Trust Board Public

Thu 21 December 2023, 13:00 - 14:30

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Information *Russell Hardy*

13:00 - 13:00
0 min

2. Declarations of Interest

Information *Russell Hardy*

13:00 - 13:00
0 min

3. Minutes of Meeting held on 19th of October

Decision *Russell Hardy*

Minutes Public Board Oct 23 SFM.pdf (11 pages)

13:00 - 13:00
0 min

4. Matters Arising and Actions Update

Discussion *Russell Hardy*

TB Action schedule.pdf (1 pages)

13:00 - 13:05
5 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Information *Glen Burley*

December CEO Report WAHT V1.pdf (5 pages)

5.2. Integrated Performance Report

Discussion *Helen Lancaster*

Trust Board IPR Dec-23 (Oct-23_Data)_FINAL.pdf (33 pages)

5.2.1. Quality

Discussion *Sarah Shingler*

5.2.2. Activity Performance

Discussion *Helen Lancaster*

5.2.3. Workforce

Discussion *Tina Ricketts*

5.2.4. Finance Performance

Discussion *NEIL COOK*

5.3. Perinatal Safety Report

Discussion *Justine Jeffery*

- Perinatal Safety Report Oct 2023 v4.pdf (18 pages)
- Midwifery Safe Staffing Report October 2023.pdf (9 pages)

13:05 - 13:35
30 min

6. Items for Approval

6.1. Addressing the Significant Financial Challenges following Industrial Action

Decision *NEIL COOK*

- Addressing the significant financial and operational challenges created by IA.pdf (14 pages)

6.2. Patient Safety Incident Response Plan

Decision *Sarah Shingler*

- PSIRPFront sheet.pdf (3 pages)
- PSRIP FINAL.pdf (44 pages)

6.3. CNST Declarations

Decision *Sarah Shingler*

- CNST Report to Board Document.pdf (56 pages)

6.4. Maternity Safety Support Programme

Decision *Justine Jeffery*

- Request to exit the maternity safety support programme WAHT 161123.pdf (16 pages)
- MSSP Appendix 1.pdf (5 pages)

13:35 - 14:05
30 min

7. Items for Noting and Information

7.1. Communications & Engagement Report

Information *Richard Haynes*

- Communications_and_Engagement_Update_Dec23.pdf (7 pages)

7.2. Committee Terms of Reference

7.2.1. Financial Recovery Board Terms of Reference

Information *Erica Hermon*

- 20231208 Revised Draft FRB Terms of Reference v3 (1).pdf (4 pages)

7.3. Committee Summary Reports and Minutes

7.3.1. Foundation Group Board Minutes

Information *Russell Hardy*

- Draft Public FGB Minutes (WAHT) - 1 November 2023 - Master.pdf (17 pages)
- FGB Public Actions Update Report - 1 November 2023 - Master.pdf (1 pages)

7.3.2. Quality Governance Committee

Information *Julie Moore*

QGC minutes Oct 23 SS.pdf (7 pages)

7.3.3. Audit and Assurance Committee

Information *Colin Horwath*

Audit Minutes 28 September 23 nc.pdf (8 pages)

7.3.4. People and Culture Committee

Information *Karen Martin*

PC Minutes Oct 23.pdf (8 pages)

14:05 - 14:20
15 min

8. Any Other Business

Information *Russell Hardy*

14:20 - 14:25
5 min

9. Questions from Members of the Public

14:25 - 14:30
5 min

10. Date of Next Meeting

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON MONDAY 19 OCTOBER 2023 AT 1:30 PM VIA MICROSOFT TEAMS AND STREAMED ON YOUTUBE

Present:		
Chair:	Russell Hardy	Chair
Board members: (voting)	Glen Burley	Chief Executive
	Simon Murphy	Non-Executive Director
	Colin Horwath	Non-Executive Director
	Dame Julie Moore	Non-Executive Director
	Karen Martin	Non-Executive Director
	Helen Lancaster	Chief Operating Officer
	Sarah Shingler	Chief Nursing Officer
	Tony Bramley	Non-Executive Director
	Christine Blanshard	Chief Medical Officer/Deputy Chief Executive
Board members: (non-voting)	Sue Sinclair	Associate Non-Executive Director
	Richard Haynes	Director of Communications and Engagement
	Jo Newton	Director of Strategy & Planning
	Vikki Lewis	Chief Digital Information Officer
	Michelle Lynch	NExT Director
	Tina Ricketts	Director of People and Culture
In attendance	Justine Jeffery	Director of Midwifery
	Jo Wells	Deputy Company Secretary
	Jo Ringshall	Healthwatch
	Ben Furlow	Living With & Beyond Cancer Project Manager
	Jo Kirwan	Deputy Director of Finance
	Erica Hermon	Company Secretary
	Anna Sterckx	Head of Patient, Carer and Public Engagement
	Chris Douglas	Director of Performance
	Alag Raajkumar	Guardian of Safe Working
Public		Via YouTube
Apologies	Neil Cook	Chief Finance Officer/Deputy Chief Executive
	Richard Oosterom	Associate Non-Executive Director

088/23 **WELCOME**

Mr Hardy welcomed all to the meeting.
During the morning, the Board had focused on flow throughout the hospital and financial performance.

Mr Hardy thanked staff for their hard work through continued pressures, particularly during industrial action challenges.

The new A&E had opened earlier this week and thanks were extended to Clare Bush, Scott Dickinson, the Estates team, Helen Lancaster and all of the teams involved in its effective opening.

The ongoing challenges with A&E waiting times and ambulance handover delays were recognised and apologies were extended to the public and ambulance crews. Assurance

was given that the Board are doing everything in our power to resolve the challenges we are experiencing.

