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

Shift leader supernummary

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

One to one care in labour

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

Staffing incidents

There were 25 staffing incidents reported in August. No harm/insignificant harm was recorded. The themes reported this month are:

- Availability of CoC midwives (3) – ongoing work to improve reporting of availability.
- Availability of medical staff (1) – no cover for elective list
- In escalation and requirement to deploy staff to delivery suite to ensure that 1:1 care is provided and the shift leader remains supernummary (21).

Staffing levels were maintained at or above minimum agreed levels with the support of the on call community midwife and the continuity team midwives were also requested to provide cover due to the increase in COVID related absence. No harm was reported in this period however some reports continue to be incorrectly initially scored as minimal harm – further training is planned with the team to ensure that harm levels are appropriately recorded although this has not been completed to date due to current staff shortages in the governance team.

It continues to be acknowledged that any reduction in available staff can result in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and concern about staffing levels, burnout and staff health and well – being. A Trust psychologist has been working with the team to support staff wellbeing and initial feedback from the team has been very positive however this was not available throughout August and is expected to recommence in September.

Medication Incidents

There were 9 medication incidents and no harm was reported.
The fi incidents were due to:

- Additional doses of medication given before the appropriate interval (2)
- Contraindicated medication – Codeine administered to BF mother
- BCG vaccine error
- Omission in administration (5)

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

Unify data

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

The fill rates demonstrate an improvement for RM cover on day and night shifts however it demonstrates a reduction of MSWs on day shifts but an improvement on night shifts.

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

	Day RM	Day HCA	Night RM	Night HCA
Antenatal Ward	93%	80%	102%	95%
Delivery Suite	75%	58%	97%	91%
Postnatal Ward	89%	84%	87%	93%
Meadow Birth Centre	69%	88%	86%	85%

Daily staff safety huddle

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

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

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

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

Two national SitReps are also completed to provide assurance for provision of the full range of maternity services, capacity and safe staffing.

Sickness

Sickness absence rates were reported at 6.62% in August which represents a sustained decrease in sickness absence within the inpatient areas. The reason reported for the majority of absence continues to be recorded as 'mental health' or 'other'.

The following actions remain in place:

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

Actions throughout this period:

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

Conclusion

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F1

We have seen a increase in the number of available staff throughout August alongside a higher than expected birth rate/activity which has reduced the ability to meet acuity. Additional actions taken did provide appropriate mitigation to maintain safe staffing levels.

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

Redeployment of staff and requests to community colleagues to support the inpatient area were made. Continuity of Carer team support was required in August.

Sickness absence rates have been reported at 6.62% which continues to demonstrate an improvement however it is noted that rates remain above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively. Workforce data is now routinely available for this group of staff and will support future workforce planning.

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

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

Recommendations

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

Appendices

NHS
Worcestershire Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F2

Maternity Service Improvement Plan - update

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

Accountable Director	Paul Brennan – Chief Operating Officer		
Presented by	Justine Jeffery – DoM Becky Williams – DDOps Angus Thomson - DD	**Author /s**	Justine Jeffery – DoM Becky Williams – DDOps Angus Thomson - DD

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	21/09/2021	Noted (front sheet narrative since updated for QGC)
QGC	30/9/21	Noted

Recommendations	The Trust Board are asked to: • Note the contents of the paper • Note the update to the plan

Executive summary	This paper provides a background to the current position of the maternity service at Worcestershire Acute Hospitals NHS Trust and an outline of the maternity service improvement plan (MSIP). This is the first quarterly report on the MSIP; with an update to the content of the previous paper first presented in July 2021. The following actions have been completed to progress the MSIP and have been added to the previous paper as an update: • Formal MSIP launch event booked for 29th September 21 and communicated to whole maternity team • Work stream leads appointed • MSIP discussed at Divisional & Director of Midwifery Briefings • Commenced process to monitor delays in IOL pathway so an improvement can be demonstrated. • Funding for posts required to support the plan have been agreed and recruitment has commenced The MSIP provides a structure for future service improvement in collaboration with the wider team in maternity services. The MSIP follows on from actions that have been completed by the leadership team over the last 18 months in response to the challenges faced by the service. These are summarised below.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Staff and wellbeing

- 40 midwives employed in the last 18 months across the whole maternity service; increased midwifery leadership and new roles to improve quality
- Employed agency midwives, explored general nurses to support the rota
- Non clinical midwives regularly deployed to support clinical area
- Offered additional financial incentives to support the rota
- Secured additional funding to ensure that staff can be released for mandatory and role specific training
- Project completed to identified team members eligible to complete MSW training to support community and postnatal teams in the future
- Psychologist working with team to improve wellbeing
- Reduced sickness absence by 50%

Leadership, visibility, communication

- Daily walk-arounds by a member of the DMT / Monthly Divisional Briefings
- Recommenced team meetings and the Community Forum
- Monthly DoM Q&A
- Staff private FB page – used to compliment other forms of communication
- Introduced 'matron of the day' bleep to improve communication & escalation
- Introduced leads for continuity of carer to improve communication and support to ensure that the model is delivered effectively

Operational management of the service

- Paused continuity of carer roll out
- Introduced self- rostering in 3 teams – plan to roll out to whole service
- Daily safety huddles and escalation process to request further huddles as required to manage capacity & flow
- Introduced dedicated elective CS team
- Reviewed escalation policy, introduced maternity SitRep and attendance at hospital bed meetings to improve escalation and visibility of challenges

Safety and quality

- Increased incident reporting culture
- Reviewed and published new RFM and IOL guideline
- Introduced fetal surveillance midwives to support midwives in clinical practice
- Introduced Badgernet information system & continue to roll out additional functions and changes in response to staff feedback

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

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

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

Worcestershire Acute Hospitals NHS Trust

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Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N		
If no has the action plan been revised/ enhanced	Y		N		
Timescales to achieve next level of assurance	**January 2022**				

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F2

Maternity Service Improvement Plan

Worcestershire Acute Hospitals NHS Trust

Authors:

Justine Jeffery – Director of Midwifery

Becky Williams – Director of Operations Women and Children's Division

Angus Thomson – Divisional Director Women and Children's Division

June 2021

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1. Introduction

The maternity service at Worcestershire Acute Hospitals NHS Trust (WAHT) delivers 5000 women per annum. The service is staffed by an establishment of 218 midwives, 55 non registered midwifery support workers and 16 consultants (obs & gynae) and 35

middle grade/junior medics shared across obstetrics and gynaecology. Services provided are shown in diagram 1:

