Foundation Trust (foundation group member)		**Cleaned with:** Clinell Universal Wipes or Tristel **Frequency:** Frame is cleaned daily and underneath weekly. In line with National Standards of Healthcare Cleanliness 2021 **Discharge cleans** : **Non infected**: Encourage Tristel, but more frequently Clinell Universal wipes are being used **Infected** Tristel + fogging if C.diff or CPE etc.	This reduction is largely due to AMS and a revised antimicrobial guideline for Frailty and ward rounds.
Sandwell and West Birmingham NHS Trust	No	Beds are cleaned within the ward environment **Cleaned with:** ChlorClean or Clinell wipes by ward staff. In an infectious patient then is done by Support Services. **Frequency:** Bed Base and frames done daily by Support Services Staff using General Purpose Detergent. **Discharge cleans:** **Non infected**: By ward staff on the ward using ChlorClean or Clinell wipes – all surfaces. **Infected –** ChlorClean by Support Services – all surfaces.	Over trajectory
The Dudley Group of Hospitals NHS Foundation Trust	No	Beds are cleaned within the ward environment Cleaned daily **Non infected Discharge infected** Facilities full clean either Amber and Violet.	Over trajectory
The Royal Wolverhampton NHS Trust	Yes	SOP requested	Over trajectory
Walsall Healthcare NHS Trust	No	**Cleaned with:** Clinell routinely(nursing)/ chlorclean routine (domestic) **Frequency:** Frame daily, underneath weekly. **Discharge cleans** : (attached matrix)	Over trajectory

		Non infected: chlorine and detergent **Infected:** Amber Tristel, Violet UVC, Red Hydrogen peroxide	

Note: the two Trusts who have dedicated bed cleaning facilities are still over trajectory for C.Diff cases, however as outlined in this paper there are many other factors that need to be considered over and above bed cleaning practices.

From completing the bench marking exercise **we have ascertained that the Trust is not an outlier for not having a bed cleaning facility.** Four other trusts do not have a facility and clean beds within the ward environment. We are not an outlier for being over trajectory as there is only one Trust: South Warwickshire University NHS Foundation Trust who are currently under trajectory, and they do not have a bed cleaning facility.

5. Other Considerations

Inadequate bed cleaning (at clinical base level) is one of the reasons that we are seeing more cases than other Trusts. The use of bed pan washers at the Worcester site is believed by the IPC team to be another reason. The Worcester site has far more cases of C.diff than the Alexandra hospital site. The Alexandra site has bed pan macerators and Worcester has bed pan washers which frequently breakdown, soiled bed pans are frequently cited in IPC audits. Since November 2022 there has been an open action to commence a bed pan macerator trial at WRH. A DAF is now in place to progress this work, if the trial is a success (drains on site can manage use) then a capital bid will be required to expand bed pan macerator use at the site. Another factor is Antimicrobial Stewardship, South Warwickshire University NHS Foundation Trust is under trajectory for C.diff cases. To date only having 7 cases against a trajectory of 28 they have introduced a frailty guideline for antibiotic prescribing which includes AMS ward rounds.
Electronic patient prescribing is not yet in place at the Trust, when this is implemented this will enable the targeting of resources to areas who are noncompliant against prescribing guidelines. Due to the extreme staff constraints ward rounds to review antibiotic prescribing is not currently completed (apart from ITU).

6. Education and training of clinical staff focus required.

Infection prevention and control are in the process of recruiting more trained nurses for link practitioner roles, as currently there is greater representation from ward assistants and healthcare support workers. This will be monitored as part of the Trust fundamentals of care Committee.

IPC fundamentals of care were launched at the start of September 2023 at Infection Prevention Link Nurse days which focused on practical education and demonstrations on how to decontaminate bed frames during green cleans, noting the hard to reach places, which have been common failures on audits. There were also demonstrations of how to clean Mattresses and commodes. More practical sessions are planned.
Compliance of clinical cleans will continue to be monitored via the Micad audits reported via Patient Experience Oversight Group and TIPCC. As well as IPC audits.

7. Options

1. To remain as current practice :

Daily clinical clean and weekly facilities cleaning of beds in the ward environment in line with national cleaning standard frequencies.
To improve cleanliness of beds, a focus on clinical staff education regarding responsibilities of clinical staff green cleans and daily /weekly bed cleaning and how to clean is required. The need for wards to keep hold of their own beds and ensure daily and weekly cleans are completed along with the critical discharge green cleans-documented through the use of the bedspace check list.

2. Introduction of a Dedicated bed cleaning team

The introduction of a dedicated facilities led bed cleaning team to complete all routine bed cleans: daily and weekly cleaning of beds. The team would clean the beds using Tristel chlorine dioxide which is sporicidal and active against C.diff spores. Green clinell wipes which are used by the clinical team are not effective against C.diff spores (they will remove C.diff spores through the physical act of cleaning but will not deactivate them). The team would also complete discharge full cleans of beds (infected and non-infected) using Tristel. By having a dedicated team to clean which focus totally on bed cleaning will release nursing time to care for patients. This option will require Divisions to identify funding.

3. Dedicated bed cleaning facility

To have a bed decontamination facility at each hospital site. Initial feasibility studies have been undertaken which suggest that significant capital investment costs between £1.5 million and £3 million would be required. However, a location is still not identified on both the Redditch and Worcester sites which will potentially increase the costs. Space is a premium particularly on the Worcester site and the cleaning facilities would need to be linked to main site buildings. This option will require a Capital bid to identify funding. Bed cleaning facilities are not included within the Capital Prioritisation List.

8. Chief Nursing Officer/Director of Infection, Prevention and Control recommendation:

Given the outputs from the benchmarking exercise and the sustained non-compliance of clinical cleans from ward and department staff the Chief Nursing Officer's recommendation is that the Trust focusses on the education of clinical teams regarding their ward ownership of beds, their cleaning responsibilities, use of bed space check list and that assurances are sought through peer review checks of bed cleanliness on top of current assurance processes with Infection, Prevention and Control and Micad audits.

In parallel, the learning from South Warwickshire will be explored further in relation to AMS and the outputs from the macerator trial will also be considered and appropriate actions taken depending on the outcome of the results.

If there is no improvement in bed cleaning audits over the next 6 months then the option of a dedicated bed cleaning team will be considered, however the ward and department teams will need to consider how such a team would be funded out of existing resources.

Worcestershire Acute Hospitals NHS Trust

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The Chief Nursing Officer will be reviewing the current C-Diff action plan with the IPC team and NHSE to ensure that the actions included within the plan are conducive to the Trust reducing C-diff cases.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc H

Accountability Framework

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

Accountable Director	Helen Lancaster, Chief Operating Officer		
Presented by	Chris Douglas, Director of Performance	**Author /s**	Chris Douglas, Director of Performance

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
Trust Management Executive	23 August 2023	Approved
Finance & Performance Committee	27 September 2023	Approved
Audit & Assurance Committee	28 September 2023	Approved

Recommendations	Trust Board is asked to: • Note the adoption and implementation of the Performance and Delivery Accountability Framework • Agree a period of concurrent running of Finance and Performance Committee and, Finance and Performance Executive

Executive summary	Robust oversight and assurance through system and processes provide a foundation for accountability of effective performance management and operational delivery. A key element of the Trust's approach is a robust performance and delivery accountability framework, which puts our commitment to Putting Patients First at the centre and enabled effective accountability inside a compassionate and inclusive culture. The framework supports a Ward to Board assurance approach across four domains – operational delivery, quality, workforce, finance and is reliant on the annual business planning cycle to agree priorities and objectives which the Trust, Divisions and individual services will be enabled to deliver. The framework is underpinned by eight principles which support a data driven approach with clear lines of accountability and empowerment, with a proportionate and balanced focus on delivery. The Framework is based on five elements which operate in a cycle:

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	• Clear targets and expectations linked to planning requirements and the NHS Oversight Framework • Effective Monitoring • Meeting Arrangements • Good Performance Conversations • Feedback and Outcomes The Framework established a new Finance and Performance Executive, to replace our existing Divisional Performance Review Meetings, as well as additional delivery groups for Trust-wide focus on two of the Trust's priorities of Hospital Flow and, Elective and Cancer recovery It provides the opportunity for more freedom and autonomy to be delegated to Divisions and teams (within agreed limits and Trust policies) and recognises the need for effective support to enable the Trust to deliver.

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

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

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

Effective performance management, and associated accountability for performance and delivery are foundation of a high performing culture – where teams and individuals are clear on their roles and responsibilities and the expectations placed upon them by the Trust.

A performance and accountability framework supports the Trust to ensure that clarity and sets out the systems and processes that the organisation uses to ensure that there is effective performance management and accountability for delivery from services to Divisions to Trust Board.

The Trust recently established a Director of Performance post, which has provided an opportunity for a review of the Trust's approach to performance and delivery accountability, which has resulted in a revised Performance and Delivery Accountability Framework.

Situation and Proposal

Current Situation

The Trust priorities for Hospital flow, Elective and Cancer Recovery, and financial sustainability represent a significant challenge for the organisation. This is demonstrated in our segment three rating against the NHS Oversight Framework, legal undertakings remaining in place and our placement, as a Trust, in tier 1 for Cancer Recovery and tier 2 for Elective recovery and, as a system, in tier 2 for Urgent an Emergency Care. Additionally, as part of an ICS, with enhanced financial controls in place due to the submission of a deficit plan.

As such there is increased external scrutiny of our organisational performance and a clear expectation of performance improvement and delivery of the annual planning requirements (which would support reallocation to segment two of the NHS Oversight Framework and compliance with legal undertakings).

There is a clear expectation on clinical divisions to deliver commitments made in the Trust's annual planning submission and on corporate teams to support and enable delivery though there are limited opportunities for divisional and corporate team to come together to focus on delivery of key organisational priorities of Hospital Flow and Elective and Cancer delivery, which may limit the development and delivery of these priorities and by extension, the ability of the Trust to progress to segment two of the NHS Oversight Framework or compliance with legal undertakings.

The Trust currently has in place a set of executive-led meetings through which Divisions are held to account for their performance. These are known as Performance Review Meetings (PRMs). Historically, these meetings are chaired by the Chief Operating Officer and attendances from other members of the executive team has been limited, due to the previous scope of these meetings. Discussion has often focussed on operational performance and finance, with limited discussion on quality and safety, or workforce. Divisional teams are engaged in this approach though have recognised the opportunity to make improvements to enable Divisional and organisational success though there is variability in the Divisional approach to Directorate performance review meetings but good practice is being shared.

Proposal (full details are included in the draft framework in the separate paper)

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A revised Performance and Delivery Accountability Framework has been developed. This sets out a clear framework which provides a clear system for the monitoring and management of the delivery of divisional and departmental objectives, which will enable organisational success – by improving performance we ultimately delivery better outcomes for patients and the best services we can for our local population.

The framework is designed in line with our signature behaviours:

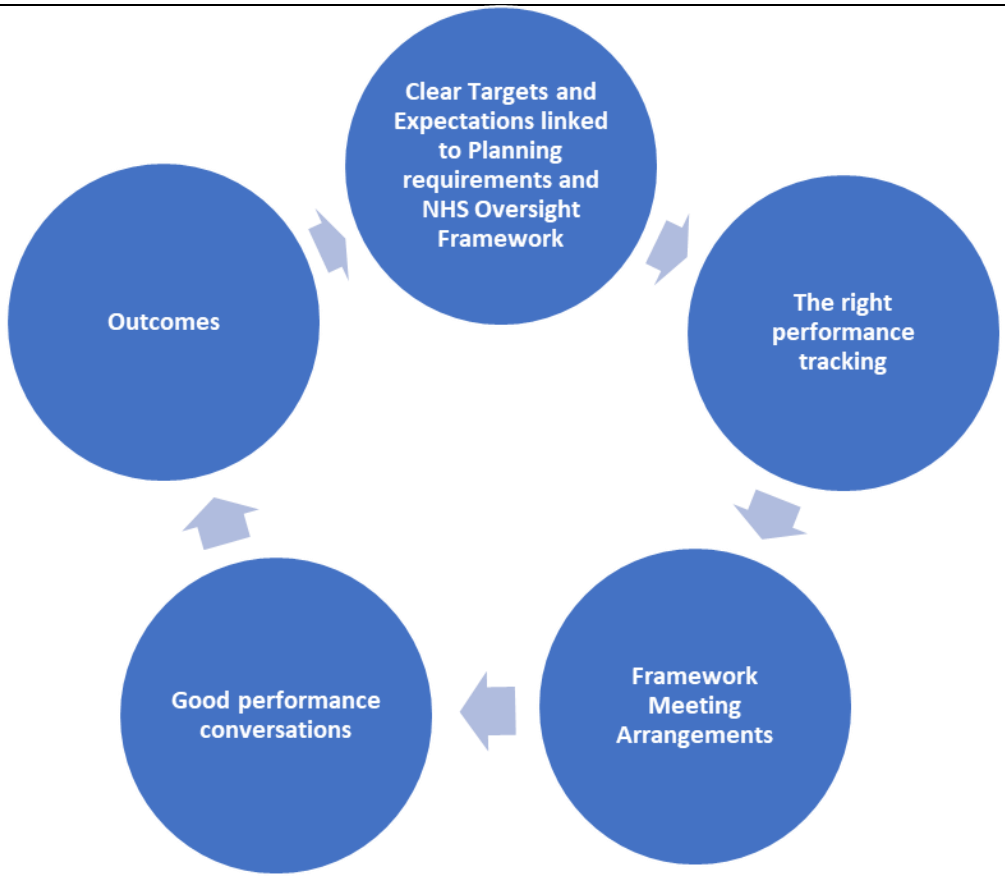
- Do what we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together

And is underpinned by a set of principles, which support a consistent, robust approach to the way performance and delivery is managed, monitored, communicated, reviewed and reported:

- Data Driven – we make evidence based decisions using sufficient, available intelligence to understand drivers for our performance and plan our delivery
- Clear lines of accountability – from board to individual and back again, through clear objectives
- Empowerment with accountability
- Compassionate leadership – listening, understanding and enabling are key to success
- No Surprises – openness and transparency are key – we work together to solve challenges early
- Critical friends – we challenge each other, no matter our role, in a constructive and professional manner, recognising the values of every individual
- Delivery focus – integrated, action oriented focussing of delivering improved performance sustainably
- Proportionate and balanced

The Framework sets out the role of key individuals, teams and more formal groups in relation to performance management – being clear on accountability, responsibility and authority

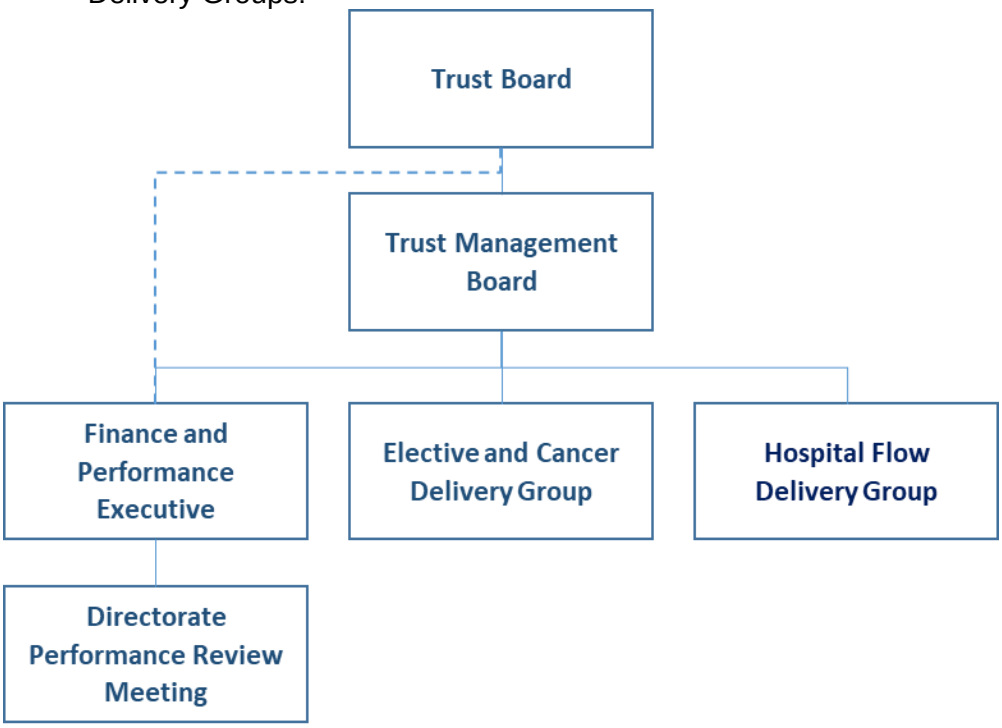
The Framework is built around a five-stage cycle:



1. <u>Clear Targets and Expectations linked to Planning Requirements and NHS Oversight Framework</u>
    - Objectives and priorities will be agreed through an effective annual business planning cycle, which will ensure the alignment of Trust, divisional, departmental and individual objectives (the latter in line with the relevant workforce policy) that contribute to the delivery of the Trust's objectives.
    - Where appropriate, Delivery plans will be developed to support the operational management of delivery and will form the basis for accountability conversations

2. <u>Effective Monitoring</u>
    - Effective use of data and information are core component
    - Use data and information to monitor and assess delivery of objectives and key results but also to understand drivers for performance, which support development of effective, achievable deliver plans
    - Use data and information to forecast and therefore enable delivery plans to mitigate forecast underperformance or, reallocate resources where over performing
    - Single Integrated Performance Report format for Trust, Division and Directorate level supported by comprehensive data pack, aligned to Foundation group model where appropriate.

3. Framework meeting arrangements
   - This is the backbone of how the governance of accountability for delivery is managed throughout organisation
   - New framework will disestablish Divisional Performance Review Meetings and establishes a Finance and Performance Executive, alongside two other Delivery Groups:



   - The two proposed delivery groups enable executive-led discussion and oversight of delivery of two organisational priorities.
   - Draft terms of reference for Finance and Performance Executive, and the Delivery Groups are available in the appendices of the draft Framework.
   - These new groups will be supported by existing organisational committees, programme boards and groups which focus on quality and safety, workforce and finance.

4. Good Performance Conversations
   - Performance and accountability conversations would align to the principles of compassionate leadership and the Trust's signature behaviours, and the principles set out in the Framework.
   - It is the responsibility of those that are accountable to account for the performance delivery of the relevant areas of accountability and ensure the necessary plans are in place.

5. Outcomes and Feedback
   - Delivery of agreed objectives, alongside assurance of delivery of action and the Trust's seven levels of assurance will inform the allocation of each Division

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and Directorate to one of four tiers with tier one being high performing and tier 4 experiencing significant challenge.

- The tier will determine the level of autonomy for decision making as well as level of scrutiny and bespoke hands-on support in place.
- Where support is required, the specific support will be agreed with the leaders of the area in tier three or four.

Conclusion

To support and enable delivery of Trust objectives, it is important that the Trust develops high performing culture, with clear objectives and accountability for deliver. To enable a consistent approach that demonstrates the Trust's commitment to delivering its objectives, including operational planning commitments and the requirements of the NHS Oversight Framework, a revised Performance and Delivery Accountability Framework is proposed that will support and enable delivery as well as the necessary accountability from board to ward and back again.

Recommendations

- Approve the adoption and implementation of the Performance and Delivery Accountability Framework
- Agree a period of concurrent running of Finance and Performance Committee and, Finance and Performance Executive

Performance and Delivery Accountability Framework

Version:	0.5
Name of Author	Chris Douglas, Director of Performance
Name of responsible committee	Finance and Performance Committee
Date issued for publication	
Review Date	March 2024
Expiry Date	
Target Audience	Members of Trust Board and its subcommittees; Trust Management Executive Divisional Management Teams Directorate Management Teams Corporate Services Functions
Relevant CQC Standards	All

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PERFORMANCE AND DELIVERY ACCOUNTABILITY FRAMEWORK

Introduction

Successful delivery of our Trust commitments is key to Putting Patients First. These commitments are part of how the Trust will achieve its vision of Working in partnership to provide the best healthcare to our communities, leading and supporting our teams to move 4ward. These commitments include the delivery of our Trust operational plan (in response to NHS England Operational Planning guidance) as well as standards set out in the NHS constitution and in line with the NHS Oversight Framework and Care Quality Commission (CQC). Where applicable, additional locally agreed standards will form part of the framework.

All colleagues are accountable for delivering the best, safest, most compassionate care we can, in the most effective and sustainable way possible. This is dependent on a clear understanding of individual and collective roles and responsibilities, clarity on priorities and training and development to ensure colleague have the capacity and capability to succeed.

To achieve excellence, the colleagues must embrace individual and collective accountability inside a compassionate and inclusive culture.

A robust Performance and Delivery Accountability Framework ('framework') forms part of the foundation of effective governance, through an integrated Trust wide approach to the management of delivery of our Trust priorities, through Divisional and Departmental objectives enabled through the delivery of robust annual delivery plans aligned to our four strategic objectives:

- Best Services for Local People
- Best Experience of care and outcomes for our patients
- Best Use of Resources
- Best People

This Framework sets out the Trust's integrated approach from service level through our Clinical Divisions and Corporate teams, to Trust board. It details the Trust's internal mechanisms for the effective monitoring and management of delivery that will contribute to the success of the Trust and form the basis for internal and external assurance. It does not define specific divisional or departmental objectives, which should be covered as part of the Trust's Business Planning cycle.

Success is dependent on compassionate leadership, aligned to our 4ward signature behaviours

- Do what we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together

It is designed to provide a consistent approach to the way performance and delivery is managed, monitored, communicated, reviewed and reported at all levels in the organisation. The aim of improving performance is ultimately to deliver better outcomes for patients and the best services that we can.

Purpose and Principles

The purpose of the Framework is to provide a clear system for the monitoring and managements of the delivery of Divisional and departmental objectives, which enable the delivery of the Trust's strategic objectives. The framework is underpinned by a set of core principles and organisational structures that will enable the organisation to deliver a consistent approach to performance and delivery management from service level to Board. It enables the organisation to provide effective assurance to the Board, stakeholders and the public that the organisation has strong systems in place to govern delivery of the highest standards of regulatory care.

The framework is underpinned by the following principles:

- **Data Driven.** The effective use of available data drives our planning, delivery and response. We make evidence based decisions using available intelligence. We use data and intelligence to understand our performance, its drivers and therefore are able to proactive manage delivery through understanding the past and forecasting the future, including effective demand and capacity modelling and planning.
- **Clear lines of accountability**. There are clear lines of accountability from the Board to the individual and back again, through clear, agreed objectives aligned to Trust strategic objectives and organisational priorities. Performance management arrangements will ensure that all parties are clear where lines of accountability lie.
- **Empowerment with accountability**. Our workforce has access to the right tools to enable them to deliver their objectives, and therefore contribute to the success of the organisation. Sustained delivery may lead to increased autonomy, persistent non-delivery may lead to increased escalation.
- **Compassionate leadership**. Listening and understanding are key to enabling success. We work together to support and enable teams to deliver their objectives.
- **No surprises**. Openness and transparency are key – we work together to solve challenges, responding early.
- **Critical Friends**. We challenge each other in a constructive, professional manner, recognising the value that different perspectives may bring to enabling delivery.
- **Delivery focus.** The performance management approach is integrated, action oriented and focussed on delivering improved performance, whilst considering the impacts on finances, workforce and quality
- **Proportionality and balance:** Performance management arrangements will seek to ensure that performance management interventions and actions are proportional to the scale of the performance risk and that a balance between challenge and support is maintained.

Roles and Responsibilities

Name	Role regarding performance management
Divisional triumvirate	Accountable for the delivery of Divisional objectives, as agreed in line with this Framework. Accountable for the monitoring and management of performance and delivery of Divisional Annual Plans, as agreed through the Business Planning Cycle Responsible for implementation of Trust-agreed initiatives to support the delivery of performance and delivery improvements as directed Responsible for the delivery of Divisional actions agreed through the mechanisms set out in this Framework Authorised to make management decisions within the scope of their division's remit, in line with the Trust's governance framework and SFIs which support and enable delivery of Divisional objectives Responsible for the implementation of this framework, with specific regard to Directorate Performance Review Meetings and the active participation in other associated

Name	Role regarding performance management
Information and Performance Team	Responsible for provision of relevant and timely analysis and interpretation of performance data to inform Divisional and Executive decision-making, performance and delivery management, and operational management. Responsible for the provision of information to support the implementation of the Framework, as agreed with the Director of Performance in partnership with Executive leads.
Chief Executive	Accountable, on behalf of the Board, for ensuring that the requirements of the Performance and Delivery Accountability Framework are appropriate and meet the needs of the Trust and its strategic objectives.
Managing Director	Responsible, on behalf of the Chief Executive, for ensuring that the requirements of the Performance and Delivery Accountability Framework are appropriate and meet the needs of the Trust and its strategic objectives Accountable for ensuring the implementation, adoption and review of the Framework
Chief Finance Officer	Accountable for the Trust's financial strategy and planning including delivery of the financial position. Accountable for deliver relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework
Chief Operating Officer	Accountable for operational performance of the Trust. Accountable for Trust-wide improvement action plans as they pertain to operational delivery, including but not limited to, independent reviews and regulatory requirements. Accountable for delivery of relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework.
Director of Performance	Responsible for ensuring systems and processes are in place for the effective monitoring and delivery of the Framework, therefore enabling operational and strategic objectives to be met. Provides direction on the development, production and distribution of integrated performance reports aligned to this framework including for Trust Board and, Finance and Performance Executive, working with executive and non-executive leads.
Chief Medical Officer and Chief Nursing Officer	Accountable for driving professional accountability in delivering Trust and Divisional objectives and engendering clinical leadership across the trust in these agendas. Accountable for the delivery of Quality and Safety objectives and priorities Accountable for delivery of relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework

Name	Role regarding performance management
Chief Digital Officer	Accountable for Digital services including information, performance and business intelligence Accountable for delivery of relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework
Director of People and Culture	Accountable for workforce strategy and planning and organisational development including training and talent management and actions to develop a performance culture. Accountable for delivery of relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework
Director of Strategy, Improvement and Planning	Accountable for the development and implementation of the business planning cycle, enabling development of clear Divisional objectives aligned to the Trust's objectives. Responsible for the development of the Trust's strategic plan and annual operational plan, including the submission of planning requirements as defined by NHS England Accountable for delivery of relevant supporting programmes of work, structures and processes to ensure corporate performance is delivered. Accountable for the delivery of assigned actions agreed through the mechanisms set out in this Framework
Service Leaders	Accountable to Divisional Triumvirate and Divisional Board for service performance and delivery Responsible for delivery of actions agreed with Divisional Triumvirates Responsible for understanding main drivers for service performance and taking mitigating actions to improve performance.