089/23 **ANY OTHER BUSINESS**
No further business was declared.

090/23 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

091/23 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 18 SEPTEMBER 2023**
The minutes were approved with the following amendment:

081/23 – Integrated Performance Section: Workforce: The sickness absence target had been reduced to 4% but was not yet achieved.

RESOLVED THAT: The Minutes of the public meeting held on 18 September 2023 were confirmed as a correct record.

092/23 **ACTION SCHEDULE**
The actions were updated as per the log.

093/23 **CHAIR'S REPORT**
There was nothing further to escalate outside of the Chair's introduction.

RESOLVED THAT: The Chair's report was noted.

094/23 **CHIEF EXECUTIVE'S REPORT**
Mr Burley highlighted the following areas within his report:

- Outpatient Transformation and long waiting times. There are pressures to tackle those waits, implement Getting it Right First Time (GIRFT) best practice and patient initiated follow ups. The Further Faster programme will hopefully soon be rolled out to include a further cohort of trusts including ourselves.
- Integration Frontrunner: The Warwickshire-wide project is having an encouraging impact. Work would continue to focus on pathway discharges to ensure that patients are home first.
- NHS Finances: An £800m deficit across the NHS had been reported. There had been further industrial action and inflation which will have an impact. Difficulties were being experienced throughout the NHS to deliver cost improvement plans.
- Alex Theatres: Two brand new Theatres opened at the Alex during September and would assist with the elective recovery challenge.
- The new A&E opening would feature in the next report.

RESOLVED THAT: The report was noted.

Best Services for Local People

095/23 **10 POINT PLAN**
Mr Burley introduced the Plan which had identified a smaller number of bigger items to focus upon. When agreed, they would be structured to be more staff focused.

Flow was a highlighted opportunity for improvement to ensure that patients get the right care at the right time in the right place. This includes tackling long ambulance waits.

Home First Mindset: Creating a service delivery model to care for patients at home was encouraged. Teams were aware of the harm that can occur when patients remain in hospital.

Staff Experience: There was too much dependency on agency staff and car parking changes were afoot.

Mr Hardy reiterated the 'There's no Place Like Home' mindset, advising that the evidence was clear that, generally, home is best due to hospital acquired functional decline and delirium that patients often suffered from.

Ms Martin was supportive of the plan and queried how it would be shared within the organisation in order for staff to understand the priorities.

Mr Burley replied that it was clear for staff to see the elements that that they can help to deliver. Lead Executive Directors had been identified to support the ideas within the plan. The plan had been shared with senior leaders and a bigger communications exercise would be planned.

Mr Bramley welcomed the clarity of the plan and was supportive. Mr Bramley encouraged flexibility to changing circumstances and using simple, accessible language.

Mr Burley advised that improvement work would be shared between the Group. A cultural approach to improvement is important to get right. Teams needed to respond to emerging issues and the aim is to get as many of our workforce using these methodologies as possible.

Ms Newton added that the Trust were in the second year of a supplier relationship with Virginia Mason and a review had been scheduled to ensure that it is still fit for purpose and works to the needs of the strategic objectives.

RESOLVED THAT: The 10 Point Plan was approved.

Patient Story

096/23 **PATIENT STORY**

Annie and Tracy joined the meeting to share their story.

Ms Shingler welcomed and thanked Annie and Tracy for sharing their experience, which was an invaluable tool to hear firsthand.

In February 2022, Annie was diagnosed with rectal cancer and following a quick referral, she had an operation 6 weeks later. Annie has a permanent colostomy and has received excellent support from the stoma nurses.

Annie commended the colorectal team, who were fantastic.

Annie started attending Wellness Days November last year which was opportunity to chat and have coffee with other cancer patients which she found beneficial. Through attending Wellness days, she heard of Active Always and rehabilitation has been key to her recovery.

Annie stated that she had learnt so much along the way and that was testament to the staff and support groups.

Overall, Annie had a positive experience and was happy with all the care she received. The only lesson that could be learnt was in relation to the delivery of bad news. Annie felt this could be softened and she feared the worst while she waited 4 weeks until her next consultation, where her mind was then put at rest.

Mr Hardy reiterated the importance of empathy during such conversations.

Tracy advised that it was quickly overcome as the consultant surgeon was very helpful and though the treatment went well, chemotherapy did take its toll.

Annie downloaded an app called HealthZone and through this, was able to access counselling when she was suffering with fear of recurrence. Tracy added that the Contact and Meet the Team sections of the app was really helpful and commended the team involved.

Mr Furlow advised that Annie and Tracy had really engaged with the service. Mr Furlow thanked Tracy for providing feedback when the app was being built. Their engagement with the Wellness Days and support groups highlighted how important they are. Feedback is really helpful to grow our services.

Mr Hardy thanked Annie and Tracy for sharing their story and wished them well for the future. It was a good example of the great work we that do and should be proud of.

Best Experience of Care and Outcomes for Patients

097/23 **INTEGRATED PERFORMANCE REPORT**

Dr Blanshard introduced the report. Focus was on improving urgent and emergency care throughout the hospital.

The new ED has now opened.

Board members were informed about a Multi-Agency Discharge Event (MADE) that had takien place to improve discharges during the Board Workshop held earlier in the day.

Industrial action took place in September. Junior doctors took action on 20th-23rd September and Consultants on 19th-21st September. Both groups of doctors provided Christmas day cover which did result in some elective care work being cancelled.

Operational managers were thanked for ensuring that there was safe cover and no clinical safety incidents were reported as a direct result of industrial action.

The new west theatres at the Alex had opened and will be key to progressing elective recovery plans.