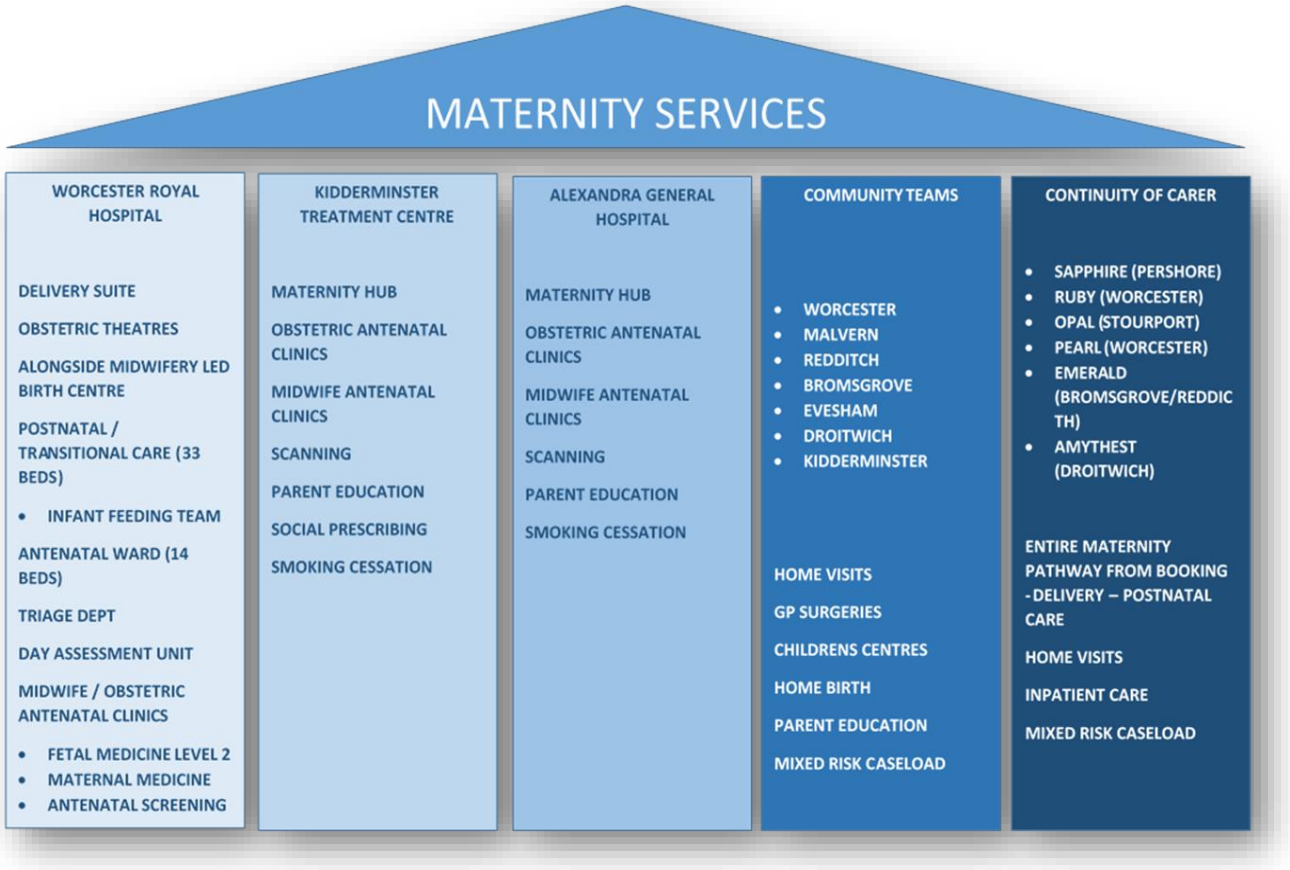


Diagram 1 Maternity services WAHT by site

The service sits within the Herefordshire and Worcestershire Local Maternity and Neonatal System (LMNS), and has worked within the system to deliver the National Maternity Transformation Programme requirements over the past 3 years.

In the past year the maternity service at WAHT has experienced decreasing staff morale, an increase in staff CQC whistleblowing / negative press and concerns raised by team members regarding the safety of the service. This has led to increasing internal and external scrutiny of the service, with the CQC undertaking an unannounced inspection in November 2020, and the downgrading of maternity from ‘good’ to ‘requires improvement’ on well led.

The position of the maternity service has been driven by midwifery staffing shortage, the impact of the COVID-19 pandemic on staffing and leadership deficits. These

challenges have been overlaid with the change management process to deliver Continuity of Carer, a key requirement of the National Maternity Transformation Programme.

Due to the challenges faced by the service, a decision has been made to put on hold further roll out of the large scale transformation of the service, Continuity of Carer. Since October 2020 the Division has undertaken some key transactional actions to remedy concerns raised by team members and the CQC. Whilst this action plan is having some impact, it is now recognised that, moving forward, a structured service improvement programme is required to ensure engagement of team members across the service, and ultimately support cultural change. It is hoped that this will then facilitate the positive restart of our transformation programme in line with national requirements.

This paper provides detail on the journey of the maternity service to date together with an outline of the proposed service improvement plan with:

- A progress update on delivery of the National Maternity Transformation Programme within the WAHT maternity service
- An outline of quality and safety measures within the service, and a provision of assurance that these measures are being followed and indicate that the service is safe
- A description of the challenges the service has faced
- An overview of the work to date on service improvement actions
- The proposed service improvement plan to address challenges going forward, key performance indicators, risks and timeline

2. Maternity transformation – the national and integrated care system (ICS) context

The national vision for maternity services is described in

- Better Births: improving outcomes of maternity services in England (DH,2016)
- NHS Long Term Plan
- The National Maternity Transformation Programme

The maternity strategy in Herefordshire and Worcestershire is aligned to the National Maternity Transformation Programme. The local strategy seeks to achieve the vision set out in Better Births by bringing together a range of organisations under the umbrella of the Herefordshire and Worcestershire Local Maternity and Neonatal System (LMNS). Over the last 3 years WAHT maternity service has been working within the LMNS to deliver the national transformation programme.

Work streams for national transformation are shown the diagram below:

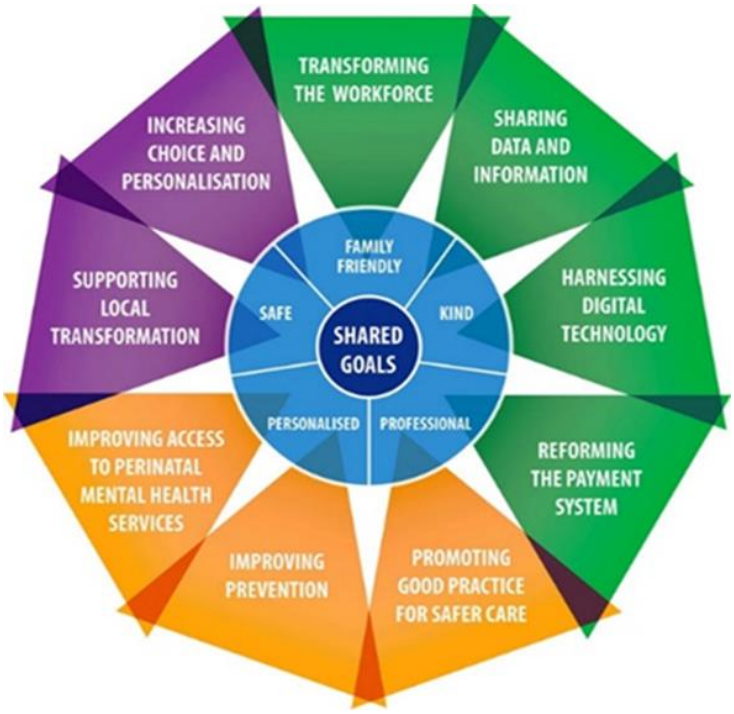


Diagram 2 National Maternity Transformation Work streams (NHS England/RCM, 2020)

3. Progress with maternity transformation at WAHT

Working within, and enabled by, the Herefordshire and Worcestershire LMNS the Maternity team at WAHT have made progress on a number of key areas of the local system transformation programme. These are:

3.1 Supporting transformation

a. Delivery of Continuity of Carer to 28% (target 35% by March 2021)

- The roll out of continuity across Worcestershire has been successful to date, with demonstrable improved outcomes for mothers and babies on a continuity pathway. The challenges of introducing & maintaining the model will be discussed later in the paper.

3.2 Harnessing digital technology

- The Badgernet maternity system was introduced in 2020, including the roll out of patient held digital maternity records.

- Virtual safety huddles are taking place between Wye Valley Trust and Worcester Acute

3.3 Transforming the workforce

- The midwifery leadership team have been working with Health Education England to transform the midwifery support worker workforce.
- The nationally recommended tool, Birth Rate Plus, has been utilised to ensure the midwifery establishment is right sized
- A Continuity of Carer coach has been employed to support the workforce to develop autonomy as self-managing practitioners.

3.4 Perinatal Mental Health (PMH)

3.4.1 Maternal mental health services (MMHS)

- MMHSs are a key part of NHS England and NHS Improvement's (NHSE/I) programme to transform specialist perinatal mental health services across England, as outlined in the NHS Long Term Plan

- In 2020 the LMNS submitted a successful proposal to NHSE/I and received funding to take part in the development and testing of Maternal Mental Health Services. The work that sites will do in 2020/21 and 2021/22 will be vital to ensure that MMHSs are available across the country from 2023/24. This will combine maternity, reproductive health and psychological therapy for women experiencing moderate-severe/complex mental health difficulties directly arising from, or related to, the maternity experience. The service is currently on track to commence in Autumn 2021.

3.5 Personalisation

3.5.1 Introduction of Maternity 'hubs' - at Kidderminster and Alexandra hospitals

- The hubs have brought together services to support women in the antenatal and postnatal period; thus, improving personalisation and choice and prevention, for example, smoking cessation initiatives.

