meet criteria	Yes
Case 2	Stillbirth	Yes	Did not meet criteria	Yes
Case 3	Neonatal Death	Yes	Yes	Yes

- **Update on Quarter 4 reported Serious Incidents**

	WEB Ref	Incident Category	Declared SI	HSIB referral	DOC completed	Progress to date/lessons learnt
Case 1	151907/ 152939	Pre term resuscitation issues	Yes	N/A	Yes	**Progress** Report approved at SIRG 24.05.21 awaiting closure by CCG. **Learning** Issues with oxygen cylinder identified and checking process confirmed- assurance of process confirmed during safety champion walk abouts. Antenatal assessment and referral to preterm clinic. GBS documentation
Case 2	152939/152897	Neonatal Death	Yes	N/A	Yes	**Progress** Report approved at SIRG 26.07.21 awaiting closure by CCG. **Learning**

						Antenatal pathway and earlier delivery indicated– new draft guideline currently out for comments
Case 3	153127	Intrapartum Stillbirth	Yes	Yes	Yes	**Progress** Final report received 03.08.21 action plan to be developed and submitted to SIRG 16.08.21. **Learning** Recommendation that clear guidance re when IOL is declined is included in the updated IOL guideline.
Case 4	154545	Pre term delivery	Yes	N/A	Yes	**Progress** 60 day deadline 07.08.21 extension agreed. **Learning** Preterm prevention pathway – changes made to booking process in Redditch & Bromsgrove implemented.
Case 5	154909	Shoulder Dystocia / cooling	Yes	Yes	Yes	**Progress** Final report received from HSIB on 03.08.21 action plan to be developed and submitted to SIRG 16.08.21 **Learning** Importance of fresh eyes. highlighted and relaunch of fresh eyes completed in July Escalation of concerns and loss of situational awareness noted – included in PROMPT training. Storage of placentas for later histology – required new SoP.

Conclusion

In conclusion there were 3 cases reported as Serious Incidents and confirmed at the SIRLG meeting. One of the cases met the criteria for referral to the Health Safety Investigation Branch (HSIB). Where indicated

immediate actions have been taken and disseminated. Themes identified are:

- Prescribing LMWH in the post - operative period
- Fetal monitoring in the antenatal period – new guidance and implementation underway led by fetal surveillance midwives
- Smoking cessation for all family members

Duty of Candour has been completed as appropriate.

The Serious Incidents reported in Q4 have progressed and actions identified to address safety issues identified throughout the investigation. Learning is shared via effective handover, private staff social media groups and at team meetings. Information boards to display learning from incidents, the local dashboard and other safety information are planned for all clinical areas and this is expected to be in place by the end Q2.

Recommendations

To note the Serious Incidents reported in Maternity in Q1 March – June 2021 contained within the report and the progress to date and learning from SIs that were reported in Q4.

To share the findings with the LMNS as a minimum every 3 months as per the recommendations of the Ockenden report.

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Paper number	Enc F3

Standing Financial Instructions and Scheme of Delegation - updated

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

Accountable Director	Robert Mackie – Interim Chief Finance Officer		
Presented by	Robert Mackie – Interim Finance Officer	**Author /s**	Lynne Walden – Head of Financial Planning and Financial Services Charlotte Ogden – Deputy Financial Accountant

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Audit and Assurance	13 July 2021	Approved

Recommendations	The Trust Board is requested to note the changes made to the Standing Financial Instructions and Scheme of Delegation as at July 2021 and noted below – this was approved at the Audit and Assurance Committee on 13th July 2021.

Executive summary	The purpose of this paper is to provide the Trust Board with the updated Scheme of Delegation (SoD) and the Standing Financial Instructions (SFI's).

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 7 - *If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.*

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

Financial Risk	As noted above – BAF 7

Action

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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						

Introduction/Background

The purpose of this paper is to provide the Trust Board with the updated Standing Financial Instructions (SFI's) and Scheme of Delegation (SoD).

The SFI's and SoD were reviewed and updated in July 2021. They were published on the Trust Intranet where all Budget Holders and Budget Mangers were asked to review and confirm (via the Voting Button on Outlook email) to evidence that they have been received.

The SoD and the SFI's are reviewed annually and amended as required.