The digital team were commended for the introduction of the new electronic patient record rollout of ITU and clinical managers. It was anticipated that on average, 2 hours of nursing time would be saved per day and 2.5 prescription errors per day due to electronic prescribing.

A reforecasting of our position was being undertaken as a consequence of one-off expenditure, cost of industrial action and high bank and agency spend which is partly due to staffing overspill capacity and industrial action.

Operational Performance

Ms Lancaster advised that the new ED opened on 16th October. There had been some small challenges but there was a concerted effort to ensure that we were in the best possible position to move in and function as an ED doing today's work today. It was reported that this week, there had been a 50% reduction in over 1 hour ambulance handover delays and a 10% increase in the 4 hour access target.

Teams were getting used to the new environment and were managing flow well. Plans are in place to maintain improvements and practices.

Due to the hard work of teams, the Trust had been removed from tier 1 oversight arrangements with elective recovery. Work was underway to ensure that 65 week waiters have an appointment by the end of October.

Cancer remains a challenge but recovery plans are in place with trajectories. The 28 day faster diagnosis standard is being driven down and the service was getting closer to the standard of 75%.

There had been a significant increase in cancer 2 week wait referrals within dermatology, which is a fragile service. Teams were continuing partnership arrangements to improve that service.

Maximising opportunities in theatres was being explored and teams were looking at how to embrace the Faster programme moving forward.

Data Quality

Ms Lewis informed that the maturity index value of 92.5 remains higher than the national average.

The emergency data set for EPR phase 7 was being reviewed and phase 3 had been delivered successfully.

Referral to Treatment Patient Tracker List (RTT PTL) 99.48% with 4.64% of pathways identified as having a possible data quality error.

Quality

Ms Shingler informed that there had been IPC challenges due to outbreaks of CPE, C-Diff, norovirus and 7 wards reported active covid. These outbreaks were having a significant impact on managing flow. The Regional team have shared some concern regarding the number of outbreaks. Corridor care and boarding on wards contribute to outbreaks.

Flow and ambulance handover risks were highlighted due to decisions having to be made about beds on blocked wards.

A high number of complaints remained overdue. Main concern remained the surgery division, however Women's & Children's did have some complex complaints which were taking time to resolve. Surgery has secured additional support to clear the backlog and the trajectory for full completion of overdue complaints is the end of November.
The Trust had commissioned a specialist governance lead to review management of the risk process. A report was due next week.

Dr Blanshard informed that there had been improvements with HSMR and SHMI. Overcrowding has meant a more normalised higher mortality rate, and
2 never events had been reported. One investigation had completed and resulted in additional training and an investigation is underway in regard to the other.

Mr Bramley asked for a response to the deteriorating position on use of sepsis bundle. Dr Blanshard replied that compliance is reliant on a manual audit. Performance had deteriorated since the EPR rollout. An improvement workshop had taken place around recording elements. A new module was being introduced in EPR which will trigger the bundle and will improve the ability to audit.

Ms Shingler added that ED is struggling with sepsis. A quality huddle board was being introduced and would be reviewed daily. Audits were taking place twice weekly.

Dr Blanshard informed that mortality from sepsis is below the expected range and there had been no unexpected deaths from sepsis.

People & Culture
Ms Ricketts advised that focus was on reducing temporary staffing costs.

Investments made to the recruitment function was being seen and the plan was on trajectory for vacancy rates and turnover by March.

More traction with sickness absence was required. The target of 4% had been set in line with the Foundation Group.

The Health & Wellbeing offer had been updated but was yet to see the benefits.

All long term sickness plan had been reviewed and Occupational Health were providing support with mental health sickness.

Job plan compliance has seen an improvement and a review had taken place at the People & Culture Committee this month. A deep dive was underway to ensure the of quality of job plans and that they link to activity.

Finance
Ms Kirwan informed that there was a £2.7m deficit reported in month 5 against a planned deficit of £0.9m, presenting an adverse variance of £1.8m.

Variances had been split in to 3 categories: Timing, as a consequence of the final plan, Exceptional items which are incurred costs with industrial action and Productivity & Efficiency, which is the largest contributor to variance.

Cumulative deficit to date is £16.5m against a plan of £8.1m deficit. A forecasting scenario was being drafted.

Capital remains challenged and brokerage discussion was underway with the ICB.
There was a cash balance of £5.1m.

Mr Burley informed that there was likely to be around £35m deficit. Teams needed to focus on the plans in place and that they are delivered.

RESOLVED THAT: The report was noted for assurance.

098/23 **COMMITTEE ASSURANCE REPORTS**

- Finance & Performance – Concerns were expressed in relation to the PEP and Committee reviewed the Accountability Framework.
- Quality Governance Committee – There were a number of escalations, particularly in relation to IPC. Concerns were raised around urology pathways and investigation work would be presented back to the Committee.
- People & Culture Committee – There was an increased level of risk around job planning compliance. The NHS People impact would be reviewed through the Committee.

RESOLVED THAT: The Committee reports were noted for assurance.

099/23 **MATERNITY SAFETY REPORT**

Ms Jeffrey presented the report, advising that adjustments had been made for it to be presented in the Public meeting. The following key points were highlighted:

- KPI targets have been realigned to the Foundation Group.
- There was slight concern regarding turnover and vacancies but plans were in place.
- An announced CQC visit took place last week. A clear action plan is in place to address any issues quickly. Responses to be returned by next Friday.
- CNST continued to make good progress.
- A Cosmos platform was being developed locally to allow a large volume of actions to be monitored in one area.

Mr Hardy commended the team for their quick responses to the CQC.