In addition, the following Committees and Groups within the Trust have a role in relation to performance and delivery management:

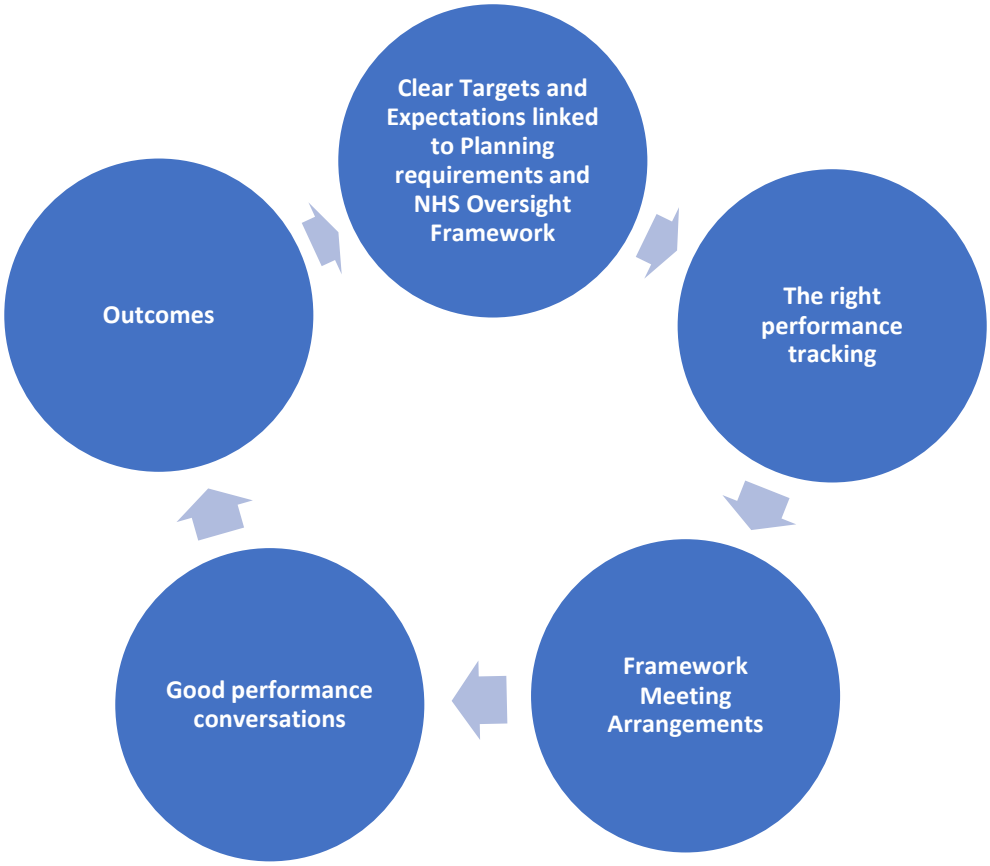
Name	Role regarding performance management
Trust Board	Chaired by Trust Chair; overall responsibility for setting Trust Strategy and assures risks to delivery of strategy are mitigated. Review performance and seek assurance on delivery of the corporate objectives and management of risks.
Quality Governance Committee	Meets monthly and is chaired by non-executive director with delegated responsibility from Trust Board for oversight of quality (safety, clinical effectiveness and patient experience) performance by assuring risks to quality are mitigated.
Finance and Performance Executive	Meets monthly and is chaired by a Chief Officer, with delegated responsibility from Trust Management Board for oversight of financial and operational performance.

People and Culture Committee	Meets bi-monthly and chaired by non-executive director with delegated responsibilities from the Board for oversight of workforce performance by assuring risks to quality are mitigated.
Trust Management Board	Meets fortnightly and is responsible for the overall performance of the Trust of designated performance indicators, programmes of work and contracts in support of delivering the corporate objectives.
Divisional Boards	Accountable for divisional performance; assure performance of division and its constituent services and set divisional strategy; hold service line leaders to account. To support Divisional Boards to ensure they have the appropriate arrangements in place as they pertain to their responsibilities under this framework
Directorate Meetings	Place for routine performance management of service lines including problem solving and escalation to Operational Directors and divisional boards.

Performance and Delivery Accountability Framework

Effective accountability for performance and delivery is dependent on a strong foundation, with a clear organisational vision and purpose, which are the basis on which Trust, Divisional and service line objectives are agreed. This is driven by the Trust's Annual Business Planning Cycle, overseen by the Strategy and Planning Team and includes, but is not limited to, our obligations in relation to the NHS England Annual planning cycle.

This foundation underpins the Framework:



1. **Clear Targets and Expectations linked to Planning requirements and NHS Oversight Framework**

The Trust is expected to undertake planning on an annual basis, in line with the NHS Operational Planning guidance. This set out a number of standards that every provider or system is expected to delivery.

As part of NHS England oversight arrangements, as set out in the NHS Oversight framework, every NHS provider and ICB in England is also allocated to a segment, based on their performance against a number of metrics in six domains:

- Quality of Care, Access and Outcomes
- Preventing ill-health and reducing inequalities
- Finance and Use of Resources
- People
- Leadership and Capability
- Local Strategic Priorities

In addition, the Trust may define other local priorities that will support the delivery of the requirements of the Operational Planning Guidance and NHS Oversight Framework. The metrics for 2023/24 are included in Appendix 1

Objectives and priorities will be agreed through an effective annual business planning cycle, which will ensure the alignment of Trust, divisional, departmental and individual objectives (the latter in line with the relevant workforce policy) that contribute to the delivery of the Trust's objectives.

Where appropriate, Delivery plans will be developed to support the operational management of delivery and will form the basis for accountability conversations.

2. **Effective Monitoring**

The effective use of data and information is a core component of the framework. The measures and evidence used to assess performance will be clearly set out. In this context, the Trust will use data and information to:

- Assess performance against clear objectives and key results (across the four domains – activity and performance, quality and safety, workforce, finance)
- Inform strategic and operational decisions to support and enable delivery, particularly through the identification of performance drivers
- Support the development of delivery action plans, particularly in relation to the expected impact and outcome
- Forecast future capacity, demand and performance based on agreed assumptions to support future planning
- Undertake gap analysis between current, forecast and planned performance to enable the development of robust action plans to address drivers for performance
- Benchmark organisational, department and service line performance against peers and national standards
- Identify any systemic problems using trend analysis
- Monitor the delivery and realisation of programme and business case benefits

Data and information used for support the implementation of this framework will be available through a standard set of defined reports on WREN across the four domains. This will include, but not limited to, metrics directly relating to:

- NHS operational planning guidance
- NHS Oversight Framework

- Trust Annual plan
- CQC

A comprehensive data pack will be available via WREN which will inform the development of the monthly Integrated Performance Report at Trust, Division and Directorate Level.

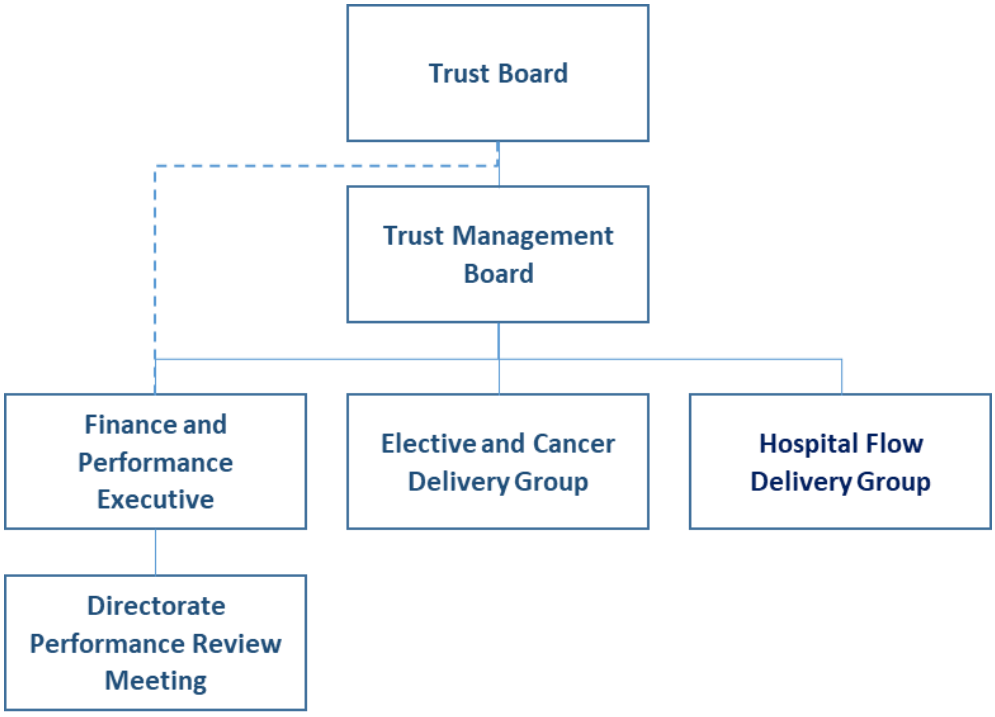
This does not replace the reporting of programme based metrics, which are monitored to assess the relative success of improvement and transformation programmes of work.

Additional information to support local monitoring and operational management will be available via a single information portal (WREN) and supplemented by an Adhoc Information Request service.

3. Framework Meeting Arrangements

Performance and delivery management of all divisions and their directorates will be monitored and assessed through a formal monthly review process, as part of the wider Framework.

Key meetings are shown the diagram below:



Finance and Performance Executive

The Finance and Performance Executive, reporting into Trust Management Board, is the key executive-led meeting to enable the effective scrutiny of performance across the four domains of operational delivery, quality, workforce and finance. It enables the executive team to have oversight and gain assurance of delivery at Divisional level to support board assurance and oversight including in relation to the NHS Oversight Framework.

The Executive will ensure that performance is effectively managed and that the appropriate operational oversight and assurance mechanisms are in place to support and enable the achievement of Trust objectives.

Overall Divisional ratings will be monitored and reviewed with support packages agreed and managed where necessary

Minutes, action and decision logs will be maintained and reviewed at subsequent meetings

The meeting will be a supported by the provision of Divisional Integrated Performance Reports

Minutes, action and decision logs will be maintained and reviewed at subsequent meetings.

Terms of reference are included in appendix 2

Directorate Performance Review Meeting

The Directorate Performance Review Meeting is led by the Divisional Triumvirate to enable the Divisional Management to ensure effective scrutiny of performance across the four domains of operational delivery. Quality, workforce and finance.

Through this forum the Divisional management team will ensure performance is effectively managed and that appropriate delivery and recovery actions are in place and being implemented to ensure delivery of Directorate objectives, as aligned to Divisional and Trust objectives.

Overall Directorate ratings will be monitored and reviewed, with support packages agreed and managed where necessary

Minutes, action and decision logs will be maintained and reviewed at subsequent meetings

It will report into Divisional Board and Finance and Performance Executive.

Terms of reference are included in appendix 3

Elective and Cancer Delivery Group

The Elective and Cancer Delivery Group, reporting into Trust Management Board, will oversee the performance and delivery management of the Trust's elective recovery, with a particular focus on the delivery of waiting time standards as set out in the Trust's Annual Operational Plan (aligned to the NHS England Operational Planning Guidance and requirements of the NHS Oversight Framework).

Where applicable, the Group will be responsible from the production and delivery of the action plan required in line with any Undertakings agreed with NHS England.

The Group will be responsible for the approval of Divisional Delivery and Recovery plans.

It will include a focus on the Trust's response to improvement action plans including IST and Regional Diagnostics as well as the Theatre and Outpatient Productivity Programmes.

It will oversee the delivery and utilisation of insourcing and outsourcing provision as well as monitoring the use of core Trust capacity

Minutes, action and decision logs will be maintained and reviewed at subsequent meetings.

Terms of reference are included in appendix 4

Hospital Flow Delivery Group

The Hospital Flow Delivery Group, reporting into Trust Management Board, will oversee the performance and delivery of the Trust's UEC Improvement plan, with a particular focus on the delivery of the requirements as set out in the Trust' Annual Operational Plan (aligned to the NHS England Operational Planning Guidance and requirements of the NHS Oversight Framework).

Where applicable, the Group will be responsible from the production and delivery of the action plan requried in line with any Undertakings agreed with NHS England.

It will include a focus on the Trust's response to improvement action plans such as Dr Ian Sturgess and ECIST

Minutes, action and decision logs will be maintained and reviewed at subsequent meetings.

Terms of reference are included in appendix 5

Other Groups

These will be supplemented by existing organisational committees, board and groups which focus on Quality and Safety, Workforce and Finance.

4. Good Performance Conversations

Performance and accountability conversations should align to the principles of compassionate leadership and the 4ward signature behaviours. Conversations are underpinned by the framework principles – being open and transparent, as well as proportionate and balanced. Further information to support the broad approach to performance and assurance discussions is available in appendices 6 and 7.

It is the responsibility of those who are accountable to be able to update any group or committee. As a minimum this should include the following:

- An assurance rating, in line with Trust assurance system, for each of the four domains for their areas of accountability.
- Updates on performance across the four domains, including details of the drivers for performance and internal action plans in place to recover the position with evidence based interventions
- Details of risks to delivery, including controls and mitigations, as well as clarity on any support requirements
- Highlight areas where departmental/divisional mitigations have been unsuccessful and further support is required
- Be able to review and understand their own performance data provided on the Worcestershire Reporting Network (WREN)

Good performance conversations will be supported by appropriate data and information, with key lines of enquiry identified based on adverse performance or areas of significant improvement.

5. Outcomes

Increased assurance and consistent sustainable delivery of agreed levels of performance in any domain, may allow the Division (or a Directorate within a division) to earned increased autonomy in line with this framework and may result in a reduction in oversight frequency.

Decreased assurance and persistent non delivery of agreed levels of performance in any domain, may result in an increase in internal scrutiny in any or all domains.