3.5.2 Consultant Midwife

- In 2018 the Trust employed a Consultant Midwife who is the strategic lead for the implementation of Continuity of Carer across Worcestershire. This full-time post is shared equally with the University of Worcester.

- In the recent Ockenden report it is recommended that each Trust considers the maternity leadership requirements set out by the Royal College of Midwives in 'Strengthening midwifery leadership: a manifesto for better maternity care' which recommends an increase of Consultant Midwives to provide enhanced midwifery leadership.

3.6 Prevention

- The maternity team have worked with Public Health England partners to implement smoking cessation and now pelvic floor services within the acute setting.
- Funding has been provided for 1.8WTE public health midwives in Worcestershire for 2 years to focus on smoking, obesity and lifestyle.

4 Assurance of quality, good practice and safer care

The assurance of quality and safety within our maternity service is achieved in a number of ways: Regulatory assessment via CQC, submission of quality and safety measures under the Clinical Negligence Scheme for Trusts (CNST) together with evaluation against service reviews such as Ockenden. This is underpinned via submission of the maternity minimum data set which is a set of key quality performance indicators for the service.

4.1 CQC

In 2018 the maternity service at WAHT was rated 'good' by the CQC. In 2020, prompted by a number of whistle blows focussing in the impact of midwifery staffing levels and continuity of carer on the safety of the service, the CQC made an unannounced visit to the maternity service. The outcome of this visit was a reduction in the 'well led' key line of enquiry to 'requires improvement'. This then reduced the overall rating of the service to 'requires improvement'.

No concerns regarding service safety were raised, acknowledging the escalation policy in place to ensure safe staffing. 'Must dos' were related to staffing, recording of escalation and leadership.

As a result of the reduction in the CQC rating on well led the maternity team has been supported by the NHSE/I maternity service improvement team who are helping to identify specific interventions to improve the service.

4.2 Mortality and Morbidity

4.2.1 MBRRACE

MBRRACE – UK publishes a number of reports to monitor national perinatal mortality and morbidity and also maternal deaths. The three sets of published reports are:

Confidential Enquiry into Maternal Death and Morbidity (latest publication January 2021 reporting on deaths that occurred in 2016-18)

Perinatal Mortality Surveillance Report (latest publication 10th December 2020 reporting on deaths that occurred in 2018)

Perinatal Mortality and Morbidity Confidential Enquiries. (latest publication 28th November 2017)

The Perinatal Mortality Surveillance report provides trust specific data and this is presented in *Table 1.* The figures below provide a comparison to the average still birth and neonatal death rates for similar Trusts in the UK.

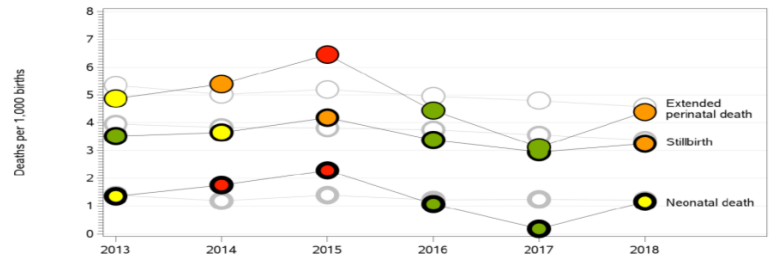
Table 1. Comparison to the average for similar Trust

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	17	3.24	3.40 (2.76 to 4.16)	Up to 5% higher or up to 5% lower
Neonatal	6	1.15	1.14 (0.72 to 1.79)	More than 5% and up to 15% lower
Extended perinatal	23	4.38	4.53 (3.81 to 5.64)	Up to 5% higher or up to 5% lower

In summary the Trust reported fewer neonatal deaths in this period and slightly higher numbers of still births (up to 5% higher). This is due to a slightly higher than national intrapartum stillbirth rate as the Trust reported 3 deaths in 2018 when the national average rate was 1.5 cases. It is recognised that these rates are subject to random variation, especially when the number of deaths is small.

The stabilised & adjusted mortality rates are presented in chart 1 which provide more reliable estimates of the underlying (long-term) mortality rates for the Trust.

Chart 1 Crude mortality rates for the Trust



4.2.2 Healthcare Safety Investigation Branch (HSIB)

HSIB conduct independent investigations of patient safety concerns in NHS-funded care across England. WAHT have made referrals to HSIB since 2018 following agreed criteria which includes:

a. Babies

- Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour, who have one of the below outcomes.
- Intrapartum stillbirth - Where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death - When the baby died within the first week of life (0-6 days) of any cause.
- Potential severe brain injury - Potential severe brain injury diagnosed in the first seven days of life, when the baby:
  - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE).
  - Was therapeutically cooled (active cooling only).
  - Had decreased central tone and was comatose and had seizures of any kind.

b. Maternal Deaths

- Investigate direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

Following the receipt of each report an action plan is prepared which is monitored via the Maternity Governance Meeting and the Trust Serious Incident Review Group.

HSIB provide regular quarterly feedback to the Trust; this feedback is a summary of the reports completed. To date the following themes have been identified:

4.3 CNST maternity incentive scheme

CNST supports the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. In order to meet the incentive, scheme the Trust must achieve 10 safety actions. Including

- Achievement of Saving babies lives care bundle version 2
- Evidence of perinatal mortality reviews
- Trust maternity safety champions
- Coproduction with MVP
- Safe staffing levels

In 2021/22 the Trust will be submitting compliance with all 10 safety actions.

4.4 Review of Maternity Services across England

Following the National Maternity Review in 2016 the publication of 'Better Births' provided a number of recommendations to improve safety for women and their babies. This informed the national maternity transformation plan and was implemented locally via the LMNS.

Since the publication of 'Better Births' two formal inquiries have been undertaken in England and significant safety issues have been identified at both Shrewsbury & Telford NHS Trust (Ockenden inquiry) and East Kent Hospitals University NHS Foundation Trust. Nottingham University Hospitals NHS Trust has recently been highlighted as having significant safety issues and it is unknown at this time whether another national inquiry will be requested.

Due to the repeated, reported safety concerns in some of England's maternity services a change in local and national surveillance has been developed to monitor and provide assurance that progress against inquiry recommendations is delivered.

4.4.1 Ockenden Review

The recommendations of the Ockenden inquiry were published in December 2020 and each Trust was required to submit initial evidence against eight immediate and essential actions. Initial submissions suggested a positive position with no immediate actions to be undertaken and where gaps were identified progress has been made e.g. recruitment of a fetal wellbeing midwife and development of a process to review serious incidents at Trust Board before submission to the LMNS.

A further submission of evidence (approximately 200 documents) to NHSEI was completed on 30th June 2021. The outcome of this submission will be reported to the Trust and further opportunities for improvement will be highlighted at that time.

4.4.2 Perinatal Surveillance Model

Published in December 2020 the revised quality oversight model has the following four principles;

Principle 1 – Strengthening trust-level oversight for quality (local)

Principle 2 – Strengthening LMS and ICS role in quality oversight (system)

Principle 3 – Regional oversight for perinatal clinical quality (region)

Principle 4 – National oversight for perinatal clinical quality (national)

To date the maternity service at WAHT has succeeded in implementing principle one and is currently working with the LMNS to develop a standard operating procedure to ensure that principle 2 is embedded

4.4.3 Expected future quality and safety reviews / measures

Further inquiry recommendations are expected in autumn 2021 as the Ockenden inquiry continues and the East Kent inquiry will be concluded.

5 Challenges to the maintenance of safety and future transformation

To date the safety of our maternity service has been maintained, as demonstrated by our KPIs and submissions to CNST and the CQC inspection. However, the maintenance of safety has been demanding in the face of leadership deficit (vacancy and skill set) and staffing shortage overlaid with transformation change in the service. This is reflected in the reduction in our CQC rating on well led, and has a causal link to:

- Low morale in the midwifery team
- Increased whistle blowing, outside normal Trust escalation routes, by maternity team members concerned over the safety of the service which resulted in negative stories in the media
- Concerns from the multidisciplinary maternity team regarding inequalities in care related to continuity of carer

The above concerns have led to a decision to hold further advancement with the major transformational change in the service, Continuity of Carer. The narrative below describes in greater detail the challenges which have contributed to the current position.