Mr Horwath queried if anything surprising emerged from the CQC visit. Ms Jeffrey replied that there were some small practice issues. All other items raised were known by the team and plans were in place. The CQC inspector had commented that a number of the plans would be complete and in place within the next 6 months.

Mr Bramley commended the move of the report for information into the public domain.

Mr Hardy requested a visit to maternity and Dr Sinclair advised that she would accompany him.

Ms Shingler thanked the maternity teams and Ms Jeffrey their efforts whilst hosting the visit and the return of evidence.

RESOLVED THAT: The report was noted for assurance.

100/23 **BED CLEANING REPORT**

Ms Shingler informed that bed cleaning is a legacy issue and that designated bed cleaning facilities has been on the action plan since 2021.Proposed costs for a specialist facility to provide bed cleaning ranged from between £1.5-3m and there was no allowance in the capital plan.

Bed cleaning national guidance dictates that a designated facility is not a requirement but there are national standards of cleanliness. A current policy for bed cleaning is in place but the issue is that we were not adhering to the policy. Audits are in place in regard to ward cleaning responsibilities, as are those for ISS and undertaking red cleans.

Following a compliance audit, the failures are in our ward cleaning and clinical teams.

Other Trusts within the Region had been approached regarding their facilities and 7 Trusts responded. Out of the 7, only 2 have dedicated bed cleaning facilities but both were over trajectory with c.diff. Our Trust was the second worst performing Trust within the Region with c.diff. SWFT is below c.diff targets and have done a lot of work with antimicrobial prescribing. The lead would be meeting with the Trust to share learning within the next 2 weeks.

Currently, Worcester were using a bed pan cleaning machine and the Alex use macerators. Worcester would trial bed pan macerators and a decision would be required moving forward.

The recommendation is to continue as we are. An annual bed clean is in place and the ISS compliance is high. The next steps are educating and holding to account to ensure the ward teams are undertaking cleaning responsibilities. A review in 6 months was proposed with consideration of a bed cleaning team within existing budgets.

Dame Julie commended that there is a plan to move forward and agreed with a review in 6 months. Electronic prescribing will assist once it had been embedded.

Mr Burley cautioned to not pursue capital spend when the issue related to compliance. Mr Burley added that he was not supportive of implementing a seperate team as cleaning is part of the nursing role.

RESOLVED THAT: Accepted the recommendation that focus is on the education of teams regarding their ownership and there would be a further review in 6 months.

101/23 **IPC UPDATE**

Ms Shingler updated that conversations were taking place with the PFI contract holder and concerns had been escalated. A meeting was being finalised with the senior teams for mid-November. An invite would then be extended to attend a Board Workshop in December.

A fully costed proposal regarding CPE in kitchens was expected by the end of next week. Response has improved significantly.

Mr Hardy encouraged PFI partners to recognise it is a partnership and there is a real joint interest in engaging actively with us.

RESOLVED THAT: The update was noted.

Best Use of Resources

102/23 **ACCOUNTABILITY FRAMEWORK**

Ms Lancaster introduced the Framework which had been reviewed at sub-Committees and sets out our approach to performance and delivery across the Trust. Divisions will have the opportunity to develop autonomy around the work they do as they improve on standards.

Mr Douglas joined the meeting and highlighted the following key points:

- The Framework details the systems and processes for effective management of delivery and being clear on responsibilities.
- The Framework would provider broader oversight for Executives.
- The invite list had been expanded to include divisional performance.
- There had been increased focus on oversight framework to ensure there was more visibility.

- A tiering system was being introduced for divisions.
- Operational delivery required a forum for focused work in a formal way.

Mr Hardy reiterated the importance of improving operational grip going forward.

Ms Martin was supportive of the principles but was unclear on how to ensure the Framework linked to the strategy, 10 Point Plan and improvement schemes in place. Ms Lancaster replied that there would be a clear set of objectives from the 10 Point Plan and the divisional objectives would come through sub-Committees on a quarterly basis to monitor the movement and delivery against it. Mr Hardy added that all Non-Executive Directors would be invited to observe at the Finance Executive Meetings.

Mr Hardy advised that the absolute priority over the next 18 months is delivery on core standards in the 10 Point Plan. The Framework was key to ensuring that the Trust can demonstrate that we are improving our performance and delivery.

RESOLVED THAT: The Accountability Framework was approved.

Best People

103/23 **SAFEST STAFFING REPORT**

a) Adult/Nursing

Ms Shingler highlighted the following key points of the report:

- Safe staffing was met.
- Insignificant harm had been reported due to staffing.
- Chief Nursing Officers across the Group were working together to align workforce reports.

b) Midwifery

Ms Jeffrey highlighted the following:

- There were continued issues with support staff vacancies.
- A number of recruited midwives had arrived as expected and more were due to start in November.
- There was currently a 6% vacancy rate for midwives, but this would reduce to 3% in November.
- Acuity was being met 84% of the time.
- Agency will cease at the end of October.
- Safe staffing levels had been maintained using PA shifts.
- Supernumerary status was not maintained in month. An action plan was in place and is linked to the Scrub Nurses Theatre Business Case.

RESOLVED THAT: The reports were noted for assurance.

104/23 **GUARDIAN OF SAFE WORKING**

Dr Raajkumar joined the meeting to present the report and highlighted the following key points:

- The total number of reports received was 40.
- Common themes were working beyond working hours and issues raised by Foundation Doctors.

- 1 immediate safety concern was reported which related to short notice sickness.
- Escalation pathways are available.
- Self-Development Time issues had been reported. The contract states that 2 hours are provided for self-development per trainee per week which was difficult to monitor. It had been agreed that the time would be combined and taken on a Tuesday.
- 6-weekly Guardian and HR meetings are in place.
- A business case for a Junior Doctor Liaison Officer was being drafted and reminders from Allocate software would be introduced.