Using the Trust's seven levels of assurance, the Trust Executive Team will allocate each clinical Division and corporate directorate to one of four tiers:

Triggers for each tier are set out below:

Tier One
• Meeting or exceeding delivery against areas aligned to NHS Oversight Framework • Delivering against priority annual plan requirements including activity and performance • Quality metric compliance • Financial plan compliance including PEP and Agency spend
Tier Two
• Baseline rating
Tier Three
• Multiple areas of concern within reasonable limits or single area of concern outside of reasonable limits • There are recovery plans in place
Tier Four
• There is a perceived lack of capacity/capability to deliver • Multiple areas of concern outside of reasonable limits across a number of domains • There are no/limited plans in place or plans in place are off-track and unmitigated

Services in Tier One will have more freedom and autonomy to take on increased decision-making at Divisional level with reduced executive oversight (within agreed limits and remaining in line with Trust policies)

Services in Tier Three and Four, bespoke support packages will be co-produced with the executive team. In addition, services in these tiers will be subject to increased scrutiny and oversight.

Summary

This framework formalises how the Trust will measure and manage the delivery of its services to ensure it delivers its annual plan. It clarifies the need for clear expectations to be set out through the business planning cycle.

The Performance Management and Accountability Framework is designed to ensure:

- Divisions and departments are suitably prepared for their performance and are accountable.
- There is a consistent monitoring process to assure that all divisions are delivering their annual business plans and contractual obligations.
- Divisions take a proactive approach to performance management and are well supported.
- Areas of concern are identified early with plans and support secured.
- Meetings are structured in a manner that makes efficient use of time.
- Meetings are attended by all those who are required, or a suitable representative.
- Reviews are at frequency and depth which is responsive to the performance of the directorate.
- Support service, individual and team development.

Appendix 1: 2023/24 NHS Oversight Framework Metrics

Oversight Theme	NHS Priority Area	Measure Name (Metric)	ICB level metric	Trust level metric
Quality of care, access and outcomes	Elective care	**Total patients waiting more than 65 weeks to start consultant-led treatment**	✓	✓
		Value weighted activity vs target / plan	✓	✓
	Diagnostics	**Proportion of appropriate activity completed within 6 weeks of referral**	✓	✓
	Cancer	**Total patients waiting over 62 days to begin cancer treatment vs target**	✓	✓
		Proportion of patients meeting the faster cancer diagnosis standard	✓	✓
	Urgent and emergency care	**Proportion of patients admitted, transferred or discharged within four hours**	✓	✓
		Ambulance average Category Two response time		✓
	Maternity and children's health	Neonatal deaths per 1,000 total live births	✓	
		Stillbirths per 1,000 total births	✓	
	Primary care and community services	Proportion of regular general practice appointments delivered within 14 days of request	✓	
		Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	✓	
		Proportion of Urgent Community Response referrals reached within two hours	✓	✓
		Proportion of adult general and acute beds occupied by patients not meeting the criteria to reside	✓	✓
		Proportion of virtual ward beds occupied	✓	
	Mental health services	Number of children and young people accessing mental health services as a % of population	✓	
		Number of people accessing IAPT services	✓	
		Access rates to community mental health services for adult and older adults with severe mental illness	✓	
		Inappropriate adult acute mental health placement out-of-area placement bed days	✓	✓
		Proportion of adults discharged from mental health inpatient settings with a length of stay of over 60 days		✓
		Proportion of older adults discharged from mental health inpatient settings with a length of stay of over 90 days		✓
		Dementia diagnosis rate	✓	

		Perinatal mental health access rate	✓	
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	✓	
		Inpatients with a learning disability and/or autism per million head of population	✓	✓
	Safe, high-quality care	**Overall CQC rating**		✓
		Summary Hospital-level Mortality Indicator		✓
		National Patient Safety Alerts not completed by deadline		✓
		Potential under-reporting of patient safety incidents		✓
		Acting to improve safety - safety culture theme in the NHS staff survey		✓
		Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		✓
		Clostridium difficile infection rate		✓
		E. coli bloodstream infections	✓	✓
		Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓	
		VTE risk assessment		✓
Preventing ill health and reducing inequalities	Prevention and long-term conditions	% of hypertension patients treated to target	✓	
		Proportion of people with CVD treated for cardiac high-risk conditions	✓	
	Screening, vaccination and immunisation	Bowel screening coverage - patients aged 60 - 74 screened in the last 30 months	✓	
		Breast screening coverage - females aged 53 - 70 screened in the last 36 months	✓	
		Cervical screening coverage - females aged 25 - 64 attending screening within the target period	✓	
		Proportion of people over 65 receiving a seasonal flu vaccination	✓	✓
		Population vaccination coverage – MMR for two doses (5-year-olds)	✓	
	Health inequalities	**Performance against relevant metrics for the target population cohort and focus clinical areas requiring accelerated improvement[1]**	✓	✓
Leadership and capability		**Aggregate score for NHS staff survey questions that measure perception of leadership culture**	✓	✓
		CQC well-led rating		✓

		Proportion of staff in senior leadership roles who are from a) a BME background, b) are women or c) are disabled	✓	✓
Finance and Use of Resources		**Financial efficiency - variance from efficiency plan**	✓	✓
		Financial stability - variance from break-even / plan	✓	✓
		Achievement of Mental Health Investment Standard	✓	
		Agency spending		✓
People	Compassionate and inclusive culture	**Staff survey engagement theme score**	✓	✓
		Staff survey bullying and harassment score	✓	✓
		Leaver rate	✓	✓
		Sickness absence rate	✓	✓
		Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants	✓	✓
		Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	✓	✓
	More people	Number of additional direct patient care professionals in General Practice per 1k patients	✓	

Appendix 2: Finance and Performance Executive Terms of Reference

FINANCE AND PERFORMANCE EXECUTIVE

Terms of Reference

1. Purpose

1.1. The Finance and Performance Executive is the key executive-led meeting to enable the effective scrutiny of performance across the four domains of operational delivery, quality and safety, workforce and finance.

1.2. The Executive will have oversight and provide assurance to the Board on key national requirements as set out in the NHS Oversight Framework.

1.3. The Executive will ensure that performance is effectively managed and that the appropriate operational oversight and assurance mechanisms are in place to support and enable the achievement of Trust objectives.

1.4. Through this meeting the Executive Team will hold to account all Divisions for their delivery of key objectives across the four domains, as required by the Board and regulators. This will ensure that the appropriate management actions are being exercised and that the organisation can demonstrate it is well led from “ward to board”

1.5. Where legal undertakings are in place, the Executive will have oversight and provide assurance to the Board on key actions to deliver compliance.

1.6. The Executive will agree an overall rating for each division in line with the Trust’s Performance and Delivery Accountability Framework.

2. Membership and Attendance Requirements

2.1. The membership of the Finance and Performance Executive is as follows:

a) Chief Executive
b) Managing Director
c) Chief Digital Officer
d) Chief Finance Officer
e) Chief Medical Officer
f) Chief Nursing Officer
g) Chief Operating Officer
h) Director of People and Culture
i) Director of Strategy, Improvement and Planning

2.2 The Executive will be chaired by the Chief Operating Officer with the Chief Finance Officer as Deputy Chair.

2.3 The following are regular attendees at the Executive:
a) Director of Performance
b) Deputy Director of Finance
c) PEP Programme Director

2.4 All Non-Executive Directors are invited as observers of the Executive.

2.5 Attendance is required from each Division for their allocated agenda. Core Divisional Attendees should be:
a) Divisional Director
b) Divisional Operations Director
c) Divisional Director of Nursing

2.6 In addition, the following are invited to attend as observers:
a) Finance Business Advisor
b) HR Business Partner

2.7 Members are expected to attend all meetings and Divisional Teams must be suitably represented. Suitably informed and empowered deputies should be nominated when members are exceptionally unable to attend.

3. Quorum

3.1. A quorum shall be four members, including the chair or deputy chair.

4. Conduct and Frequency

4.1. The Executive will be held monthly, as a minimum ten times a year. It will take place prior to the Trust Board meeting.

4.2. Secretarial support will be provided by a member of the Executive Support Team

4.3. Minutes, action and decision log will be circulated within 3 calendar days of the meeting end

4.4. Papers will be circulated at least 5 working days prior to the meeting.

5. Duties

5.1. The overall duty of the Executive is to use a data driven approach to provide assurance to the Board that the Trust is monitoring and managing performance against the NHS Oversight Framework and fulfilling its statutory duties, contractual obligations and business objectives in respect of financial management and service delivery.

5.2. Utilising a standard Divisional Integrated Performance Report, the Executive will review performance against agreed quality, operational, workforce and finance metrics to ensure the objectives and operational plans are delivered

5.3. Monitor agreed metrics through a balanced scorecard approach, aligned to the Trust's performance and accountability framework, taking action where delivery or performance are off track

5.4. Receive and monitor reports which include forecasts, cost and productivity improvement programmes and use of resources

5.5. Consider delivery forecasts against planned position, and seek assurance from divisions on delivery and recovery plans

5.6. Review progress against agreed action plans and trajectories to achieve sustainable performance improvements. This will include but not be limited to action plans in place in response to any legal undertakings in place.

5.7. Provide forum for Divisional escalation of risks and issues requiring executive decision making, to support Divisional delivery

5.8. The executive will report on any risk or issue where Board may require additional assurance or where a Board decision is required.

5.9. Members will agree Divisional assurance levels, which will inform the level of scrutiny for each Division, in line with the Trust's Performance and Delivery Accountability Framework

5.10. Agree and monitor bespoke support packages for Division's in line with Divisional Assurance levels as set out in the Performance and Delivery Accountability Framework

6. Relationships and Reporting

6.1. The Finance and Performance Executive will report into the Trust Management Board

6.2. Relevant elements will feed into the Integrated Performance Report to the Board of Directors but there is no requirement for formal reporting to Board.

7. Review Period

7.1. Terms of reference will be reviewed on an annual basis as a minimum

7.2. Terms of reference are approved by the Executive and ratified by Trust Management Board

Appendix 3: Directorate Performance Review Meeting Terms of Reference

DIRECTORATE PERFORMANCE REVIEW MEETING

Terms of Reference

1. Purpose

1.1. The Directorate Performance Review Meeting (PRM) is the key meeting for the Divisional Triumvirate to enable the effective scrutiny and management of performance across the four domains of operational delivery, quality and safety, workforce and finance and to hold individual Directorates to account for their performance and delivery.

1.2. The PRM will support the Divisional team to have oversight and provide assurance to the Finance and Performance Executive on key national requirements as set out in the NHS Oversight Framework as well as demonstrating that the organisation is well led from ward to board.

1.3. The Divisional Management Team will ensure that Directorate performance is effectively managed and that the appropriate support is in place to enable Directorate's to successfully delivery their core business

1.4. The Division will agree an overall rating for each Directorate in line with the Trust's Performance and Delivery Accountability Framework.

2. Membership and Attendance Requirements

2.1. The membership of the Directorate PRM is as follows::

a) Divisional Operations Director
b) Divisional Director
c) Divisional Director of Nursing
d) Director of Midwifery (W&C only)
e) Appropriate multidisciplinary Directorate / Services Management Teams

2.2 In addition, the following will attend the Directorate PRM:

a) Divisional Finance Business Advisor
b) Divisional Workforce Business Partner

2.3 The Directorate PRMs will be chaired by the Divisional Operations Director, with the Divisional Director as Deputy Chair.

2.4 Members are expected to attend all meetings and Directorate teams must be suitably represented. Suitably informed and empowered deputies should be nominated when members are exceptionally unable to attend.

3 Quorum

3.1 A quorum shall be two members of the Divisional Management Team and at least one Directorate representative.

4 Conduct and Frequency

4.1 PRMs will be held monthly, as a minimum ten times a year.

4.2 Secretarial support will be defined by the Divisional Management Team

4.3 Minutes, action and decision log will be circulated within 3 calendar days of the meeting end

4.4 Papers will be circulated at least 5 working days prior to the meeting.

5 Duties

5.1 To use a data driven approach to provide assurance to the Finance and Performance Executive that the Division is monitoring and managing performance against the NHS Oversight Framework and fulfilling obligations and business objectives in respect of financial management and service delivery.

5.2 The Divisional Management Team will ensure all services have robust delivery plans in place aligned to the drivers of performance and to deliver continuous improvement, and will monitor their implementation

5.3 Utilising a Directorate Integrated Performance Report, the Division will review performance against agreed quality, operational, workforce and finance metrics to ensure the objectives and operational plans are delivered

5.4 Receive and monitor reports which include forecasts, cost and productivity improvement programmes and use of resources

5.5 Consider delivery forecasts against planned position, and ensure appropriate recovery plans are in place and being delivered

5.6 Review progress against agreed action plans and trajectories to achieve sustainable performance improvements.

5.7 Provide forum for escalation of risks and issues requiring Divisional support or decision making, to enable Directorate delivery

5.8 Members will agree Directorate assurance levels, which will inform the level of scrutiny for each Division, in line with the Trust's Performance and Delivery Accountability Framework

5.9 Agree and monitor bespoke support packages for Directorates in line with Directorate rating as set out in the Performance and Delivery Accountability Framework

6 Relationships and Reporting

6.1 The Directorate PRM will report to the Divisional Management Board and Finance and Performance Executive

7 Review Period

7.1 Terms of reference will be reviewed on an annual basis as a minimum

7.2 Terms of reference are approved by the Executive and ratified by Trust Management Board

Appendix 4: Elective and Cancer Delivery Group Terms of Reference

ELECTIVE AND CANCER DELIVERY GROUP

Terms of Reference

1. Purpose

1.1. The Elective and Cancer Delivery Group is responsible for the management and oversight of the recovery and operational delivery of Elective and Cancer activity and performance (including diagnostics), in line with the Trust's annual plan and associated national, regional and ICS requirements to facilitate the sustained improvement in service delivery across elective and cancer pathways to ensure that the organisation is putting patients first.