5.1 COVID-19 pandemic

The workload within maternity services is all Priority 1 and 2 work that cannot be deferred. Consequently, the maternity workload throughout the COVID pandemic continued with more complex delivery pathways due to Covid, whilst the staff available to deliver the service were depleted due to sickness, shielding and isolation.

During COVID-19 waves 1&2 the focus of leaders in the maternity service was to enact required national guidance, managing pathways and day to day command and control within the service to maintain safety.

Leadership visibility at levels of the service was reduced. Normal meeting arrangements at all levels of the Division ceased in line with Trust guidance; reducing normal routes of communication and support and lessening the ability to cascade/escalate through normal governance routes such as team and Directorate meetings.

The unintended consequence of this was a reduction in communication from ward to board and back, and a reduced access to leaders at all levels to listen to and raise non-COVID-19 related concerns.

5.2 Change management

In the past 2 years the midwifery team at WAHT have seen 2 significant changes which affect working practices and patterns.

5.2.1 Increasing unpaid breaks in a 12-hour long shift

In 2016 the Trust moved the majority of nursing teams to an hour unpaid break in a 12-hour shift; this ensured that team members were taking their requisite rest period. In Women's and Children's, only the gynaecology nursing team moved to the new working pattern. Maternity and Children's services were undergoing centralisation of inpatient services to WRH, and therefore a decision was made to not progress with the change at that time. It was identified in 2019 that this change needed to be enacted to provide equity across the Trust, support rest periods and provide efficiencies where paid breaks were being taken. In 2020 the Division undertook a formal management of change process across nursing and midwifery teams to move them in line with the rest of the Trust. This process closely followed the change management policy and staff side were involved.

Following the change, the impact of staffing shortage and high acuity/activity in Q3 of 2020 meant that the midwifery team were having difficulty in taking their hour breaks. They also felt aggrieved that not all services in the Trust had moved from ½ hour to an hour unpaid break; including ED.

5.2.2 Continuity of Carer

Part of the national transformation programme, Continuity of Carer presents a very different way of working than the traditional community / inpatient model that the maternity team at WAHT have worked within. It also requires midwives to increase flexibility and autonomy at work. The Division took the decision to initially roll out the

current 6 continuity teams via 'willing volunteers' and newly appointed midwives, with a gradual increase in the number of pregnant women cared for under a continuity pathway.

The impact of this gradual change on the remainder of the team was underestimated by the Directorate and Division. The maternity team raised concerns regarding the impact on staffing and pathways within inpatient and traditional community service as well as individual work/life balance and working arrangements. These concerns grew over time, and events to communicate how the new model worked did not touch enough of the maternity team and did not change hearts and minds.

Midwifery staffing shortages in the inpatient area were attributed by the inpatient team to the roll out of continuity, exacerbated by the stepped reduction in numbers on inpatient rotas in line with the roll out of each team, and a lack of communication to the team regarding the true drivers for staffing shortage. This in turn led to poor behaviours demonstrated between different parts of the service.

The gradual roll out also meant that there were 2 models of care running alongside each other. The obstetric consultant team raised concerns that, at times of high induction /suboptimal midwifery staffing numbers, women on a continuity pathway were able to jump the induction queue because they were being cared for by a non-unit midwife, raising the possibility of delay in higher risk inductions of women on a traditional pathway.

5.3 Staffing

The midwifery establishment at WAHT (218 WTE) is in line with the 2018 findings of the Trust Birth Rate Plus (BRP) audit; this was based on 5500 deliveries (the rate in 2017/18). The Trust now delivers circa 5000 women per annum, and subsequent high level 'desk top' evaluations of the service suggest that the establishment could be reduced. The Division is awaiting a date its next formal BRP audit, at which point the establishment will be formally reviewed in line with findings.

In Q2 / 3 of 2020/21 the midwifery workforce, and the staffing levels required in the inpatient areas, were impacted significantly by:

- sickness (8-14%),
- COVID-19 related absence, including high shielding /CEV level
- Small vacancy rate
- flexible working arrangements in the inpatient areas
- a change in the induction policy outside of national guidance which increased induction numbers and acuity (45% induction rate)

This led to suboptimal midwifery staffing levels in the inpatient areas, which were particularly marked during high activity in September & October 2020. Safety in the service was maintained by enacting the maternity escalation policy, but this required the

movement of midwives from their normal working areas on the inpatient wards or community / continuity service. Some midwifery team members did not feel comfortable working outside of their usual working environments, and again this led to a feeling of being unsupported.

HR data has historically been aggregated to Directorate / Divisional level for reporting, therefore the sickness challenges in the midwifery team, were being masked by good performance in other areas of the Division. Sickness hotspots in the service have now been identified as pre-dating COVID-19.

5.4 Staff wellbeing

The maternity team have been well supported in the last 2 years with psychological input and debrief following specific incidents such as maternal death.

COVID-19 presented a new challenge to the support of staff wellbeing. With the leadership team initially very focussed on the operational delivery of new COVID 19 guidance in the service, and managers pulled to cover staffing shortage, support for staff wellbeing was not at the level that it could have been. The Trust wellbeing offer is extensive but may not have been accessed by team members without signposting.

5.5 Leadership

For a period of time during 2019/20 there were significant vacancy gaps in the maternity leadership team, clinically and operationally. It has also now been recognised that there were also some skills deficits in the existing clinical leaders within the service.

This, together with the pandemic, resulted in reduced accessibility and visibility of leaders at all levels of the service. This was highlighted in the Divisional staff engagement sessions in Oct/November 2020 and led to the team feeling unsupported and unable to escalate concerns appropriately.

6 Service improvement plan

6.1 The journey so far

In order to address the challenges described in section 5, the Women and Children's Division developed an action plan. This transactional plan was designed to move towards 'getting the basics right' in the management of the maternity service and combined action from staff feedback sessions with the Divisional and Executive team together with CQC must and should do's.

There are 100 actions within the combined plan and it is recognised that there is some repetition. However, of the 100 actions 76 have now been completed. The action plan is being led by managers within the maternity service.

6.2 Managing future service improvement

In order that the Maternity Service at WAHT can move forward with future transformational change in line with the national programme, it is recognised by the Division that further work needs to be undertaken on service improvement, with increased co-production, engagement and communication with staff within the service. Diagram 3 below outlines the service improvement plan, with 3 key areas of focus.

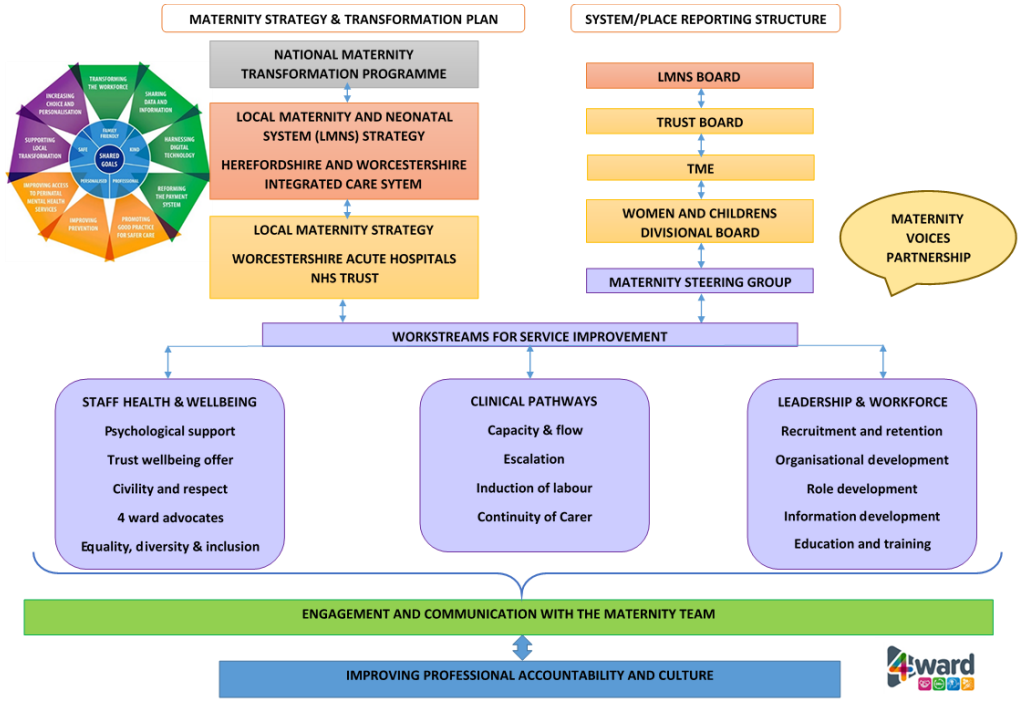


Diagram 3 WAHT Maternity Service Improvement plan

6.2.1 The work streams

As described in diagram 3, the workstreams cover our main areas of challenge; health and wellbeing, clinical pathways and leadership & workforce.