Ms Martin queried if there was any data or information on comparisons available in regard to the 40 exception reports received. Dr Raajikumar replied that he had liaised with other Trusts and it was found that numbers had increased due to industrial action.

There is a trend of increasing exception, but this is indicative that there is better engagement and issues are being addressed.

Mr Hardy encouraged linking in with colleagues within the Foundation Group to share best practice.

Mr Murphy queried whether it was felt that doctors in training are confident to report issues. Dr Raajikumar replied that there was confidence. Different platforms were available, there were no time limits for reporting and there are Junior Doctors forums where they can raise concerns.

Dr Blanshard advised that teams were sharing the learning across the Group. Wye Valley has better compliance of realising the 2 hours for self-assessments by consolidation into one block.

RESOLVED THAT: The report was noted for assurance.

105/23 **RESPONSIBLE OFFICER REPORT**

Dr Blanshard presented the report which was a statutory requirement.

For the last reporting year, there were only 9 Doctors (2% of the Doctors in the Trust) who have had a delay in appraisal which had not been approved. These doctors were under active management to get back on track.

63 recommendations for revalidation were made, of which 56 were revalidated, 5 were deferred due to delays in the 360 degree process which was usually due to doctors being redeployed and 2 were deferred subject to an ongoing process. No doctors were referred for non-engagement.

The Framework for quality assurance is included to state we are complying with our statutory responsibilities.

Mr Hardy queried the percentage of Consultants who undertook private practice. Dr Blanshard replied that she would provide this information offline. **Action.**

RESOLVED THAT: The Responsible Officer Report was approved.

Governance

106/23 **AUDIT & ASSURANCE REPORT**
Mr Horwath presented the report which was taken as read.

The UEC processes would be looked at in a more forensic fashion to understand what issues had been encountered and why.

Mr Hardy stated that the UEC was a fantastic facility but there had been significant overspend which needed to be understood.

RESOLVED THAT: The report was noted for assurance.

107/23 **BOARD ASSURANCE FRAMEWORK**
Ms Harmon presented the report which was taken as read.

Work was underway with Ms Shingler to develop the risk management process further.

RESOLVED THAT: The Board Assurance Framework was noted for assurance.

108/23 **ANY OTHER BUSINESS**
Healthwatch were invited to comment.

Ms Ringshall stated that the 10 Point Plan was interesting. There is a cultural piece around Home is Best and preparing communication so that it doesn't come as a surprise that patients are going home.

The meeting reflected the shared learning of the wider Group and it was encouraging seeing the offers of support.

DATE OF NEXT MEETING
The next Public Trust Board was scheduled for 21st December 2023.

Signed _____ **Date** _____
Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
13.01.22	Charter	158/21	Mrs Ricketts and Mr Hopkins to continue the conversation regarding meaningful action and outcome measures and report back to Board in two months	TR	March 2022	Dec 2023	Regular updates on progress against implementation of the Charter are provided to the People & Culture Committee. The programme of Board workshops are being reviewed.	

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Chief Executive Officer's Report

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

Accountable Director	Glen Burley Chief Executive Officer		
Presented by	Glen Burley, Chief Executive	**Author /s**	Glen Burley, Chief Executive

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
N/A		

Recommendations	The Trust Board is requested to • Note this report.
Executive Summary	This report is to brief the Board on various local and national issues.

Risk														
Which key red risks does this report address?	N/A			**What BAF risk does this report address?**	N/A									
Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	X
Financial Risk	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						

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Introduction/Background

NHS Finances and the Productivity Challenge

Elsewhere on the agenda we report on the assurances that the Trust has made as part of the national exercise which requires each Integrated Care System re-confirm finance and activity plans. As explained in the report, this was undertaken within a short timescale following on from national discussions with the Treasury. I have previously reported concerns about the overall financial position of the NHS which had been further exacerbated by the impact of Industrial Action. The NHS National CFO had asked for around £2bn of additional funding to ensure that the NHS operated within its overall financial plan. Whilst the ask was broadly predicated on the direct and indirect costs of Industrial action the NHS also faces challenges regarding general inflation, recruitment gaps and demand pressures. Unfortunately, the discussions with the Treasury did not result in any additional funding on top of the extra allocation of £200m announced in July. Instead, the NHS was asked to review national and local plans to offset the pressures. As part of this, tentative permission was given to review elective recovery plans, particularly where premium costs were planned to achieve the milestones set out in the national plan. This therefore would allow some parts of the NHS to not achieve the 65-week maximum elective referral to treatment target. In doing so, it was made clear that managing urgent care over the winter period was the more pressing priority including maintaining the planned performance on ambulance handover targets. Confirmation of performance intentions against the key national targets was therefore including in the returns alongside financial trajectories.

The review of national budgets, alongside the plan to devolve the £200m allocation did provide additional funding to ICSs. The transfer of this funding to providers was mainly transacted through an IA allocation to each system based on clinical staff headcount as well as an adjustment to the threshold above which elective activity is paid for on a 'payment by results' basis. It should therefore be noted that any planned reduction in elective performance would also result in a corresponding reduction in income for any Trust above the threshold – which I am pleased to report includes all of the Trusts in the Group. I therefore concluded that a reduction in elective activity would not only compromise care for our patients, but it would have a very marginal impact on our finances. As a consequence, we are not recommending that we follow this path across the Group.

The details of the consequences of the exercise are set out elsewhere in the Board pack. In summary this leaves all four Trusts in the Group in a challenging financial position. The plans will also be reviewed by the national CFO on an ICS by ICS basis in the first week of December. This may impact on my ability to attend all of this week's Board meetings.