1.2. The group empowers those that do the work to make rapid changes to workplace processes, where these are considered viable contributors to improvements in operational delivery

1.3. The group is delivery and action focussed – enabling and unblocking solutions that facilitate delivery of programme and operational activity through effective, data-supported decision making

1.4. The group brings together the operational and programmes leads across the Elective and Cancer portfolios which includes the following:

- Elective Recovery
- Access and Validation
- Cancer
- Diagnostics Delivery
- Operational and Clinical Productivity
- Transformation

1.5. The group provides oversight and assurance mechanism and supports operational and programme teams to support and enable delivery of improvement initiatives and transformation programmes

2. Membership and Attendance Requirements

2.1. The membership of the Elective and Cancer Delivery Group is as follows:

a) Chief Operating Officer (Chair)
b) Director of Performance (Deputy Chair)
c) Deputy Chief Operating Officer
d) Director of Operations – All Divisions
e) Head of Elective Performance and Patient Access
f) Cancer Services Manager
g) GIRFT lead
h) Business Intelligence Representative
i) Digital Representative
j) Communications and Engagement Representative
k) People and Culture Representative
l) Finance Representative
m) PMO Representative

2.2 Additional representatives may be invited on a needs basis.

2.3 Members are expected to attend all meetings. Suitably informed and empowered deputies should be nominated when members are exceptionally unable to attend.

2.4 The meeting will be considered quorate when at least 7 members are present including the chair or deputy chair and representatives from at least 2 clinical divisions and at least 1 other corporate team

3. Conduct and Frequency

3.1. The Elective and Cancer Delivery Group will meet monthly

3.2. Secretarial support will be provided by the Executive Assistant to the Chief Operating Officer

3.3. Minutes, action and decision log will be circulated within 3 calendar days of the meeting end

3.4. Papers will be circulated at least 3 working days prior to the meeting. Papers are due to the meeting secretary at least 5 working days prior to the meeting.

4. Duties

The following provides a non-exhaustive list of duties of the Elective and Cancer Delivery Group

4.1. Provide the executive forum for the oversight of NHS Oversight Framework metrics as they pertain to Elective and Cancer

4.2. Monitor agreed metrics through a balanced scorecard approach, aligned to the Trust's performance and accountability framework, taking action where delivery or performance are off track.

4.3. Regularly review information using benchmarking processes and tools to ensure optimum practice service models are embedded in the organisation and delivered consistently.

4.4. Development and delivery of the Trust's action plan in relation to legal undertakings (where they exist) aligned to elective and cancer performance

4.5. Hold workstream leads to account for the delivery of their workstream, in line with the Trust's Performance and Accountability Framework

4.6. Provide a forum for workstream leads to escalate solutions for executive decision-making in line with the Trust's governance framework

4.7. Use data to identify improvement and transformation opportunities, identifying appropriate leadership to explore opportunities further. This includes the use of Model Hospital / System, GIRFT alongside other benchmarking information

4.8. Identify and oversee delivery of improvement initiatives, through a PDSA approach

4.9. Oversee programme and operational delivery risks as they pertain to Elective and Cancer Delivery

4.10. Oversee the development and delivery of additional capacity such as insourcing and outsourcing solutions

4.11. Monitors and manages improvements in productivity and efficiency opportunities as they pertain to Elective and Cancer delivery

4.12. Provide the executive forum for the oversight of delivery of the Trust's annual plan as it pertains to Elective and Cancer Delivery

5. Relationships and Reporting

5.1. The Elective and Cancer Delivery Group will report into Trust Management Board

5.2. The Elective and Cancer Delivery Group will provide a report to the ICS Elective, Cancer and Diagnostic Board on a monthly basis.

6. Review Period

6.1. Terms of reference will be reviewed every six months or earlier if necessary

6.2. The terms of reference are agreed by the Elective and Cancer Delivery Group and ratified by the Trust Management Board

Appendix 5: Hospital Flow Delivery Group Terms of Reference

HOSPITAL FLOW DELIVERY GROUP

Terms of Reference

1. Purpose

1.1. The Hospital Flow Delivery Group is responsible for the delivery and oversight of the operational delivery and Trust's internal Hospital Flow Improvement Programme to facilitate the sustained improvement in hospital flow across urgent and emergency care pathways to ensure that the organisation is putting patients first.

1.2. The group empowers those that do the work to make rapid changes to workplace processes, where these are considered viable contributors to improvements in operational delivery

1.3. The group is delivery and action focussed – enabling and unblocking solutions that facilitate delivery of programme and operational activity through effective, data-supported decision making

1.4. The group operates as the formal programme board for the Hospital Flow Improvement Programme and brings together the operational and programmes leads across the Hospital Flow portfolio which includes the following workstreams:

- Front Door Delivery
- Operational and Clinical Site Management
- Workforce
- Transformation
- Winter Planning

1.5. The group provides oversight and assurance mechanism and supports operational and programme teams to support and enable delivery of improvement initiatives and transformation programmes

2. Membership and Attendance Requirements

2.1. The membership of the Hospital Flow Delivery Group is as follows:

a) Chief Operating Officer (Chair)
b) Chief Medical Officer (Deputy Chair)
c) Chief Nursing Officer
d) Deputy Chief Operating Officer
e) Deputy Chief Medical Officer
f) Deputy Chief Nursing Officer
g) Director of Operational and Clinical Site Management
h) Divisional Directors – All Divisions
i) Director of Operations – All Divisions
j) Divisional Directors of Nursing – All Divisions
k) Director of Performance
l) Digital Representative
m) Communications and Engagement Representative
n) People and Culture Representative
o) Finance Representative
p) PMO Representative

2.2 Additional representatives may be invited on a needs basis.

2.3 Members are expected to attend all meetings. Suitably informed and empowered deputies should be nominated when members are exceptionally unable to attend.

2.4 The meeting will be considered quorate when at least 10 members (including at least 2 members in clinical roles) are present including the chair or deputy chair and representatives from at least 3 clinical divisions.

3. Conduct and Frequency

3.1. The Hospital Flow Delivery Group will meet monthly

3.2. Secretarial support will be provided by the Executive Assistant to the Chief Operating Officer

3.3. Minutes, action and decision log will be circulated within 3 calendar days of the meeting end

3.4. Papers will be circulated at least 3 working days prior to the meeting. Papers are due to the meeting secretary at least 5 working days prior to the meeting.

4. Duties

The following provides a non-exhaustive list of duties of the Hospital Flow Delivery Group:

4.1. Provide the formal programme board for the Hospital Flow Improvement programme

4.2. Use data to identify improvement and transformation opportunities, identifying appropriate leadership to explore opportunities further.

4.3. Regularly review information using benchmarking processes and tools to ensure optimum practice service models are embedded in the organisation and delivered consistently.

4.4. Hold workstream leads to account for the delivery of their workstream, in line with the Trust's Performance and Accountability Framework

4.5. Provide a forum for workstream leads to escalate solutions for executive decision-making in line with the Trust's governance framework

4.6. Identify and oversee delivery of improvement initiatives, through a PDSA approach

4.7. Oversee programme and operational delivery risks as they pertain to Hospital Flow

4.8. Monitor agreed metrics through a balanced scorecard approach, aligned to the Trust's performance and accountability framework, taking action where delivery or performance are off track

4.9. Oversee the development and delivery of the Trust's internal winter plan

4.10. Monitors and manages improvements in productivity and efficiency opportunities as they pertain to Hospital Flow

4.11. Provide the executive forum for the oversight of delivery of the Trust's annual plan as it pertains to Hospital Flow

5. Relationships and Reporting

5.1. The Hospital Flow Delivery Group will report into Trust Management Board

5.2. The Hospital Flow Delivery Group will be supported by weekly Accountability wall sessions, led by the Chief Medical Officer. All individual workstream leads will be expected to attend these sessions at least two times per calendar month

5.3. The Hospital Flow Delivery Group will provide a report to the two external groups:

a) Home First Committee
b) ICS Urgent and Emergency Care Programme Board

6. Review Period

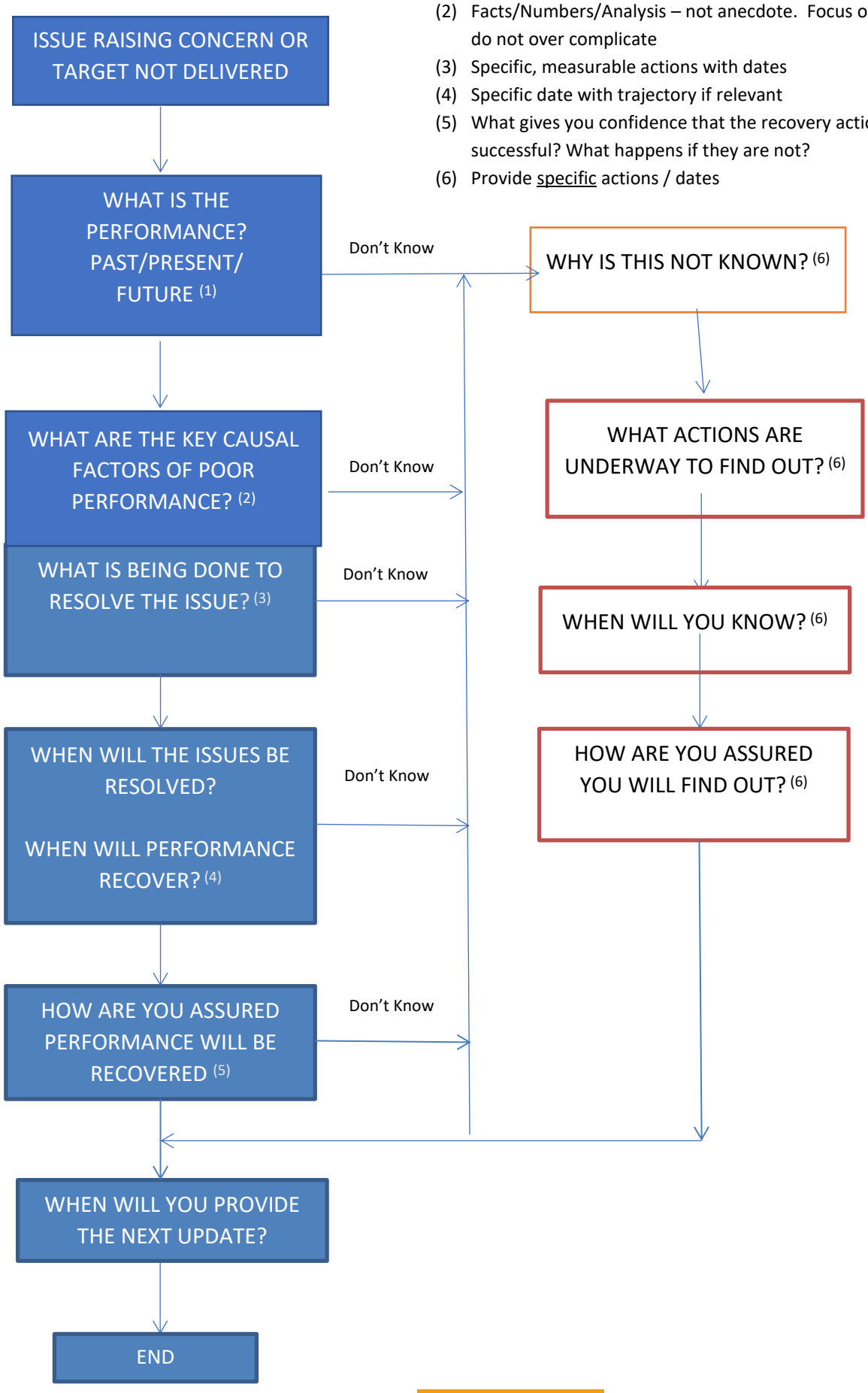
6.1. Terms of reference will be reviewed every six months or earlier if necessary

6.2. The terms of reference are agreed by the Hospital Flow Delivery Group and ratified by the Trust Management Board

Appendix 6: Performance Management and Assurance Algorithm

Notes:

(1) What is the standard? What is the current performance? What is the Trend? Provide specific numbers
(2) Facts/Numbers/Analysis – not anecdote. Focus on Key issues – do not over complicate
(3) Specific, measurable actions with dates
(4) Specific date with trajectory if relevant
(5) What gives you confidence that the recovery actions will be successful? What happens if they are not?
(6) Provide specific actions / dates



Appendix 7: Fundamental questions to ask in monitoring performance

Why is performance at the current level?

Is the target being met?

Why has the variance occurred?

What difference does it make?

What are the implications of not meeting this target, e.g. quality, safety, finances, reputation, impact on other services, etc.?

Do resource levels need to be looked at?

What impact will this have on patients, partner agencies, regulators, etc.?

How will this affect our priorities?

Is there an impact on sustainability or efficiency?

How can we make sure that things get better?

What performance is predicted for the next period?

How can performance be improved, e.g. process improvements, productivity improvements, additional staff, outsource, insource, investment, etc.?

When will performance be back on track?

What do we do next?

What decisions need to be taken?

What are the risks involved?

What can we learn from this for the future?