Each work stream will have a lead from the maternity service, and team members from across all areas of the service will be asked to join to shape the outcomes.

Engagement will be sought from service users via the Maternity Voices Partnership. The designated leads for the work streams are as follows:

Work stream	Lead	Co - Lead
Staff Health & Wellbeing	Becky Fox	Nita Nagah

Clinical Pathways	Kate Horton	Anna Fabre-Gray
Leadership & Workforce	Margaret Stewart	Rachel Duckett

6.3 Communication and engagement

The improvement plan will be underpinned by a communication and engagement strategy to ensure team members are fully informed of progress and changes within the service.

This will also be supported by existing routes of communication that are now back in place following the pandemic; ward huddles, team meetings, Directorate and Divisional meetings.

Current leadership visibility routes will be assessed and discussed with the wider team to ensure maternity colleagues feel that leaders at all levels are accessible and visible and that escalation and communication from ward to board is effective.

The Service Improvement Plan has now been shared with the maternity team and a formal launch date is planned for Wednesday 29th September although dates for some of the individual work streams have been shared and are planned to commence in early October.

6.4 Culture

The current culture within the maternity team has contributed, and to some extent been driven by, the challenges the service has faced. There is a level of disempowerment amongst team members, and a lack of civility between individuals, teams within the service and professions.

It is recognised that a positive team culture supports the delivery of a safe service, and is therefore key to maintaining our safety position. The aim of the 3 work streams in the plan is to create a culture where:

- Team members feel positive about coming to work, and attitudes are positive
- Team members / teams are empowered to create their own solutions
- Colleagues at all levels and in all disciplines are treated with civility and respect
- Colleagues feel included and listened to
- Poor behaviours are not accepted
- The Trust 4ward behaviours are demonstrated in all that we do
- All areas of the service feel welcoming to enter
- ‘Leaders’ at all levels promote honesty and demonstrate empathy

The Division recognise that culture takes time to change, but it is hoped that the improvements made will facilitate positive change in the service.

7 Resource requirements to support service improvement

7.1 Operational support

The Directorate structure in the Women and Children's Division has a single Directorate manager covering both the Women's (Maternity and Gynaecology) and Children's (Paediatrics and Neonates) Directorates. The Division recognise that the operational & business support provided by this structure to the maternity service is very limited.

In order to increase the operational support to the maternity service, the Division need to move in line with other clinical Divisions with an 8b Directorate manager for each directorate. This would strengthen the directorate structure, supporting the clinical director and matrons in Women's services and improve engagement and visibility of the Directorate management team within the maternity service.

The Division need agreement/support to the funding of an additional 8b Directorate Manager. The funding required is outlined in Appendix 1 which has now been agreed and recruitment to these posts is underway.

7.2 Governance support

With the increasing workload associated with delivering recommendations of national inquiries it has been identified that an additional governance support is required by the Division. The current team (8a,7, 6 and band 4) cover all specialties within the Division, but current demands mean that governance work is by necessity being added to the workload of other Divisional and Directorate team members.

The Division need an additional band 6 audit & guidelines support and a band 7 governance manager to support the requirements around maternity safety and reporting, and ensure that governance is supported in all Directorates. The band 6 is expected to be covered from Ockenden funding.

7.3 Midwifery roles

The Division await a date for the next Birth Rate Plus audit. Following the outcome of the audit a review of the midwifery establishment will be undertaken to ensure that the service is supported with the requisite number of midwives delivering directly clinical care. and also the requirements of national transformation / inquiry outcomes. This work will be presented once it is available to provide assurance of staffing to national recommendations.

7.4 Corporate support

Support will be required from finance, HR, business intelligence and the project management team.

8 Risks

- If leadership and management skills are not developed in the maternity service there is a risk of non-delivery of the national plan leading to risk of increased turnover, poor reputation, and safety issues
- Non-delivery of national plan leading to a deficit in skills, risk of increased turnover, poor reputation, and safety issues
- Continued low staff morale and poor culture – potential to lead to safety issues, inability to recruit perpetuating staffing shortage resulting in increased escalation and a reduction in leadership capacity
- Loss of income due to poor reputation - if national programme is not delivered / staff morale does not improve then women may choose to birth elsewhere
- Risk of poor reputation leading to lower number of women choosing to book at the Trust and a loss of income

These risks link to BAF risks on clinical strategy, organisational culture, workforce and reputation.

9 Key performance indicators

To monitor service improvement, the following metrics have been agreed to demonstrate success:

9.1 Workforce

Key Performance Indicator	Trust target	Current position
Sickness absence	<4%	Total 7.9%
Turnover	<10%	9.22%
Midwifery Vacancy	<2.5%	5% (vacancies filled awaiting start)
PDR compliance	>90%	67%
Mandatory Training Compliance	>90%	80%
Role specific Training	>90%	75.4%

Table 2 Midwifery workforce data

Main staffing concerns and challenges have focussed on midwifery. Staffing KPIs for the medical team and other professions within the service will continue to be monitored via Directorate and Divisional meetings.

9.2 Quality & Clinical Indicators of Safety

Key Performance Indicator	Trust target	Current position
Induction of labour Rate	< 38%	43%
Elective Caesarean Section Rate*	No national target	13.8%
Emergency Caesarean Section Rate*	No national target	15.6%
Delay in IOL (transfer to DS)	<4hours	TBC
Home births	4%	4.2%
Complaint trend	No target	Trend to be reported

Table 2 Quality and Safety KPIs - whole service

* CQC no longer recognise caesarean section rate as an indicator of safety

9.3 Continuity of Carer

Key Performance Indicators	National Average	Trust Target	Current performance*
No of Births per month	-	108	TBC
Spontaneous vaginal births	55%	<55%	59.4%
Instrumental Births	12%	<12%	10.5%
Elective c/s	13.1%	<13.1%	13.2%
Emergency c/s	16.9%	<16.9%	16.7%
Total c/s	30.1%	<30.1%	29.9%
Home births	2.0%	>2.0%	1.4%
Water birth (of SVB)	-	-	11.1%
% of women receiving I/P care from a CoC midwife	70%	70%	TBC

Table 3 Continuity of carer KPIs

10 Timescales

The work on the improvement action plan continues, with the intention to fully launch the service improvement programme in *September 2021(confirmed date 29th September 2021)*; at this point all vacancies should be filled to required levels allowing the release of staff who wish to engage directly in the work streams.

Work streams will develop individual project plans, with the aim of seeing benefits within 1 year. The Division acknowledges that service/quality improvement is an iterative process and there will be continuing quality improvement beyond this date. The programme will be tied in with the Trust single improvement methodology, when launched, to support ongoing cultural change and staff involvement.

11 Conclusion

The Maternity service at WAHT has had some significant challenges over the last year which have resulted in poor staff morale and the cessation of the roll out of the transformational Continuity of Carer model.

In order to move forward the service needs a structured service improvement programme to support staff and leaders, improve culture and ensure that safety is maintained.

The service improvement plan will aim to deliver:

- Improvements against KPIs within 1 year
- Maintenance of maternity safety
- A re-evaluation and restart of the roll out of continuity of carer
- Continued roll out of other aspects of the national maternity transformation programme
- Improved escalation and reporting from ward to board and back, facilitated by better communication channels and leadership visibility
- Improved morale as demonstrated by direct feedback to leaders and local staff surveys
- Improved staffing levels – driven by improving sickness, turnover and vacancy
- Improvements in behaviours and team dynamics
- Leaders who are equipped with the skills, tools and time to undertake their roles effectively

The Divisions assurance level has been rated as 4. This is based on our current position on midwifery staffing together with the hold on further roll out of Continuity of Carer. The assurance level will be raised to 7 when the service improvement plan delivers the above points and is this reflected in the KPIs.