The submission for our Trust reports a significant variance from plan. As a result we have put in place some additional measures to regain financial control. This includes the appointment of a fixed-term Turnaround Director as well as drawing on some of the expertise within the Group to review our plan and tighten up its project management. We have also been asked to identify areas where we could reduce expenditure linked to our winter plans and to elective recovery. These will be the subject of further discussion with system and NHSE colleagues.

One of the challenges faced by the NHS is that we have seen what is in some parts quite a significant increase in headcount when staffing levels are compared with the pre-Covid position. In some cases, these have delivered increases in activity but in many, the activity increases are minimal. As a very large consumer of public money, we have a duty to explain this and to improve

upon it where we can. I have therefore asked each of the Executive teams to consider how we tackle the productivity challenge as part of next year's objectives setting exercise. Our group arrangement provides a very helpful platform to tease out the differences in productivity and to seek out best practice solutions.

I have also been involved in a recent exercise to refresh a document which was previously referred to as 'The Intelligent Board'. The document sets out best practice on how Boards should function including the types of performance indicators which should be considered. As part of this refresh, I think that it will be important to make sure that Boards spend sufficient time and are effectively appraised on productivity measures. Whilst a focus on quality is of course one of our main concerns, it is also important for everyone to be conscious of the link between productivity and providing more care. I have never seen managing the money and maintaining high quality care as mutually exclusive and I am sure that none of our Board members do either.

On the 22nd of November, the Government set out its Autumn Statement which did not include any revisions the NHS spending plans. In addition to the pressures on revenue funding set out above, we face significant challenges regarding capital expenditure. It had been hoped that the Statement might at least make some further provision to cover the implications of the RAC concrete issue, but it did not. We await to see how this will be handled within the NHS but it could lead to a reduction in our base capital allocation as a system.

Volunteering

At our recent '4 Boards' meeting, the invited speaker at our morning workshop was Sir Thomas Hughes-Hallett. Sir Tom has had a very impressive CV including being Chair of the Chelsea and Westminster NHSFT. He is now the Chair and Founder of Helpforce. Sir Tom founded Helpforce in 2017 with the vision that everyone who visits the hospital will never be alone. A volunteer will pick them up and take them to their appointment. His vision is that they will stay with the patient, explain what the treatment involves and take the patient home afterwards and remain a companion on the patient's journey. Sir Tom recently spoke at the national Chief Nursing Conference about the volunteering activities of the Group and has flagged with us the possibility of accessing some national funding to support our 'waiting well' support initiative to people on NHS waiting lists.

Leadership Development

I recently attended a meeting of the Association of Groups (AoG) Senior Operational Leaders Network (SOLNET). The AoG are in the process of reviewing their offer to member Trusts and we have indicated our support for the continuation of a programme. In discussion with the Managing Directors and other Execs we have also agreed to establish a programme of Group webinars for our leaders, probably targeted at the triumvirates. This will draw on the skills of individuals across the Group to provide a series of 'teach ins' on subjects such as budgetary management, business case production, job planning etc. All of which will supplement local development programmes which are already in place and will help to skill up our leaders to help to tackle the complexity of their roles.

More from our great teams:

Staff Psychological Wellbeing

Clinical Psychologists specialising in staff psychological wellbeing were first employed by Worcestershire Acute Hospital Trust in September 2020 funded by COVID monies to support staff during the pandemic. The focus of this intervention was to support staff working directly with COVID patients (COVID wards and Critical Care); those re-deployed to work with COVID patients and those shielding; which developed to include other staff and teams within the Trust.

Engagement with staff has been strong and feedback very positive. Permanent funding was achieved in July 2022 with further investment made by the Trust so that a dedicated, in-house service is now available. The underlying principles of the service are based upon evidence-based practice around wellbeing which includes whole system thinking, relationships being the key to recovery and maintaining psychological wellbeing, alongside normalisation of human distress and taking a strengths-based approach to recovery from psychological distress, including the promotion of psychological responsibility.

The Staff Psychological Wellbeing Service offers direct input to individuals and teams; a responsive service following traumatic incidents; is part of the Health and Wellbeing Steering Group and sits on Directorate Board Meetings to aid the organisations thinking around psychological wellbeing of staff. No staff member or team is the same, needs are diverse, but there are common stresses including the challenge of pursuing excellence in care, as well as protecting the welfare of staff, amidst staff shortages; and the burden of moral stress and injury in making difficult decisions.

Individual support is offered to staff where their psychological wellbeing is impacting upon their ability to bring their best self to work; for example, a member of staff may seek support to manage intense feelings of anxiety at work; or someone may be struggling with juggling the demands of home and work life and find that this impacts upon their ability to function at work. Examples of Team and Manager support include helping teams to identify with their values, addressing low team morale and how to manage the emotional impact of the work that the team does.

Pulmonary Rehab Team

Who are they: The Pulmonary Rehabilitation team, form part of the larger COPD Team. The team consists of specialist COPD nurses, specialist physiotherapists, CBT therapist, Exercise technicians and an admin team.

The wider COPD team see patients in hospital who have been admitted with an exacerbation of COPD, in their own homes following discharge or following a referral from GP or primary care.

What they do: Pulmonary rehabilitation is an exercise and education programme designed specifically for patients with diagnosed respiratory diseases, such as COPD, bronchiectasis, ILD or lung cancer who are limited by their breathlessness in day-to-day life. Courses are run on a rolling basis within Worcester, Kidderminster and Redditch, and alternating programmes in Evesham and Malvern. During COVID a virtual Pulmonary rehabilitation course via Teams was also provided.