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc Ia

Nurse staffing report – August 2023

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

Accountable Director	Sarah Shingler, Chief Nursing Officer.		
Presented by	Sarah Shingler, Chief Nursing Officer	**Author /s**	Clare Alexander Lead for N&M workforce

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
People & Culture Committee	3 October 2023	Noted for assurance

Recommendations	Trust Board are asked for assurance and to note: • Paediatric and neonatal safe staffing: Neonates - 98.4% of shifts were staffed to BAPM against the target of 100%. All shifts were declared safe. Paediatrics - 5 red flags reported over August x3 No harm • Staffing on adult areas was also safe throughout August 2023. • The BMA Junior Dr strikes on the 11th – 15th of August and Consultant strikes on 24th and 25th August 2023 went ahead. There were no incidents or safety concerns raised from nursing because of this action. • The summer acuity and dependency review was completed on the 27th of August 2023 – data is currently being analysed and meeting with Divisions will go in in October with Sarah Shingler (CNO) • Domestic recruitment is continuing successfully for both Registered Nurses (RN's) and Health Care support workers (HCSW) and we remain on track for the increased trajectory for the International recruitment pipeline for 2023/2024. • Use of surge capacity including Medical Same Day emergency care (MSDEC) & A&E corridor continue to be reliant on the use of temporary staffing solutions. • Following identification of areas with high bank fill and subsequent discussions with Divisional Directors of Nursing (DDN's) for Speciality Medicine and Surgery, locks were placed on RN sifts on selected wards to prevent the automatic cascade to agency. The outcome from this trial will be included in next month's paper.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc Ia

Executive summary

This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during August 2023 with numerical data presented for July 2023. Key headlines are:

- Overall demand in the Trust in July has risen. For Registered nursing and midwifery demand has increase by 410 hours from last month and unregistered nursing has increased by 138 hours from last month.
- Total filled hours have increased versus last month by 7.2% and 22% since last year. With an overall fill rate of 90.1% and a bank fill rate of 50.3%
- Overall lead-time has improved to 43 days and short notice requests have fallen to 17.2%.
- Average hourly agency rate has risen slightly to £36.24 as a result of fewer agency Unregistered shifts being booked.
- PA remains in place with executive oversight and approval with weekly reports shared to highlight usage
- Recruitment for the NHSP Care Support Worker Development (CSWD) program took place in June 2023, and the majority of successful candidates are now working in clinical areas in the Trust, Further recruitment targeting the Alexandra General hospital (AGH) is booked with NHSP for Monday 25th September 2023.
- In July 2023 there were 39 insignificant or minor incidents reported with no moderate of significant harms reported related to nursing / midwifery staffing. These were largely related to near misses due to staff absence, rather than patient harm. All incidents were included in NWAG Divisional reports and mitigation and assurance of mitigation where appropriate has been given.
- There has been continued focus on the recruitment of HCSW since November 2022. There has been a notable increase in applications and job offers made since the beginning of January 2023

	HCA Posts offered	Commenced in post
November 22	15.72	12.87
December 22	16	14.17
January 23	15	6.61
February 23	25	16
March 23	18	15.82
April 23	14	13.95
May 23	20.19	21.2
June 23	17	27

July 23	17 generic 6.6 medicine 2.0 Surgery	11.13
Totals	164.51	111.75

- Vacancy factor (July 2023 data):
  - 189.3 RN vacancies at 9.29%. Reduced from previous month (the model hospital data has been reset to 11.3 % as of May 2023 placing the Trust in the second quartile). The Urgent Care Division are carrying the highest RN vacancy at 59,57 reduced from 68.18 WTE in May.)
  - 125 WTE HCSW vacancies at 12.45% (model hospital level of 10.1%), down from 155 and 15.04% in May. The highest number of HCSW vacancies are within the SCSD at 30 WTE.
- Triangulation of data shows there are some variances in the bank and agency usage. Partly accounted for as not all areas reporting vacancy / maternity / sickness would require temporary staffing solutions.
- RN total absence due to vacancy, sickness and maternity = 370.3 WTE (378 previous month) versus bank agency use of 332.75 WTE (312.5 previous month).
- HCSW total absence due to vacancy, sickness and maternity = 262 WTE (272.7 previous month) versus bank / agency usage of 250.51 WE (233 previous month).
- There is a continued focus and commitment to supporting staff's health wellbeing, particularly the Trust's commitment to ameliorating the cost of living crisis through targeted support for financially vulnerable staff. This is now a standing agenda item on the Nursing and Midwifery Workforce Action Group (NWAG) to ensure engagement from all divisions and full awareness of available schemes.
- The Trust currently has 86 RNs and 34 HCSWs on maternity leave. Current arrangements mean that areas that require back fill must do so via temporary staffing solutions, which impacts on the bank and agency usage.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF risk 9 -If we do not have a sustainable fit for purpose and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.* *BAF risk 22 There is a risk that services will be disrupted by staff shortages due to possible industrial action by the NHS trade Unions*

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			resulting in delay to patient care and poor patient experience.

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

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

Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for June 2023

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 & options

Harms

In July 2023 there were 39 insignificant or minor incidents reported with no moderate of significant harms reported related to nursing staffing. These were largely related to near misses due to staff absence, rather than patient harm.

It was confirmed through Divisional presentations at NWAG that all red flags and staffing related incidents have been investigated, action taken where required and closed at divisional level.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)

"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwives in hospitals which are filled*".

National rates are aimed at achieving 95% across day and night RN and HCA fill.
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where able to do so.

Current Trust Position July 2023 data	What needs to happen to get us there	Current level of assurance

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	Day % fill	Night % fill
RN	94%	98%
HCA	85%	102%

This month has seen fill rates have reduced slightly with only RNs and HCAs on days below recommended targets of 95%, Rns by 1%. Drop in HCA fill may be attributed to padlocks on shifts for HCAs and reduced fill. No harm has been reported as a result of lower fill but this will continue to be monitored.

Surgical roster templates have been reset from September 23 which will see the night HCSW rate settle once demand and fill are re-calibrated.

6

Vacancy (Trust target is 6%)
July 2023 data

There is ongoing recruitment to reduce RN vacancies via the domestic and international pipelines:

- Rolling adverts for specialities have been ongoing.
- Co-ordinated adverts for speciality HCSW recruitment to prevent duplication and promote efficient recruitment is in process.

Current Trust Position WTE July 2023 data	Previous month June 2023	**Model Hospital data Jan 2023 Benchmarking**	Current level of Assurance
RN 189.3 WTE 9.29% HCA 125 WTE 12.45%	RN 196.3 WTE 9.58% HCA 144 WTE 14.04%	RN 10.0% HCA 9.7%	5

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

- deploying staff across all wards / departments to ensure safer staffing levels achieved
- employed use of bank and agency workers.

International nurse (IN) recruitment pipeline

For the 2023 / 2024 financial year, a further Health Education England (HEE) bid has been successful for 60 nurses, with an internal business case being approved, supporting up to a further 150 nurses and midwives during this period.

In April 2023, NHSE offered additional funding to Trusts with proven track records who are aiming to expand numbers and an additional bid for 30 nurses has been submitted so reducing costs from the internal business case.
To support the offers made during the recruitment campaign to the Philippines in February 2023 the additional monthly interviews with our partner agency are in progress.

The next International campaign will be to Barbados and Tobago in November 2023 to support both the 23.24 and potential 24.25 pipelines.

Domestic nursing pipeline

Trajectory of Nursing and Midwifery new starters.

	May	Jun	Jul	Aug	Sep	Oct	Grand Total
Registered Nursing & Midwifery	14	4	4	12	90	46	170
International Registered Nursing & Midwifery	8	12	10	9	14	10	59
HCSWs – support to Nursing	27	27	43	57	1		155
Grand total	49	43	57	78	105	56	

In addition to the above trajectory, a further 7 RNs were interviewed on the 18th August and offered jobs. A further 15 candidates have been shortlisted for interview in September 2023.

Representatives from the Trust will be present at the net ICS careers and recruitment fair at the Worcester Racecourse on the 27th September with a focus on HCA and MSW recruitment and 'new to care' candidates. 'Walk up' interviews will be offered on the day with support given to complete online application forms.

Further HCA interviews are planned for the 22nd September 2023 with 44 candidates being shortlisted.

In order to further support the on-boarding and retention of new HCSW the Professional Development (PD) Team have amended their induction plan for HCSWs to offer the Care certificate directly following Trust induction. The learning and development team have implemented an automated booking arrangement for new in post HCSWs and the first adapted induction commenced on both sites in July with good attendance.

Pastoral support is in place specifically for HCSW from the PD team and following positive feedback this has been extended for a further 12 months. These staff members will also support the adapted

induction and the NHA apprenticeship. A calculation of impact of this support on turnover will be provided at 6 and 12 months' intervals via this paper an NWAG.

Bank and Agency Usage
July 2023 data

Interventions to reduce Agency reliance and spend		
10th July 2023	Locks placed on all HCA shifts to prevent automatic cascade to agency HCA.	*Data on safety, quality and value impacts to follow in September report*.
1st August 2023	Following identification of areas of high bank fill and negotiations with Divisional Directors of Nursing, padlocks were placed on registered nursing shifts in the following areas. Aconbury 1 & 2, Ward 12, Discharge lounges countywide, fracture clinic, Beech head and Neck ward.	

Current Trust Position WTE July 2023	Previous Month June 2023	**Model Hospital data Feb 2023 Benchmarking**	**Current level of assurance**
RN 332.75 (16.1%) (133.12 Bank / 199.63 Agency) HCA 262 WTE (24%) 186.57agency Bank / 63.94 WTE Agency	**RN 313 WTE (15.2%)** **(129.5 WTE Bank / 183.2 WTE agency)** **HCA 233 WTE (22.5 %)** (154.97 WTE Bank / 78.41 agency)	RN 4.6% HCA Not available	5

Sickness
July 2023 data

Sickness levels are high compared to model hospital for HCA's whilst registered nursing is good as seen in quartile 2.

Current Trust Position July 23	Previous Month June 23	Model Hospital data May 202e Benchmarking	Current Level of Assurance
RN 95 WTE (4.6%) HCA 103 WTE (899%)	RN 95 WTE (4.6%) HCA 92 WTE (8.9%)	RN 5.1% HCA 7.0 %	**6**

Turnover
July 2023 data

Trust target for turnover 11 %.
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.

Current Trust Position July 2023 data	Previous Month June 2023	Model Hospital data March 2023 Benchmarking	Current Level of Assurance
RN Turnover 10.22% HCA turnover 16.71%	RN Turnover 10.42 % HCA Turnover 16.65%	RN Turnover 12.9% HCA Turnover 21%	**6**

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Recommendations

Trust Board are asked for assurance and to note:

- Paediatric and neonatal safe staffing: Neonates - 98.4% of shifts were staffed to BAPM against the target of 100%. All shifts were declared safe.
  Paediatrics - 5 red flags reported over August x3 No harm

- Staffing on adult areas was also safe throughout August 2023.
- The BMA Junior Dr strikes on the 11th – 15th of August and Consultant strikes on 24th and 25th August 2023 went ahead. There were no incidents or safety concerns raised from nursing because of this action.
- The summer acuity and dependency review was completed on the 27th of August 2023 – data is currently being analysed and meeting with Divisions will go in in October with Sarah Shingler (CNO)
- Domestic recruitment is continuing successfully for both Registered Nurses (RN's) and Health Care support workers (HCSW) and we remain on track for the increased trajectory for the International recruitment pipeline for 2023/2024.
- Use of surge capacity including Medical Same Day emergency care (MSDEC) & A&E corridor continue to be reliant on the use of temporary staffing solutions.
- Following identification of areas with high bank fill and subsequent discussions with Divisional Directors of Nursing (DDN's) for Speciality Medicine and Surgery, locks were placed on RN sifts on selected wards to prevent the automatic cascade to agency. The outcome from this trial will be included in next month's paper.

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Midwifery Safe Staffing Report August 2023

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

Accountable Director	Sarah Shingler, 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	September 2023	
People & Culture Committee	3 October 2023	Noted for assurance

Recommendations	Trust Board is asked to note the content of this report for information and assurance

Executive summary

This report provides a breakdown of the monitoring of maternity staffing in August 2023. 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 tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- COVID SitRep (re - introduced during COVID 19 wave 2)
- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board

Summary of Key Performance Indicators (August 2023)

Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	5.98%↓	7.67%↓
Turnover rate (rolling)	11.5%	7.95%↓	23.49%↑
Vacancy rate (MW)	7%	14% ↔	34%↑
Midwife to birth ratio (in post)	1:24	1:22	
1:1 care in labour	100%	100%	
Shift leader SN	100%	Not achieved	

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	There were 387 births in August. The escalation policy was enacted to reallocate staff internally as required. The community and continuity teams were required to support the inpatient team in month. Minimum safe staffing levels were maintained on all shifts in August. The supernumerary status of the shift leader was not achieved in August however 1:1 care in labour was achieved in month. There were seven staffing and seven medications (no harm) incidents reported on Datix. The suggested level of assurance for August is 6. This level assurance is recommended because sickness absence and turnover rates have reduced/sustained reduction.

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

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**October 2023**					

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

In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits.

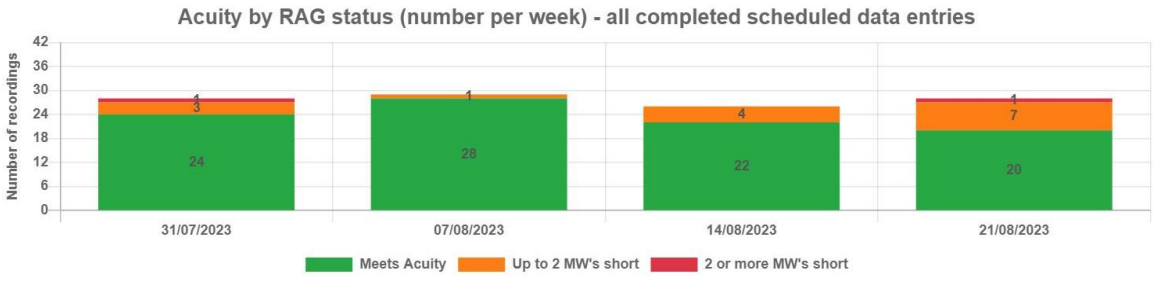
Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 66% of the expected intervals.
The diagram below demonstrates when staffing was met or did not meet the acuity. From the information available the acuity was met in 84% of the time and recorded at 16% when the acuity was not met prior to any actions taken. This is an increase from last month.

This indicator is recorded prior to any actions taken. Safe staffing levels were maintained on all shifts in August.