Issues and options

The SFI's and SoD have been reviewed and updated in July 2021. Once approved, the intention is to publish them on the Trust Intranet with appropriate communications to all staff, including all Budget Holders and Budget Managers.

Budget Holders and Budget Mangers will asked to review and confirm (via the Voting Button on Outlook email) to evidence that they have been received and understood the SoD and SFI's. This was communicated in July, following approval by Audit and Assurance Committee.

Attached is clean copy version 6, Audit and Assurance Committee having reviewed the detailed tracked changes.

Areas of change are:

SFI's

– Section 7 – Annual Accounts and Annual Report
Additional paragraph added for the approval of the Trust's Charity Annual Financial Accounts and Annual Report

SOD's

- Section 4a – Income – Authorisation of credit notes (Healthcare Income) removed, included in 4d. Crediting of income.

- Section 4d – Crediting of Income – included limits and delegated authority by role

- Section 5 – Expenditure – Non pay expenditure – Added Chief Digital Officer to authorise requisitions up to £75k.

- Section 6 – Expenditure – Non pay expenditure – Under Financial Recovery – Added Chief Digital Officer to authorised requisitions up to £50k.

- Section 7 – Expenditure – Purchase Invoices and Other Payments – internal finance team only – Removed authorising salary sacrifice provider invoices – purchase orders now raised

- Section 7 – Expenditure – Purchase Invoices and Other Payments – internal finance team only – Added Business Service Authority – Early Retirement and Other

- Section 7 – Expenditure – Purchase Invoices and Other Payments – internal finance team only – Added Authorising of Bank Refunds

- Section 7 – Expenditure – Purchase Invoices and Other Payments – internal finance team only – Authorising of Credit Notes – added Financial Accounts Assistant up to £500.

- Section 10 – Procurement, Quotation and Tendering Procedures – amendment to the OJEU limit.

- Section 11 – Waiver Procurement Procedures - add payroll deductions payovers to not requiring a purchase order.

- Section 16 – Expenditure – Charitable and Donated Funds – added Expenditure on charitable and donated funds per request – fundraising only up to £7k.

- Section 16 – Expenditure – Charitable and Donated Funds Expenditure on charitable and donated funds per request – change of signatories.

- Section 16 – Expenditure – Charitable and Donated Funds Expenditure on charitable and donated funds per request – Added General Charitable Funds

- Section 19 – Losses, Write-off & Compensation – Losses, Bad Debts, Damage, Compensation & Stock – Added up to £10,000 Requests for Write-offs – Head of Financial Planning and Financial Services

- Section 19 – Losses, Write-off & Compensation – Losses, Bad Debts, Damage, Compensation & Stock – Added up to £10,000 Bad Debts (NHS & Non NHS) and Claims Abandoned including Private Patients, Overseas Visitors and Other – Head of Financial Planning and Financial Services

Conclusion
The SFI's and SoD is an integral part of the financial governance of the Organisation and as such it is important that they are regularly reviewed, and where necessary strengthened or

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clarified. The amendments proposed in this review have been identified through internal review, and the outputs of audit work.

Recommendations

The Trust Board is requested to note the changes to the Standing Financial Instructions and Scheme of Delegation as at July 2021, which were approved at the Audit and Assurance Committee on 13th July 2021.

Appendices

Scheme of Delegation – July 2021 v6 Final
Standing Financial Instructions – July 2021 v6 Final

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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 May, June, July and August 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						

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Introduction/Background

TME is the primary executive decision making body for the Trust. It is set up to drive the strategic agenda and the business objectives for the Trust. It ensures that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets.

Issues and options

Since my last report at the May 2021 Board, TME has met on four occasions on 19 May, 23 June, 21 July and 18 August 2021. This report covers all meetings.