How the Team have linked to 4ward behaviours and their achievements to date:

The team have just become an accredited service by the Royal College of Physicians - only the 8th team out of 139 within the UK. To achieve this, a portfolio of evidence was needed to show how they met the clinical standards required and a clinical site visit was completed by the assessors to

review the service in action. The accreditation process is ongoing with virtual reviews annually and every 5 years an additional site visit, is arranged.

The process has been an opportunity to review the service, identifying areas of good practice and areas for improvement. The biggest area of improvement the service had to go through involved the prescription of exercise to each individual patient within a class. They have been able to share our good practice at the West Midlands regional Pulmonary Rehab meetings which has allowed other services to come and see what they are doing and take back learning to their own teams.

Like many services they wanted to be as efficient as possible with appointments and reduce DNAs.

To do this they now offer all patients who are referred and meet the criteria into the service, a place on the prehab session. This information session is a group-based session designed to improve uptake to the course, reduce DNAs and limit wasted clinician appointments. Many of the patients have been given a limited explanation of the programme usually "***I've been referred to learn how to breathe better***" and are not aware of the exercises involved in it, so this is the ideal chance for them to opt onto the full course.

As a community-based team spread across the whole county, the team don't often get the chance to come together face to face that often, so they have implemented an away morning every quarter where the whole team meet for teaching, sharing ideas for service development, and a general catch up.

What's next: In partnership with the BI team, they are looking at 'did not attend' (DNA) rates and identifying healthcare inequalities to the service provided and make the necessary changes. They are continuing to strive to increase the proportion of patients referred to Pulmonary Rehabilitation to get started within the national target of 90 days of referral.

In the next few months, they are looking at providing a home-based service for patients who are very breathless but are unable to attend the classes. In addition, they are reviewing the education booklet that is provided to ensure equal access to the population and considering offering an education only session for patients whom Pulmonary Rehabilitation is not appropriate.

Issues and options

Recommendations

The Trust Board is requested to

- Note this report.

Appendices – None

Putting Patients First

4ward

NHS
Worcestershire Acute Hospitals
NHS Trust

Integrated Performance Report

December 2023

TRUST BOARD | FINAL | Up to Oct-23 data

Last updated 15th December 2023

MANAGING DIRECTOR – EXECUTIVE SUMMARY

Stephen Collman

Managing Director

This report details the ongoing pressure and demand through the Trusts urgent and emergency care pathways, which have continued through November and into December. Underpinning the performance, finance and quality issues experienced is the overall increase in length of stay detailed. The consequences this is having are increased waits for ambulance handover, decreased Emergency Access Standard performance, protracted waits within the Emergency Department and, excess unfunded capacity open within the hospital sites.

To address this, schemes have been developed and implemented. These will not affect November performance but start to demonstrate improvement through January. These include the opening of two wards, one at Worcester Royal Hospital (WRH) and one at the Alexandra Hospital.

The Medical Same Day Emergency Care Unit, Surgical Assessment Unit and Cardiology Same Day Emergency Care will be configured to maximise capacity and co working. Alongside the new single point of access this should impact attendance and conversion from the Emergency department.

The Trust remains in Tier 2 for Urgent and Emergency Care.

The Trust remains challenged on the cancer pathways with skin and urology the most significant contribution to the patients waiting over 62 days. Significant work is underway with partners, ICB and region to support the dermatology service. The Trust has undertaken a peer review process with regards Urology and is undertaking detailed pathway analytics to target improvements and capacity to those areas of longest wait.

The Trust remains in Tier 1 for Cancer performance.

The Trust is delighted to have received the CQC rating Good for its Maternity services.

The consequences of increased bed occupancy and length of stay can be triangulated with several of the quality metrics.

The Trust sickness absence figure remains above target and contributes to the increased bank and agency spend, and more importantly the staff experience.

The financial position of the Trust remains in deficit. The Trust is running a financial recovery process focussing on reducing the run rate spend and ensuring an improved position to build upon in the financial year. The risks to the forecast remain the increased unfunded bed capacity, ongoing industrial action.

In conclusion, the focus on fast implementation of the winter schemes to deliver the focus on flow in the 10-point plan is the priority in month and into January. If the Trust can reduce bed occupancy and improve ambulance handover delays this will have a significant impact upon operational performance, financial run rate, sickness absence and quality metrics.

OUR OPERATIONAL PERFORMANCE

Helen Lancaster

Chief Operating Officer

We are progressing the full implementation of our Trust's winter plan as well as our part in the wider system winter initiatives. At the time of writing, we are piloting a Same Day Emergency Care service in Cardiology, with some positive initial feedback and we are in the first week of a new Single Point of Access for urgent care, which will support clinical teams across the wider system to ensure that patients are accessing the most appropriate care for their condition, reducing the need for patients to attend one of our Emergency Departments first. We're planning to open additional bed capacity at both Worcestershire Royal Hospital and The Alexandra Hospital to support the pressure over the winter period which gives us the opportunity to do more of the transformation work we know we need to do to improve the experience of our patients and staff including our new frailty model and the redesign of the GP streaming services at the Worcestershire Royal site. We're also in the process of planning another MADE event in December, as part of our commitment with system partners to continue to focus on working together to improve system wide flow.

Cancer care remains a top priority for the organisation, and we continue to confirm a diagnosis for patients referred with a suspicion of cancer within 28 days in over 70% of cases enabling us to reassure patients who don't have cancer and to support those with a cancer diagnosis. There is variation between tumour sites, and we continue to focus our efforts on those with the greatest challenge as we know that for our patients it is important to have a confirmed diagnosis as quickly as possible to ensure they can access the treatment and support they require where they do have cancer, and to rule out a cancer diagnosis where we can. Whilst many of our services are making good progress in reducing the number of patients waiting more than 62-days from referral for suspected cancer to treatment, we continue to see challenges in skin and urology. Whilst we are seeing improvements in both areas, there is certainly more work to do. We recently welcomed colleagues from the NHS England Intensive Support Team, who visited to support our efforts to improve our cancer performance and are responding to the initial feedback we received, whilst we wait for the final report.