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F2

12 Recommendation

The committee are asked to:

- Note the contents of the paper
- Note the update to the plan which includes the completion of the following actions:
  - Formal launch event planned
  - Work stream leads appointed
  - SIP discussed at Divisional & Director of Midwifery Briefings
  - Commenced process to monitor delays in IOL pathway so an improvement can be demonstrated.
  - Funding for posts required to support the plan have been agreed and recruitment has commenced.

Appendix 1. Maternity

NHS
Worcestershire Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F3

Learning from Deaths

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

Accountable Director	Mr Graham James, Acting Chief Medical Officer		
Presented by	Mr Graham James, Acting Chief Medical Officer	**Author/s**	Kira Beasley, Business Manager to CMO Gordon Stovin, Senior Information Specialist Dr Stephen Graystone, Clinical Lead for Mortality

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Learning from deaths/Mortality review group	August 2021	For information/discussion.
TME	22 September 2021	Noted
QGC	20 September 2021	Noted

Recommendations	Trust Board are invited to the note content of this report and continue to support improvements to Mortality and Learning from Deaths.

Executive summary	Both standardised measures of inpatient mortality (SHMI and HSMR) continue to be well within expected ranges. Within SHMI we continue to show as something of an outlier for out-of-hospital deaths. Whilst this is not currently having a noticeable, detrimental effect on this morality index we are continuing to explore this anomaly. Full interrogation of current information has taken place to ensure there is no pattern to the deaths reported under SHMI. We are currently unable to review community deaths, however, changes to legislation and employment of additional Medical Examiners & Medical examiner officers (paper on the agenda) will allow further scrutiny and clarity. Our HSMR continues to show us with 'fewer than expected' in-hospital deaths. There are no consistent diagnostic groups that are highlighting a cause for concern across either SHMI or the HSMR.

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F3

	Our crude mortality rate (inc. in-hospital and Covid-related crude mortality) has improved and reflects the move away from the increases witnessed during the second wave of the current pandemic. The Medical Examiner team will focus on Crude mortality alongside mortality reviews to identify themes / patterns. Ongoing / Future work: • A Mortality Information Working Group was established in May with the aim of providing timely, accurate and reliable information in support of the Divisional mortality and morbidity meetings and identifying any key changes to the current bereavement application. • Future analysis/reporting will focus on crude mortality, a review of the SPMI and reporting on the findings from the SJR process. The work undertaken to date has increased understanding of learning from deaths, with developments in ReSpect and End of Life Care. Discussions regarding information and patterns are closer to real time which allows action to be taken in a more suitable timeframe.

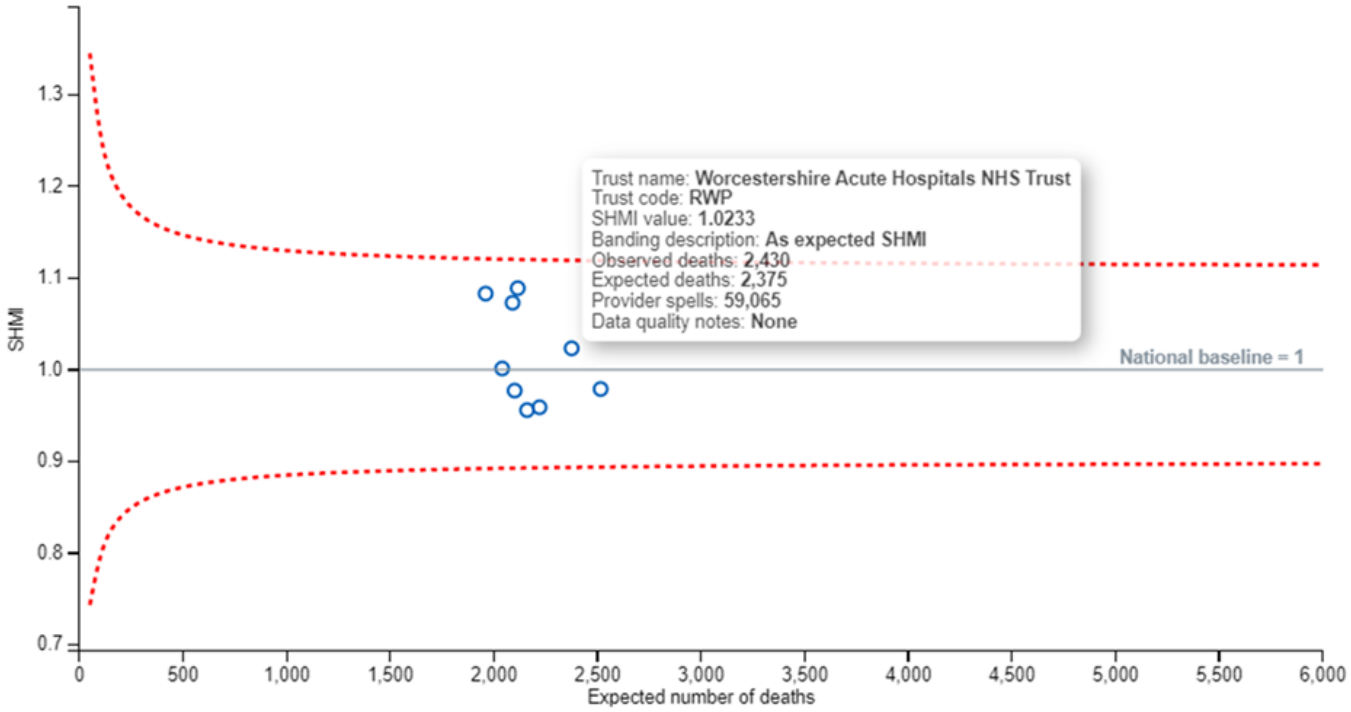
Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	Quality and Safety (4)

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	x
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	April 2022					