May TME

Items presented which were then considered by the Finance and Performance Committee (May)

- Annual Plan Priorities 2021/22 including Workforce Planning Update
- IPR
- Financial Performance Report M1
- Contract Awards
- Allscripts Digital Care Record Change Notice extension
- DCR Programme Review

Items presented which were then considered by the Quality Governance Committee (May)

- IPC Update – May 2021
- Q4 Maternity SIs
- CNST
- Harm Review Panel
- Quality Account
- Safeguarding Adults and Children and Young Persons Annual Report

Items presented which were then considered by the People and Culture Committee (June)

- ICS update with a people and culture lens
- Safest Staffing Report - Adult/Nurse Staffing and Maternity Staffing
- People and Culture Directorate Annual Report

Other items

- Location by Vocation
- Visual Identity and Branding Guidelines
- Best People Programme Board Terms of Reference

June TME

Items presented which were then considered by the Finance and Performance Committee (June)

- Annual Plan Priorities 2021/22
- ICS Update
- UEC Business Case and Budget Update
- IPR
- Financial Performance Report M2
- Contract Awards

- Progress on Digital Infrastructure Strategy
- DCR Programme Review
- Digital Aspirant Business Case
- Business Case – Digital Pathology – Benefits
- Sale of Land

Items presented which were then considered by the Quality Governance Committee (June)

- IPC Update – June 2021
- Safest Staffing Report - Adult Nurse Staffing and Midwifery Staffing
- Maternity Service – Continuity of Carer Position 2021
- Bewick Review Update
- End of Life Annual Report
- Q4 Patient Safety Alerts Report
- Q4 Patient Experience Report

Items presented which were then considered by the Audit and Assurance Committee (July)

- Clinical Negligence Claims Annual Report
- Internal Audit Report 2021 – Charitable Funds (Final)
- Gifts and Hospitality Register

Other items

- Surgical Reconfiguration Project Overview
- Addendum to Private Patients Policy
- Paediatric Escalation Plans
- CNST
- Management of Charitable Funds
- AOS Business Case
- Scanners – CT1 Upgrade, WRH Business Case and CT3 Substantive Workforce Business Case
- Academy Update
- Flexible Workforce
- Fit and Proper Persons Annual Review
- Staff Thank You Day
- Report of the Information Governance Steering Group

<u>July TME</u>

Items presented which were then considered by the Finance and Performance Committee (July)

- Strategic Transformation and Annual Plan Priorities
- Financial Performance Report M3
- Contract Awards
- Mid Term Financial Plan
- DCR Programme Review
- IPR
- Review of SFIs/Scheme of Delegation

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Items presented which were then considered by the Quality Governance Committee (July)

- IPC Update – July 2021
- Safest Staffing Report - Adult/Nurse Staffing and Midwifery Staffing
- Clinical Policy Stocktake
- Harm Panel Review Update
- Complaints and PALS Annual Report

Items presented which were then considered by the People and Culture Committee (August)

- Recruitment and Retention Update
- 4ward Update
- Responsible Officer Report – Medical Appraisal and Revalidation
- Guardian for Safe Working

Items presented which had been considered by the Audit and Assurance Committee (July)

- Internal Audit Report 2020/21 – Financial Management and Reporting (Final)
- Internal Audit Report 2020/21 – Arrangements during COVID – 19 in support of the Head of Audit Opinion

Other items

- AOS Business Case Benefits Realisation
- CT1 Upgrade, WRH Business Case Benefits Realisation
- Children's RSV Surge Planning Update – Plan in ICS Context
- Outpatients High Impact Changes
- Maternity Service Improvement Plan
- COVID Command and Control Structure Phases 11 and 12
- Single Improvement Methodology Service Specification
- Board Assurance Framework
- Trustwide Use of Mechanical Nebulisers
- Escalation Management Policy
- Update on Holistic PTL Programme
- HR Policy Review
- Corporate Risk Register Assurance Levels
- HSE Investigation

<u>August TME</u>

Items presented which were not considered by a Board Committee as meetings were cancelled in August.

- Escalation Management Policy Update
- ICS Update
- COVID-19 – Longer View Report
- West Midlands Imaging Network – Memorandum of Understanding
- Transformation Guiding Board – Terms of Reference
- Transformation Guiding Board Update
- Estates Strategy
- Children's RSV Surge (Internal Operational Plan)
- IPR

Worcestershire Acute Hospitals NHS Trust

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- IPC Update – August 2021
- Safest Staffing - Adult/Nurse Staffing and Midwifery Staffing
- Maternity SIs
- Update on MBI Healthcare Data Integrity Recommendations
- Bed Spacing Report
- Financial Performance Report M4
- Contract Awards
- ED Consultant Business Case
- Standards Of Business Conduct Policy
- Report of the Information Governance Steering Group