The mitigations taken are presented in the diagram below and demonstrate the frequency (n=15 occasions) of when staff are reallocated from other areas of the inpatient service; this is an increase from July. In addition, there were three occasion when the community and continuity teams were deployed. There were three reports of staff not being able to take breaks and no reports of staff staying beyond their shift time.

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Number & % of Management Actions Taken
From 01/08/2023 to 31/08/2023

MA1	Redeploy staff internally	15	63%
MA2	Redeploy staff from community	3	13%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	3	13%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	1	4%
MA10	Escalate to Manager on call	2	8%
MA11	Maternity Unit on Divert	0	0%

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

All of the NICE recommended red flags can be reported within the acuity app and are presented below. The labour ward coordinator reported that they were not supernumerary on five occasion as they were providing 1:1 care; this has increased in recent months. Two delays in care were reported and 1:1 care was recorded at 100%. The following actions have been agreed to address the challenge of maintaining the supernumerary status of the shift leader:

1. 24 WTE expected in September – November 2023 – pipeline on track
2. Approve business case for 4 WTE nurses to be recruited to provide theatre scrub and remove midwives from undertaking this role. ATR agreed and recruitment underway.

Number & % of Red Flags Recorded
From 01/08/2023 to 31/08/2023

RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	29%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	5	71%

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Antenatal & Postnatal Wards

The ward acuity tool remains unavailable whilst BR plus complete an upgrade of the tool.

Staffing incidents

There were seven staffing incidents reported in August via Datix and no harm was recorded. The following incidents were reported:

1. Delays in Triage due to availability of medical staffing
2. Unexpected lone worker in DAU
3. Escalation for support for Triage from AN ward staff
4. Unable to provide care on MBC (2)
5. Theatre team unable to cover scrub – midwife deployed to support (2)

It is noted that any reduction in available staff results in increased stress and anxiety for the team. Staff drop in events have continued throughout August to offer support to staff and to update staff on current challenges in maternity services. No safety issues or staffing concerns were raised at last meeting.

Medication Incidents

There were seven medication incidents in August:

- Fridge temperature not recorded
- Mismatch between medication and patient
- Incorrect dose prescribed – amended and correct dose administered
- Additional dose of analgesia (2)
- IVABs administered without complete prescription
- Late dose of IVABs
- Incorrect birth weight recorded on chart resulting in incorrect dose of antibiotics administered.

Monitoring the midwife to birth ratio

The ratio in August was 1:22 (in post) and 1:19 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Daily staff safety huddle

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

Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

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Unify Data

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service. Again the rates reported demonstrate an improvement in fill rates for registered midwives however there is a reduction in maternity support workers fill rates due to sickness, maternity leave and vacancies. MSW & MCA recruitment was successful and further recruitment events planned. There has been a focus on sickness absence management for this group. A substantive, full time MSW/MCA Practice Development Midwife lead is now in place and there will be a focus on staff development, support and health and wellbeing.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	77%	100%	n/a	n/a
Antenatal Ward/Triage	90%	87%	64%	90%
Delivery Suite	88%	90%	52%	73%
Postnatal Ward	80%	85%	70%	74%
Meadow Birth Centre	50%	78%	71%	45%

Maternity SitRep

The maternity SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and deputies.

The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional sitrep is submitted daily.

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

The national COVID SitRep continues to be completed as requested.

Vacancy

There are 29 unfilled clinical midwifery posts and 6 unfilled leaderships and specialist roles – vacancy rate 14%. Active recruitment continues.

The directorate remains in contact with the 21 WTE midwives recruited in March to support them through the recruitment process. Three further midwives are expected to join us in Q2/3.

There are 19WTE MCA vacant posts. Further recruitment is planned for MCAs.

Ongoing work continues with international recruitment with the aim to employ 3 WTE midwives by Dec 2023, it is noted that only 2 midwives have continued to engage with the ongoing process and the target has been reset with NHSE to 3 midwives arriving by December 2023. No further update available in month.

Sickness

Sickness absence rates for midwives were reported at 5.98% in month. Over the last month there has been a further decrease in sickness absence within the non-registered group at 7.67%.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Focus review of sickness management in areas with high levels of absence
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Regular walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.
- Health and wellbeing work stream actions

Turnover

The rolling turnover rate is at 7.95% for midwives and at 23.45% for non-registered staff. As planned a retention midwife will commence in post in September to work with the team and introduced a number of initiatives to improve retention. In addition, a Practice Development Midwife for MSW/MCAs will commence in post to support and develop the team; with a focus on retention and health and wellbeing.

Risk Register –staffing

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

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- Agency staff block booked to support until October 2023.
- Sitrep report completed three times per day
- Maintained focus on managing sickness absence effectively.
- Progressing IR following recruitment.
- Fortnightly ‘drop - in’ sessions led by the DoM continued in month.
- Safety Champion walkabouts

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Conclusion

There was a further increase in the % of time that acuity was not met on delivery suite without mitigation taken. To maintain safety staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. The escalation policy was utilised on 18 occasions to maintain safety.

Agency midwives continue to provided additional support however safe staffing levels were maintained. The community and continuity of carer midwives were required to support the inpatient team in August.

Red flags were reported via the acuity app; the supernumerary status of the shift leader was not maintained however 1:1 care in labour was achieved. Of the 14 datix reports submitted no harm was identified.

Sickness absence rates demonstrate an improvement in both staff groups; ongoing actions are in place to support ward managers and matrons to manage sickness effectively and maintain improvements.

The rolling turnover rate is at 7.95% (MWs) and 23.49% (MSWs & MCA's). The vacancy rate is at 14% for MWs and 34% for MSW/MCA's. There are 23WTE midwives in the recruitment pipeline and further recruitment is planned for MCAs.

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

The suggested level of assurance for August is 6. This level of assurance is recommended because sickness absence, vacancy and turnover rates continue to reduce for midwives but it is recognised that there is a need for more focus on the recruitment and retention of MCAs.

Recommendations

Trust Board is asked to note the content of this report for information and assurance

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Guardian of Safe Working for Junior Doctors Report

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

Accountable Director	Dr Christine Blanshard CMO		
Presented by	Dr Alag Raajjkumar, Guardian of Safe Working	**Author**	Dr Alag Raajjkumar Kira Beasley

Alignment to the Trust's strategic objectives (x)							
Best services for local people		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
People & Culture Committee	1 August 2023	Noted for assurance

Recommendations	Trust Board are invited to note the content of this report and be assured that the work of the junior doctors is safely rostered and are compliant with the terms & conditions of service of the 2016 contract.

Executive summary	This report gives assurance that the work of the Junior Doctors is safely rostered and that their working hours are compliant with the TCS of the 2016 contract. This assurance comes from the exception reports submitted by Junior Doctors across the Trust during the 3-month period. (1st December 2022 – 4th April 2023). A total of 40 exception reports were submitted during this time; most of which were in relation to additional hours worked. Specialty Medicine and Surgery at WRH remain the areas with the highest number of reports.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*9, Workforce*

Assurance Level (x)	0		1		2		3		4		x		6	X	7		N/A		
Financial Risk	No financial risk																		

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

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Timescales to achieve next level of assurance

Introduction/Background

This is part of the regular reporting process providing assurance on Junior Doctors' Safe Working. This report provides assurance that Junior Doctors in the Trust are working within their contractual terms and conditions is both qualitative and quantitative.

The quantitative information comes from exception reporting through the Allocate system.

The contract under which doctors in training posts are employed encourages exception reporting. This enables the doctors to report occasions on which they work in excess of their contracted hours, have insufficient clinical support or are unable to take their breaks in a period of duty.

The qualitative information comes from the Committee for Safe Working meetings, the Medical SpR meetings together with informal interactions with the doctors in training.

Issues and Options

Exception Reporting

- During the 3-month period 1st December 2022 – 4th April 2023, there were 40 exception reports submitted.
- Most of the reports come from doctors in Foundation years 1 and 2, this is a consistent finding.
- Exception reporting hot spots are in Specialty Medicine and Surgery Divisions at Worcester. Most of these exception reports are for additional hours worked.
- One Immediate Safety Concerns (ISC) has been reported, this was in General Surgery at WRH
  No patient harm resulted
- The incidents reflect occurrences of particularly short staffing of junior doctors on the wards. The ISC has been escalated to the relevant directorates who are aware and have been responsive to the issues raised.
- An ongoing problem for the Foundation doctors is the inability for them to take their Self Development Time. This is 2 hours a week and was introduced nationally in August 2021, following Health Education England's Foundation Programme Review. It comes without funding for backfill or additional staff so very often the doctors don't take the time as they feel the wards are left inadequately covered.
- Industrial action; Nursing, Ambulance and Junior Doctors may have an impact on the next reporting period as there have been episodes of additional pressures within the workload of Junior Doctors.

The CMO team have recently developed a Junior Doctor Liaison officer role that will be going to advert soon; this post will support the Guardian for Safe working and the Junior Doctors in our Trust.

Conclusion

The exception reports support compliance with safe working hours for the Junior Doctors. The doctors are working compliant rotas and are appropriately using the exception reporting system for additional hours worked.

Recommendations

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc J

Trust Board are invited to note the content of this report and be assured that the work of the junior doctors is safely rostered and are compliant with the terms & conditions of service of the 2016 contract.

Appendix 1: Divisional Exception Reporting Data

DIVISIONAL EXCEPTION REPORT DATA BY ROTA WEDNESDAY 1st DECEMBER 2022 TO TUESDAY 4TH APRIL 2023

Division	Rota	Base	Total Slots on rota	Total number of training slots on rota	Vacant training slots on rota	Total number of trainees submitted Exception Reports	Total number of Exception reports 011222-040423	Total number remaining open	Total number closed	Total number Variance A (total hours inc rest breaks)	Total Number Variance B (working pattern altered)	Total Number Variance C (Educational Opportunities/ Support)	Total Number Variance D (Service Support)	ISC (Immediate Safety Concern)	Reason for ISC	Comments
Surgery	WRH F1 Surgery December 2019	WRH	10	10	0	3	9	6	3	9	0	0	0	0		
	WRH F2/StR General Surgery December 2019	WRH	10	10	0	1	2	2	0	2	0	0	0	1	Exception report and raising issue with colleagues.	Issue raised with the respective department and addressed .
	WRH F2/StR T&O December 2019	WRH	13	13	1	1	5	1	4	4	0	0	1	0		
SCSD	WRH F1/F2 Oncology/Haematology/Micro August 2022	WRH	18	3	0	1	1	1	0	1	0	0	0	0		
Specialty Medicine	WRH F1 Medicine April 2021	WRH	16	16	0	6	21	16	5	11	7	3	0	0		
	ALX F1 Medicine August 2021	WRH	24	17	1	2	2	2	0	1	1	0	0	0		
	Total		**91**	**69**	**2**	**7**	**40**	**28**	**12**	**28**	**8**	**3**	**1**	**1**		

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc K

Responsible Officer Report – Medical Appraisal and Revalidation

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

Accountable Director	Dr Christine Blanshard Chief Medical Officer		
Presented by	Dr C Blanshard, CMO	**Author(s)**	K Beasley (Business Manager CMO) J Walton (DCMO)

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	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Quality Governance Committee	28 September 2023	Noted for assurance

Recommendation	Trust Board are invited to note the content of this report and be assured that work is continuing to improve compliance and engagement in relation to Medical Appraisals and Revalidation

Executive summary	The medical appraisal compliance figures as at 31 March 2023 below show that the we have achieved the Trust board tolerance level of 90% compliance for all medical staff. The funding for the existing has 58 approved appraisers has been moved centrally to deliver long term equity, no additional funding has been agreed; however, the costs associated with recruitment of medics needs to include this to ensure adequate appraisers are available. We currently have a ratio of 7 appraisees to each appraiser (this is within the required 5-8 ratio). As at 15th September 2023 there are currently 49 overdue appraisals. There are a total of 14 agreed exceptions. 9 doctors with delayed appraisals are being actively managed by the Deputy CMO and Deputy Appraisal and Revalidation lead for the Trust. The remained 26 joined the Trust during the revalidation year.

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc K

Risks, Implications and Funding			
Which key red risks does this report address?		**Which BAF risk does this report address?**	*9, 15, 17*
What is the impact of this decision on these risks?			
Other risks or implications			
Funding			

Assurance															
CURRENT assurance level (x)	0		1		2		3		4		5	x	6		7		N/A	
Rationale for this assurance level	*Appraisal and Revalidation has a good network and structure to maintain levels.*																	
Actions and timescale to reach next assurance level	***Develop & implement a policy and document the process for responding to concerns, including guidance***																	
Last reported assurance level	*5*				**Anticipated next assurance level**		*7*											

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Where is the plan monitored?	*Insert name of committee/group*					
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			

Introduction/Background

-

Issues and options

The appraisal year runs from 1 April to 31 March annually.

Name of organisation: Worcestershire Acute Hospitals NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	445
Total number of appraisals undertaken for 1 April 2022 to 31 March 2023	396
Total number of appraisals not undertaken for 1 April 2022 to 31 March 2023	49
Total number of agreed exceptions	14
Known delayed appraisals under active management	9
Non complete appraisals joined within year	26

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc K

This table outlines the number of Doctors with a professional connection to the Trust and those that have had their appraisals.

As at 15th September 2023 there are currently 49 overdue appraisals. Of these:

- 9 are under active management by the appraisal team
- 2 were due to career break
- 3 were due to long term sickness
- 9 were due to maternity leave

There were 59 doctors who commenced partway through the appraisal year so they may not have been due an appraisal within the reporting period – the remaining 26 doctors are in this group.

In summary, there are 9 doctors who did not have an appraisal during the 2022/2023 appraisal year who were not an agreed exception.