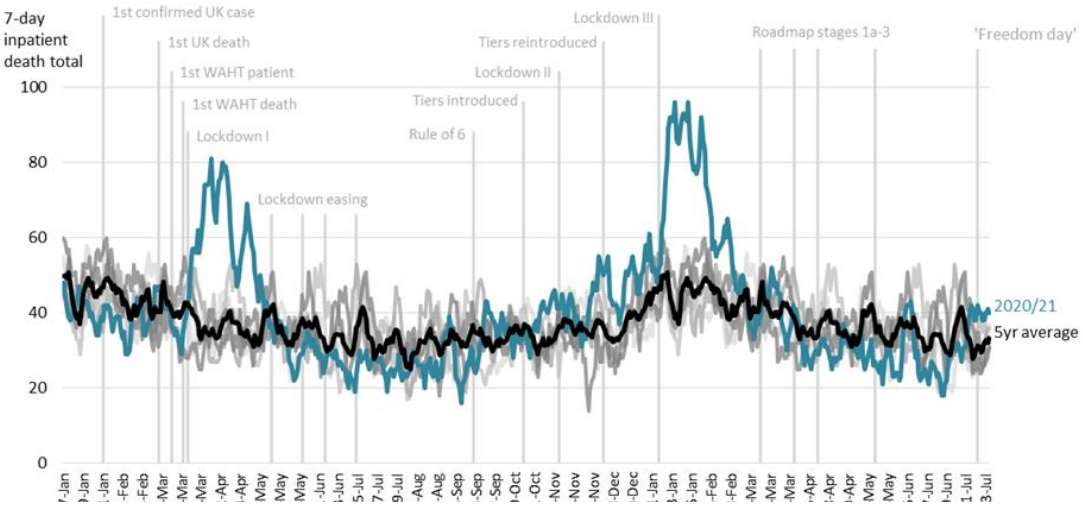
Learning from Deaths - Headlines

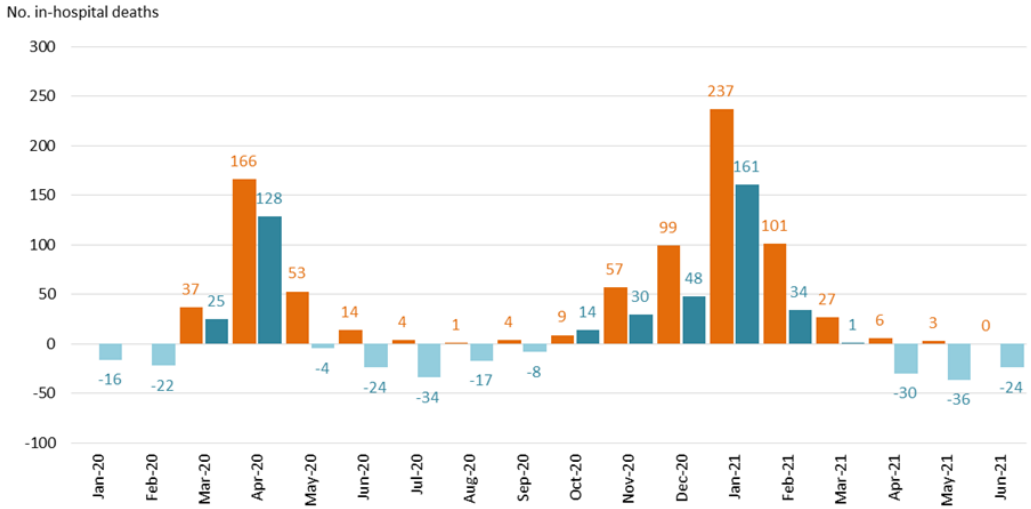
Learning From Deaths	Comments
SHMI	▪ SHMI = **1.0233** (Mar 2020 – Feb 2021) and remains well within 'expected range' at Trust-wide and site level. ▪ We remain something on an outlier for out-of-hospital deaths (within 30 days of discharge) as both a % of all mortality and associated SHMI. Although this has no apparent negative impact on our SHMI. ▪ We continue to sit within the middle of our (previously identified) 'mortality peers' and are 'as expected' ▪ No areas (e.g. diagnostic groups) are highlighted for concern. In fact both Congestive heart failure (non-hypertensive) and Cancer of Bronchus are highlighted with a lower than expected SHMI (ie. fewer deaths than 'expected'. ▪ Short-term projections suggest that our SHMI is unlikely to worsen demonstrably over the coming months. ▪ Information has been interrogated to ensure there is no pattern to the deaths reported under SHMI. We are currently unable to review community deaths, which will allow further scrutiny.
HSMR	▪ HSMR = **98.64** (Apr 2020 – Mar 2021) and is within 'expected range' and below the 'expected' number of inpatient deaths for this period. ▪ There was one possible CUSUM alert in respect of our HSMR. This relates to Abdominal pain but is likely to be a product of delayed or incomplete coding at the time of our HES submission [note: this turned out to be the case] ▪ Like SHMI, our HSMR is mid-placed compared to our mortality peers and is unlikely to worsen substantially over the coming months. ▪ That both standardised models of mortality are well within their 'expected range' suggests that, global pandemic notwithstanding, we are not seeing any unusual trends in mortality (note: SHMI and HSMR do not include deaths directly relating to Covid-19).
Crude mortality (inc. Covid-19)	▪ Crude mortality paints a slightly inconsistent picture with some areas improving whilst others worsen. ▪ As we move through the pandemic and past the peak of wave 2 we can see that our monthly crude mortality rate (inc. Covid-19) and Covid-19 crude mortality rate have improved. ▪ Our crude mortality rate for out-of-hospital Covid-19 deaths increased very slightly. Whilst this does not impact our SHMI, it is further evidence of our out-of-hospital mortality being somewhat out of kilter with our overall mortality trends. ▪ We also have a slightly elevated crude mortality rate when compared to our SHMI peers and the national average. ▪ Early July saw a slight rise in inpatient deaths compared to the five-year average and is/was not attributable to Covid-19. This follows on from three consecutive months (Apr – Jun) with fewer than average deaths. ▪ It is suggested that there should be a focus on crude mortality alongside mortality reviews to identify themes / patterns
Other mortality	▪ Our Standardised Paediatric Mortality Index (SPMI = **139.54**), whilst within expected range has increased for the second consecutive month (since we have been monitoring this). It is also noticeably higher than our mortality peers. This will be reviewed in more detail in subsequent reports. ▪ Pulmonary embolic deaths are unchanged and are similar to that reported nationally and by our SHMI peers.
Learning from deaths	▪ Whilst we are witnessing a growing backlog in completed mortality reviews (a consequence of the pandemic), those completed reviews show that the vast majority are graded 3 (adequate) or better. ▪ For the period Dec 2020 to Jun 2021 there was just one SJR with an overall care grade of 1 (very poor) and 23 with a grade of 2 (poor). This compares with 280 reviews with an overall care score of 4 (good) and 85 with a score of 5 (excellent). Future reporting will explore the reviews in more detail.
Ongoing / future work	▪ A Mortality Information Working Group was established in May with the aim of providing timely, accurate and reliable information in support of the Divisional mortality and morbidity meetings and identifying any key changes to the current (new) bereavement application. ▪ To date a bereavement/mortality dashboard has been created and changes to the bereavement application are scheduled for completion and user testing in early September. ▪ Future analysis/reporting will focus on crude mortality, a review of the SPMI and reporting on the findings from the SJR process.



Our SHMI continues to be favourable (ie. well within the expected range stipulated by the model) and we remain toward the middle of our previously established ‘mortality peers’.

Learning From Deaths

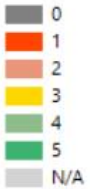


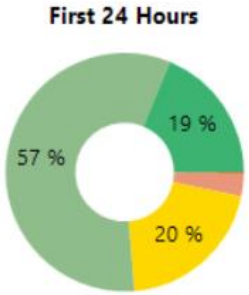


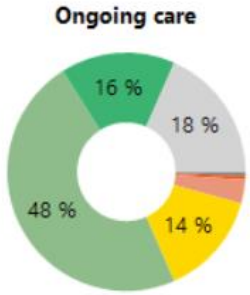
Our crude inpatient mortality has tracked at or below the five year average since the end of wave 2 (although has risen slightly in early July).

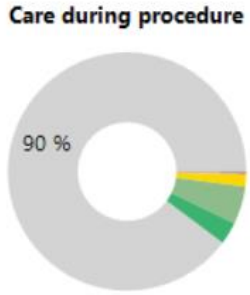
For three consecutive months (Apr-Jun) our crude inpatient mortality has been below that which we would ordinarily expect (ie. compared to 5yr average).

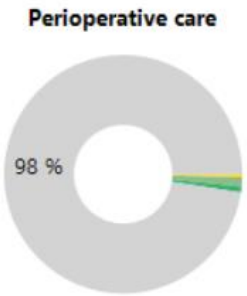
1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

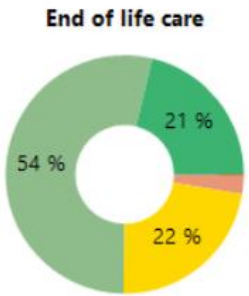


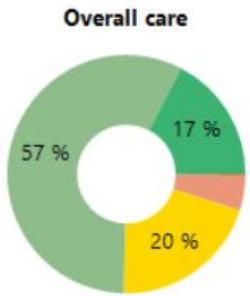


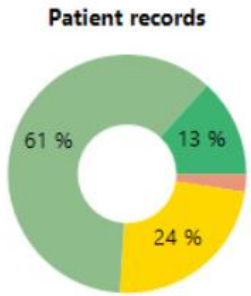












For those SJRs completed between Dec 2020 and June 2021 the quality of care described remains mostly good or excellent.

Levels of Assurance

RAG Rating	ACTIONS	OUTCOMES
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of the desired outcomes.