Conclusion
Recommendations
The Trust Board is requested to receive this report for assurance.
Appendices - None

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc F5

Audit and Assurance Committee Annual Report

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

Accountable Director	Anita Day Audit and Assurance Committee Chair		
Presented by	Anita Day Audit and Assurance 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	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
Audit and Assurance	13 July 2021	Approve

Recommendations	To receive the Audit and Assurance Committee Annual Report

Executive summary	The report outlines the key activity undertaken by Committee during 2020/21. There are no areas or matters of concern to report and the report is consistent with the Annual Governance Statement and Head of Internal Audit Opinion. If approved, the report will be referred to the Board in September.

Risk			
Which key red risks does this report address?	*N/A*	**What BAF risk does this report address?**	*All as the report reflects upon the breadth of Committee's activity*

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

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		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**Annual**					

Worcestershire Acute Hospitals NHS Trust

Audit and Assurance Committee Annual Report

For the year 1 April 2020 - 31 March 2021

1 Introduction

The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes. The Committee also reviews the effective working of the other Board subcommittees.

In order to discharge this function, the Audit and Assurance Committee is recommended to prepare an annual report for the Board and Accountable Officer. This report includes information provided by Internal Audit and External Audit.

2 Audit and Assurance Committee's Opinion

Members of the Board should recognise that assurance given can never be absolute. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

3 Information Supporting Opinion

Summarised below is the key information/sources of assurance that the Committee has relied upon when formulating its opinion.

3.1 Internal Audit

At each of its meetings the Committee receives a report from Internal Audit, detailing their work since the last report.

At its meeting on 9 June 2021, Committee received the Internal Audit Annual Report for the 2020/21 financial year, which incorporated a summary of all work undertaken throughout the financial year, and the Head of Internal Audit Opinion.

The Head of Internal Audit's overall opinion for 2020/21 is that **significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

The basis for forming the opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and managements progress in respect of addressing control weaknesses.
3. Any reliance that is being placed upon third party assurances.

The COVID-19 pandemic necessitated changes to the internal audit plan and the means by which it was delivered. It was determined as part of the revision to the plan, the minimum audit coverage required to provide an unfettered Head of Internal Audit Opinion.

The Head of Internal Audit reviewed the way in which the Board identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. This was undertaken by reviewing the Assurance Framework documents and by giving consideration to the wider reporting to the Board that informs its assessment of the effectiveness of the organisations the system of internal control.

In respect of the Assurance Framework, the Head of Internal Audit stated:

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2020/21 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The Opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2020/21 was developed to provide the Trust with independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this our internal audit plan was divided into two broad categories; work on the financial systems and then broader risk focused work driven essentially by principal risk areas.

The assurance levels provided for all reviews undertaken is summarised below:

Full Assurance
- BAF

Significant Assurance
- Health & Safety Follow Up
- Financial Assurance Review (Creditors, Debtors, Financial Ledger, Treasury Management &
- Contracted Out Payroll)
- Financial Management & Reporting Arrangements*
- Sickness Management*

There were no reviews where moderate, limited or no assurances were reported. Other reviews to highlight included Covid-19 governance and Data Security and Protection Toolkit and no issues were raised in respect of internal control measures.

3.2 External Audit

The Trust's external audit is provided by Grant Thornton, who have attended all Audit and Assurance Committee but one meeting during the year. The Audit Findings Report was received on 9 June 2021. The Auditor's Annual Report in relation to value for money is delayed as a result of the Covid-19 pandemic. The audit was completed and the audit opinion issued before the deadline specified by the Department of Health.

Grant Thornton issued a modified audit opinion/qualification of the accounts. This is due to the limitation of scope in relation to stock which was a roll over from the issues experienced in 2019/20 where as a direct consequence of the lockdown imposed by

the Government in March 2020, a visual check of inventory could not be undertaken thus this applies in 2020/21 due to comparator issues. The auditor's opinion on the financial statements remains unmodified in all other respects.

Grant Thornton referred the Trust's financial position to the Secretary of State under section 30 (Local Audit and Accountability Act 2014) taking into account the statutory duty to break even.