Over the 22/23 revalidation year, 63 recommendations were made to the General Medical Council for revalidation. 56 were revalidated, 5 deferred due to insufficient evidence and 2 were deferred subject to an ongoing process. No doctors were referred for non-engagement.

The funding for the existing has 58 approved appraisers has been moved centrally to deliver long term equity, no additional funding has been agreed; however, the costs associated with recruitment of medics needs to include this to ensure adequate appraisers are available. We currently have a ratio of 7 appraisees to each appraiser (this is within the required 5-8 ratio). The Appraisal lead and deputy appraisal lead are providing appropriate training and networking events.

There have been significant issues within the Job Planning and Appraisal & Revalidation function; this has been due to sickness, staff turnover and annual leave; this has caused delays in the responsible officer function of the Trust.

To provide a clearer oversight and management role of these functions, the Appraisal and Revalidation Teams will realign to the Chief Medical Office once the newly appointed administration teams have commenced in post and relevant knowledge transfer has occurred.

Conclusion

Although the service has experienced some turbulence over the past 12 months due to the fragility of the teams; processes and procedures have been continued to ensure appropriate action is taken where required.

Recommendations

Trust Board are invited to note the content of this report and be assured that appropriate measures and oversight are in place for Medical Appraisal and Revalidation.

Appendices

1. Submission document for Quality Assurance Framework

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Ensure Deputy Responsible officers have received appropriate training. Comments: One Deputy Chief Medical Officer trained Action for next year: 2nd Deputy Chief Medical Officer to be trained.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for efficient cover and reassign the teams to the Chief Medical Officers Team. Comments: Resilience of the appraisal and revalidation team continues to cause issues due to turnover. Action for next year: Once new team appointed & trained – Appraisal and Revalidation team to sit within the CMO Directorate

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for efficient cover and reassign the teams to the Chief Medical Officers Team. Comments: Due to the resilience issues of the team there continues to have some delays in maintaining an accurate record. Action for next year: Work to build a resilient team within appraisal and revalidation within the CMO Directorate.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Policies are monitored by the key documents team & medical resourcing Action for next year: Ensure job planning guidelines have been approved & implemented.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Explore with partner organisations if this would be possible. Comments: Action not completed due to change in Clinical Lead for Appraisal & Revalidation & appointment of deputy. Action for next year: Link with other appraisal & revalidation teams within new foundation group to allow peer reviews to take place.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: Locum doctors whose appraisal is due during their placement with us are supported to undertake their appraisal and provided with any relevant information. Where appropriate, feedback on the doctor's performance is provided to the relevant responsible officer. Action for next year: N/A

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Develop a system that allows a doctor's clinical manager to sign off whether any incidents or complaints needs to be implemented.

Action for next year: Continue to utilise feedback in appraisals. Ensure appraisals aren't used as a method of performance management. Continue wellness checks.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: There is a process for reminding doctors when their appraisal is due; escalation to the appraisal lead and responsible officer where appropriate.

Action for next year: N/A

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Policies in place and reviewed annually

Action for next year: N/A

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Work with the Appraisal Lead to ensure an adequate number of medical appraisers are trained.
Comments: New appraisal lead & deputy appointed in 22/23 who continue to monitor number of trained appraisers.
Action for next year: Further appraisers to be recruited & trained to ensure a resilient workforce.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Ensure there are networking events for Appraisers in 2022/2023
Comments: Appraisers are required to attend a minimum of 1 Appraiser Network events per year hosted by the Medical Appraisal Lead. These events provide a forum for networking and discuss any issues or challenges.
Action for next year: Continue to engage with our medical appraisers.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Further development of our quality assurance process and ensure there is a regular report to Trust Management Executive Committee. Comments: Annual RO report to People & Culture Committee Action for next year: N/A

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Worcestershire Acute Hospitals NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	445
Total number of appraisals undertaken for 1 April 2022 to 31 March 2023	396
Total number of appraisals not undertaken for 1 April 2022 to 31 March 2023	49
Total number of agreed exceptions	14

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Ensure all recommendations are made in a timely manner. Comments: Recommendations are made to the GMC in a timely manner & regular meetings with the ELA in place. Action for next year: N/A

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Ensure that where appropriate these conversations occur. Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A Comments: Clinical governance processes are in place and are supported by clinical governance teams in each division. Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Improve processes for sharing lower-level concerns with the doctor's appraiser. Comments: We have a policy for managing performance and conduct within the Trust and is in line with Maintaining Higher Professional Standards. Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation

and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Develop a policy and document the process for responding to concerns. Comments: The Trust currently uses the MHPS policy. There is a process in place for responding to concerns, but this is not formally documented. Action for next year: Develop & implement a policy and document the process for responding to concerns.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Develop a policy and document the process for responding to concerns. Comments: This is not currently in place Action for next year: Develop & implement a policy and document the process for responding to concerns, including guidance.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: N/A Comments: Appraisal and Revalidation Team support the completion of MPIT forms on behalf of the Responsible Officer to transfer information. If urgent the RO will telephone other RO Action for next year: N/A

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Develop a policy and document the process for responding to concerns, including guidance. Comments: Due to turnover of Appraisal and Revalidation administration team, this action will be rolled over to this year, Action for next year: Develop & implement a policy and document the process for responding to concerns, including guidance.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A Comments: Doctors in Training and both permanent and fixed term non-training Trust doctors are cleared for employment in line with the NHS Employment Check Standards, including the checking of GMC licence to practice and qualifications. This is also assessed through shortlisting and interview by a panel of experienced and trained consultants supplied by the specialty department. Short-term doctors (bank and agency) are recruited via NHSP who subscribe to the same standards of employment checks, and who seek approval of CVs from divisions prior to booking workers. Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following: - **Current Issues:** Issues with the resilience of the Appraisal and Revalidation team

- due to sickness / staff turnover
- **New Actions:**
- Develop a policy and document the process for responding to concerns.
- Improve processes for sharing lower level concerns with the doctor's appraiser.
- Further development of our quality assurance process and ensure there is a regular report to Trust Management Executive Committee.
- Develop a system that allows a doctor's clinical manager to sign off whether any incidents or complaints needs to be implemented.
- Ensure Deputy Responsible officers have received appropriate training.
- Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for e*fficient cover and reassign the teams to the Chief Medical Officers Team*

Overall conclusion:

The process for ensuring that doctors receive an annual appraisal and are appropriately revalidated is secure, accepting that the resilience of the Appraisal and Revalidation Team remains a risk. Further development is needed to ensure the quality of appraisals is high and that processes around concerns or escalations are transparent and fair.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc L

Audit and Assurance Committee Report

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

Accountable Director	Colin Horwath, Audit and Assurance Committee Chair		
Presented by	Colin Horwath, Committee Chair	**Author /s**	Jo Wells, 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		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 28 September 2023. The following key points are escalated to the Board's attention: **1. Internal Audit Progress Report** Terms of Reference for job planning had been agreed. Testing on complaints had completed. Budget setting work was underway and there had been a reduction in historic outstanding recommendations. Committee received an update on progress of recommendations of the Data Protection Security Toolkit Audit Report. **2. Urgent & Emergency Care Major Refurbishment Programme** Committee reviewed slides that had been presented at the Board Development Workshop. Financial impact, value for money and lessons learnt were discussed. A further report was requested to be presented at the next meeting. **3. Accountability Framework** Committee reviewed the Framework which was being presented to Trust Board for approval. The Committee undertook to review the new arrangements once they had bedded in as part of its normal cycle of reviewing Committee Effectiveness. **4. Trust Response to NHSE Letter – Verdict in the Trial of Lucy Letby** The report had been reviewed at Trust Board and provided assurance that processes are in place and monitored regularly.

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc L

5. Debt Write Off
Committee approved 19 invoices to be written off. 11 had been taken through a debt recovery process.

6. Debtors & Creditors
Committee reviewed the report which provided assurance that internal controls are in place for balances over £5k or over 6 months old.

7. Waivers
A number of the waivers were externally driven by third parties. A Business Analyst was working with the Procurement Team to assist with influencing and changing behaviours to retrospective waivers.

8. VFM Assurance
Positive progress was being made against the recommendations from the 22/23 audit.

9. Risk Management Strategy
Committee reviewed the report which would progress to Trust Board for approval.

10. Financial Performance, Controls & Governance Self-Assessment
NHSE had requested evidence to support assurance against a number of elements. A response was awaited from the Region.

11. Lessons Learnt from External Audit 2022/23
The report identified the work underway against the recommendations. The asset verification process had commenced.

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

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

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

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc M

Board Assurance Framework

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

Accountable Director	Erica Hermon, Company Secretary		
Presented by	Erica Hermon, Company Secretary	**Author /s**	Erica Hermon, 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
Finance and Performance	27 September 23	Recommended
Quality Governance	31 August 23	Recommended
People & Culture	October 23	

Recommendations	To review and approve the proposed changes to the Board Assurance Framework on a confirm or challenge basis.

Executive summary	This report sets out the full Board Assurance Framework (BAF) following a process of review by Executives and Board Committees • The full BAF (at the current point of review) is enclosed within the reading room • There have been **one change in BAF risk score** • There have been **two changes in level of assurance**; • Supporting detail and control measures for risks (at the current point of review) have been reviewed and updated. There has been significant BAF review and consideration of the implications of the ongoing industrial action. This has resulted in de-escalation and escalation of BAF risk 22 during this period. The BAF has evidenced itself to be effective and responsive during this challenging period and thus the assurance level of the BAF overall has raised to level 6.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All BAF risks as outlined in this report.*
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 x | 7 | N/A		
Financial Risk	*If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality*		

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	19 October 2023
Paper number	Enc M

	of care that is provided. Individual risks and associated controls and or mitigating actions may have financial implications.

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		As per report	
If no has the action plan been revised/ enhanced	Y		N		As per report	
Timescales to achieve next level of assurance	As outlined for each risk					

Introduction/Background

The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.

The Audit and Assurance Committee also has oversight of the BAF to inform the annual programme of internal audit activity and to allow the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which the BAF is an integral component. Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives.

This report provides assurance as to the management of strategic risks which are presented on a confirm or challenge basis.

Issues and options

BAF Summary

A summary of the risk position is as follows:

	Number	**Comment**
New Risks opened	0	
Risks Closed	0	
Risks Escalating	0	
Risks Escalating	1	BAF 22 as a result of the current position in relation to industrial action
Risks De-escalating	0	
Total risks identified	16	
Level of assurance changes	3	+1 : BAF 2 and 22 (increased) - 1 : BAF 9 (reduced)

Risk Narrative Updates

Reviews of risks are ongoing and updates made to current BAF risks in respect of the actions, controls and mitigations. The latest full BAF is enclosed in the reading room. The BAF will be further updated ahead of Board sub-committees.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
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Paper number	Enc M

Mapping of Strategic Risks Against Strategic Objectives

The table below shows a mapping of the Trust's strategic objectives and goals against the risks identified in the assurance framework. All strategic objectives and goals are covered by a range of risks.

		BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20	BAF 21	BAF 22
Strategic Objective	Best services for local people	X							X	X			X	X	X			X	X
	Best experience of care & outcomes for our patients		X	X					X							X	X		X
	Best use of resources				X	X			X										
	Best people						x	x	X		X	X		X					
Goal	Goal – strategy	X							X	X		X	X	X	X			X	
	Goal – quality		X	X					X							X	X		X
	Goal – finance				X	X			X										
	Goal – workforce and culture						X	X	x		X	X							X

Risk Appetite

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level.

The Trust Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. Committees review the BAF and can makes recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

Conclusion

The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is static from the last report and mitigating actions are as outlined in this report.

Recommendations

To review and approve the proposed changes to the Board Assurance Framework on a confirm or challenge basis.

Appendices

High level BAF risk summary

Risk Number	Theme	Risk Description	Exec Lead	Responsible Ctte	Current Likelihood	Current Consequence	Current Risk Score	Change	Previous Risk Score	Initial Risk Score	Target Risk Score	Risk Appetite	Level of Assurance	Change2
2	Engagement with patients, public and partners	If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Director of C&E/CNO	QGC	3	4	12	→	12	12	3	Moderate	5	↑
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	CMO/Dir of S&P	QGC	3	4	12	→	16	15	5	Low	4	→
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/CMO	QGC	3	4	12	→	12	20	8	Low	4	→
7	Finance	If the Trust fails to put in place a financial plan that is both credible and achievable with the resources available then it risks failure to achieve its statutory duty to remain within its resource envelope and contribute its share to delivery of the ICS Plan.	CFO	F&P	5	4	20	→	20	15	12	Low	3	→
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	CFO	F&P	5	4	20	→	16	15	12	Moderate	2	→
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Director of People & Culture	P&C/Trust Board	3	5	15	→	15	15	9	Moderate	4	↓
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People & Culture	P&C/Trust Board	2	5	10	→	10	15	6	Moderate	5	→
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of C&E	QGC	4	4	16	→	16	12	8	Moderate	4	→
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	4	16	→	16	20	10	Low	3	→
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	Trust Board	3	4	12	→	12	12	8	Moderate	5	→
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	3	4	12	→	16	20	15	Low	6	→
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	COO/Dir P&C	QGC/P&C	4	4	12	→	16	12	8	Low	5	→
18	Activity	If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase	COO	QGC/F&P	4	5	20	→	20	25	8	Low	5	→
19	System working	If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer	COO	QGC/F&P	4	4	16	→	20	16	8	Low	3	→
20	Urgent care	If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow	COO	QGC/F&P	5	4	20	→	16	16	8	Low	3	→
22	Industrial Action	There is a risk that services and patient care/treatments will be disrupted by staff shortages due to possible (ongoing) industrial action by the NHS trade unions resulting in delays to patient care, patient harm and a poor patient experience.	COO/Dir. of People & Culture	QGC/P&C	3	4	20	↑	12	20	12	Low	5	↑