Conclusion:
The work undertaken has increased understanding of learning from deaths, with developments in ReSpect and End of Life Care. Discussions regarding information and patterns are closer to real time which allows action to be taken.
The Trust will be able to develop a complete picture with Community Deaths Scrutinised in the same manner (report to TME to increase ME staffing submitted for approval)

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F4

WRES, WDES and Gender Pay Gap Report 2021

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

Accountable Director	Tina Ricketts, Director of People and Culture		
Presented by	Felicity Davies, Deputy Director of People & Culture	**Author /s**	Shane Baldwin

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	22 September 2021	Approved
People and Culture	5 October 2021	Approved

Recommendations	Trust Board are requested to: • Approve our workforce race, disability and gender pay data and action plans for publishing. • Note the actions that are being taken to improve our position

Executive summary	This report provides an update on the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standard (WDES) and the Gender Pay Gap (GPG) following preparation of the data for submission to NHS England and publication on our website by the end of September 2021. The submission of data is part of the NHS Standard Contract requirements. The WRES & WDES asks Trusts to measure themselves against 9 metrics to provide a picture of equality in organisations for staff. The GPG shows the Trusts position regarding gender pay differentials. The data has highlighted areas of improvement since 2019 but also continuing gaps in the experience and perception of BAME and disabled staff. The key data and action responses to the data are detailed in Appendix 1 and 2 for the WRES and 3 & 4 for the WDES. The GPG report can be found at Appendix 5.

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 diverse and flexible workforce, we will not be able to provide safe and effective services

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F4

			resulting in poor patient and staff experience and premium staffing costs.

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

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

1.0 Introduction/Background

The Workforce Race Equality Standards (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) reporting are part of the NHS Standard Contract and support NHS organisations to be compliant with the Equality Act 2010 and the 2017 Regulations.

This report outlines the headlines for that submission, the comparison and trends over the past two years and the priority actions that will be taken forward under our Equality, Diversity and Inclusion Strategy.

2.0 Issues and options

2.1 Workforce Race Equality Standards Summary of Trust data

The standard is designed to tackle inequality of experience and under-representation of BAME staff within NHS organisations. As the standard has been in place since 2015 there is national benchmarking data available for some metrics to compare our results with organisations of a similar size and service.

The table in **appendix 1** summarises the Trust's performance against the 9 WRES standards which is based on the 2020 staff survey results and the latest available data at national level.

The data has highlighted the following areas for improvement: -

- There is still a significant under-representation of BAME staff from Band 8a to VSM
- There has been an increase in the scores for BAME staff experiencing discrimination from managers, although this is still below the benchmarked national average.

The data also highlighted the following issues: -

- BAME staff are more likely to experience harassment, bullying or abuse from service users than in 2019 meaning that the gap has increased.
- The gap between BAME and white staffs' perception of equal opportunities for career progression is 16.2% and 2% below the BAME national average.

The data confirms that we have improved in :

- Relative likelihood of white staff being appointed from a shortlisting process compared to BAME staff has fallen from 1.52 to 1.45.
- Relative likelihood of BAME staff entering a formal disciplinary process compared to white staff has fallen from 3.42 to 0.49.

The action plan for approval is attached at **appendix 2.**

Summary of key actions.

- Implementation of the 6 high Impact actions from the Model Employer.
- Continue to support the BAME network to increase membership and implement changes to the recruitment and employee relations processes.
- Implementation of an Inclusion and Anti-Discrimination charter.
- Continue to promote and support implementation of the policies that are in place to tackle and prevent bullying, harassment and discrimination.
- Work in partnership with BAME Network on responding to and tackling abuse towards staff from service users.
- Undertake a review of disciplinary and grievance cases with subsequent actions that tackle over-representation of BAME staff entering into those processes.
- Continue to support and grow the Reciprocal Mentoring Programme.

2.2 Workforce Disability Equality Standard Summary of Trust Data

This new standard aims to decrease the inequality that disabled staff face within the NHS workforce. The standard is based on the social model of disability and it is an annual requirement that the data for WDES is collected and provides the Trust with a picture of equality for disabled staff within the organisation. As such the data has highlighted several issues that the Trust will need to address. In particular it is worth noting that: -

- 4% more disabled than non-disabled staff perceived that the Trust offers equal opportunities for career progression.
- Disability disclosure rates within ESR are low and work needs to be done to increase confidence for staff to feel able to share information about their long term health condition or disability.
- 11.9% fewer disabled staff feel that their work is valued by the Trust than non-disabled staff.
- Disabled staff are more likely to have experienced bullying, harassment or abuse from service users and from staff.
- Disabled staff are more likely to feel pressure to attend work despite feeling unwell to perform their duties.

It is also worth noting that the ESR data for the same reporting period as the WDES shows that 88 staff have shared that they consider themselves to be disabled within their self-service staff record. In the staff survey the questions were answered by 321 staff who identify as having a disability / long term condition. This suggests that a significant number of staff are choosing not to share information about impairments and long-term conditions with their employer but are happy to do so in this anonymous and confidential survey.

Worcestershire Acute Hospitals NHS Trust

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Below is a summary of the WDES activity undertaken by the Disability Network to help address issues highlighted in the report. The WDES data and action plan are included in **appendix 3 and 4** of this report.

Summary of key actions undertaken to-date by the Disability Network.

- A review of the Supporting Attendance Policy with clear guidance for managers on reasonable adjustment processes.
- A system for monitoring the number of capability processes that affect disabled staff has been established.
- Regular network meetings are held to establish a dialogue with staff about their lived experiences of working in the Trust with a disability.
- Benchmarking via the Herefordshire and Worcestershire ICS.
- A review of disabled parking provision is being carried out to address the parking issues that disabled staff report facing.

Gender Pay Gap Summary of Trust Data

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

It is a legal requirement for all relevant employers to publish their gender pay report within one year of the 'snapshot' date: this year's date being 28th August 2020.

The tables in **Appendix 5** outline the Trust's Gender Pay Gap, in summary:

- The Trust's mean gender pay gap is 31.7%
- The Trust's median gender pay gap is 16.0%
- The Trust's mean bonus gender pay gap is 39.68%
- The Trust's median bonus gender pay gap is 40.13%
- The proportion of males receiving a bonus payment is 5.94%
- The proportion of females receiving a bonus payment is 0.50%

The National median gender pay gap is 15.9% with the average GPG in the NHS being between 10% and 18%. Our pay gap is 16.0% which is 0.1% above the national average.

Conclusion

Whilst good progress has been made in increasing representation and reducing inequalities within the Trust this is just the start of our journey. Action speaks louder than words and therefore the focus over the next period is to ensure tangible improvements are made through the implementation of priority areas identified through the staff networks.

Recommendations

Trust Board are requested to:

- Approve our workforce race, disability and gender pay data and action plans for publishing.
- Note the actions that are being taken to improve our position

Appendices

Appendix 1 – WRES Data 2021
Appendix 2 - WRES Action Plan 2021
Appendix 3 - WDES Data 2021

Worcestershire Acute Hospitals NHS Trust

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Appendix 4 – WDES Action Plan 2021
Appendix 5 – Gender Pay Gap Data Report 2021

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F5

Audit and Assurance Committee Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meetings held on 14 and 17 September 2021. The following key points are escalated to the Board's attention: **<u>14 September 2021</u>** **1. Internal Audit Plan** Committee received reports with findings of significant assurance in relation to Covid Governance and Financial Management. Management actions are in place for all recommendations. **2. External Audit** The final audit certificate had not been issued due to the Value for Money (VFM) audit draft not being available. Committee escalated its concerns as to the timetable and agreed to reconvene later that week to review the draft findings and management response. **3. Counter Fraud** Committee received a progress update and approved the counter fraud escalation protocol. **4. Committee Effectiveness Reviews** Committee reviewed the efficacy of Remuneration and Finance & Performance Committees. No matters of concern are to escalated to the Board. **5. Theatres**

NHS Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	14 October 2021
Paper number	Enc F5

Committee had a detailed discussion as to issues raised during a site visit. A business case to procure a GS1 Compliant Inventory Management System along with support in process redesign from an industry expert is nearing completion, however to ensure the broader impact of this issue was considered, referrals were made to QGC, F&P and P&C committees in respect of cultural issues and serious incidents and those Committees asked to report back their assurance.

17 September 2021

1. External Audit

Committee had a detailed discussion and reviewed the draft auditors report and management responses to the recommendations raised, reiterating its concerns as to the tight timetable. Following the meeting, a number of amendments were included with the final report and letter being issued on 20th September. The final auditor's report is appended.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*N/A – the Committee reviews all strategic risks*

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

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