Due to Covid-19, there was no requirement for an opinion on the Trust's 2020/21 Quality Account.

Progress and update reports have been presented to each Audit and Assurance Committee meeting during the year providing committee members with an overview of progress with the 2020/21 audit and highlighting issues in the wider Health environment. This includes briefings on Grant Thornton's national report on Health sector issues.

Grant Thornton have also run a variety of workshops and seminars during the year which Trust representatives have attended.

3.3 Other Assurance Providers

3.3.1 Head of Counter Fraud

Regular reports were received from the Head of Counter Fraud and the Committee is satisfied that the Trust has complied with relevant guidance and directives. There were no significant frauds detected during the year.

3.3.2 Management

The Committee has considered assurances provided by the Chief Executive, Chief Financial Officer and other Directors in the Communication with the External Auditors. It has also considered the Annual Governance Statement provided by the Chief Executive. The Committee has noted that there were six significant control issues listed in the Annual Governance Statement.

4. The Role and Operation of the Audit and Assurance Committee

4.1 Membership of the Committee

The Members of the Committee during the period of the report were as set out in the Trust Board section of the Annual Report where a full disclosure of interests is also set out.

The Company Secretary ensures that the Committee functions in accordance with its Terms of Reference. The Committee was supported administratively during the year by the Company Secretary.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet at least 4 times a year. Seven meetings took place during the period April 2020 to March 2021. The attendance register is as set out in the Trust Board section of the Annual Report.

The quorum for meetings of the Committee is 2 members and all meetings held were quorate.

4.2.2 Work Programme

The Committee is satisfied that it has covered all work planned as outlined in the work programme.

4.2.3 Key Business Considered by the Committee during the year

The Committee:

a) Received assurance from the internal audit on the design and operation of the Board Assurance Framework and associated process to support the Trust's AGS.
b) Approved the 2020/21 Annual Accounts and Annual Report, recommending to the Board that these be received.
c) Reviewed and approved instances where the Waiver to Tenders procedures has been applied ensuring satisfactory explanation as to why.
d) Reviewed the Internal Audit work plan for 2020/21 and has emphasised to management, its requirement to be involved in the development of the areas to be included in the programme.
e) Reviewed progress on implementation of actions agreed through audit recommendations.
f) Reviewed the risk management system
g) Received assurance on keys areas of risk including data security and data quality
h) Received the findings of an anonymous online survey to facilitate the review of Committee self-effectiveness.

5. Conclusions

Based on the information presented and discussed at the Audit and Assurance Committee meetings during the year we have concluded that:

5.1 Board Assurance Framework (BAF)

The Assurance Framework has been reviewed by the Audit and Assurance Committee and full Board during the year. The Committee are satisfied that the process to update and manage the BAF is robust.

5.2 Governance Arrangements

The Audit and Assurance Committee has monitored the work of other Board Committees. Chairs of the committees accountable to the Board have attended the Board to present their work and to discuss their effectiveness. We are satisfied with the operation of the Committees. Further reviews of effectiveness will be undertaken by Committee as to the ongoing impact of Covid-19 on the Trust's business.

The Annual Governance Statement was reviewed by the Committee during April and May 2021.

6. Recommendation

To receive the Audit & Assurance Committee Annual report for assurance.

Anita Day
Audit and Assurance Committee Chair

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc F6

Audit and Assurance Committee Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 13 July 2021. The following key points are escalated to the Board's attention: **1. Internal Audit Plan** Committee received reports with findings of significant assurance in relation to Charitable Funds and Financial Systems and Payroll. Management actions are in place for all recommendations. **2. External Audit** The final audit certificate had not yet been issued due to Value for Money (VFM) reviews being delayed nationally due to Covid. The National Audit Office extension is in place until 20 September 2021. **3. Board Assurance Framework** Committee had a detailed discussion in relation to the development around the Board Assurance Framework following a series of Committee risk workshops. The overall summary position was the Trust's risk exposure was increasing across all areas. Levels of assurance are being applied to all risks which would be monitored and tracked. **4. Standing Financial Instructions and Schemes of Delegation** Committee recommended approval of the same by the Trust Board. **5. Sustainability** Committee requested executive leads be identified for sustainability, social inclusion and talent management where not already in place.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc F6

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						