Given the operational and financial challenges, improving our operational productivity is key to sustainable delivery. Our theatre and outpatients' transformation programmes continue to focus on delivering the improvements necessary to support productivity improvements and we have already seen progress in some areas, particularly DNA rates and theatre utilisation. However, there is still more to do to make the most of the opportunities we have and to reduce the unwarranted variation.

The new theatres have now opened at the Alexandra Hospital, providing much needed additional theatre capacity. We have been fortunate enough to be invited to join cohort two of the GIRFT Further Faster programme, which will support our efforts to reduce our waiting times further and improve the experience for our patients and staff.

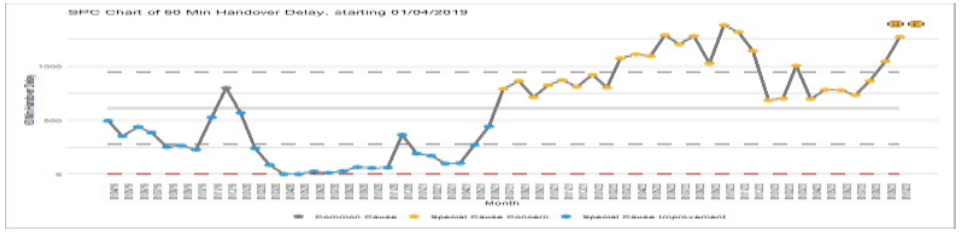
OUR OPERATIONAL PERFORMANCE - URGENT CARE

We are driving this measure because

The national Emergency Access Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at any Emergency Department. In addition, the effective and timely handover of patients arriving by ambulance enables patients waiting in the community to access care in a timelier manner and is an indicator of system flow.

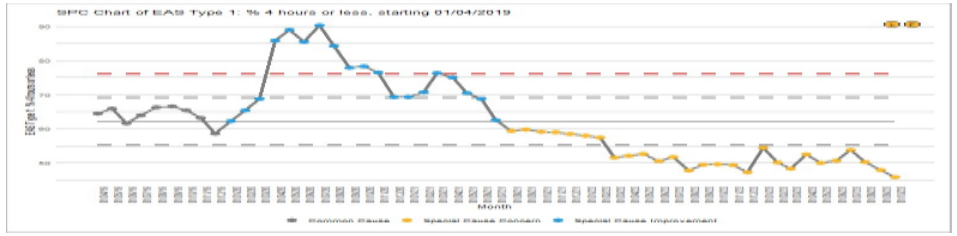
Assurance F **Variation** H

The Ambulance Handover metric is **deteriorating.** The target (0) lies below the process limits so we know that the **target will not be achieved** without change**.**



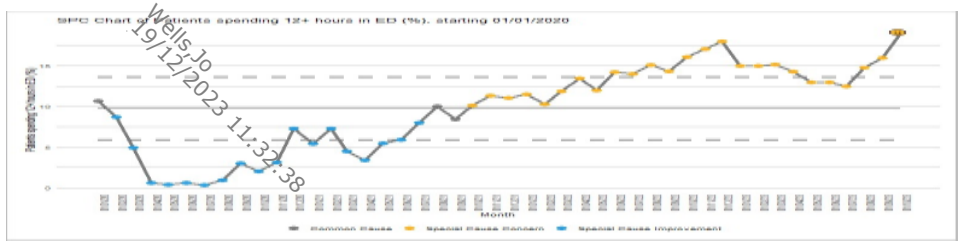
Assurance F **Variation** L

The EAS type 1 metric is **deteriorating.** The target (76%) lies above the process limits so we know that the **target will not be achieved** without change**.**



Assurance **Variation** H

The patients spending >12 hours in ED metric is **deteriorating.** There is currently no target for this metric.



Performance and Actions

12,518 patients attended the Trust's Emergency Departments in September 2023. 45.3% of those were treated and either admitted or discharged within four hours of arrival. The performance is expected to achieve 76% by the end of March 2024.

Of the 3,593 patients who arrived by ambulance, 24% were 'handed over' within 15 minutes and 1,272 waited longer than 60 minutes to be handed over. 2,380 patients (19%) spent 12 or more hours in our emergency departments.

Actions

- Additional winter beds on both sites opening mid-December
- Single point of access phase 1 launched early December
- Internal Professional Standards relaunch
- Cardiac SDEC service pilot commenced 6 Novembe
- Relocation of Surgical SDEC to 'old' ED minors footprint to release surgical assessment capacity in SAU
- MADE event planned week commencing 18 December across both acute sites
- New Overnight SDEC model planned for new year
- New Integrated Frailty Service development launch with support from Foundation Group members
- Redesign of GP streaming service to optimise throughput as alternative to core ED attendance
- Virtual Ward roll-out programme starting with COPD
- UEC Peer Review visit November 2023, with follow-up GIRFT visit planned for mid-January 2024

Risks

- In-hospital and system flow constraints due to workforce and capacity
- Patient acuity
- Fluctuating demand
- Insufficient alternatives to Emergency Department for patient with urgent, non-emergency needs

What the charts tell us

All three metrics have been a significant cause for concern since Jul-21. Type 1 4-hour performance was at its lowest point on record in Oct-23 and patients spending >12 hours in ED was the highest on record.

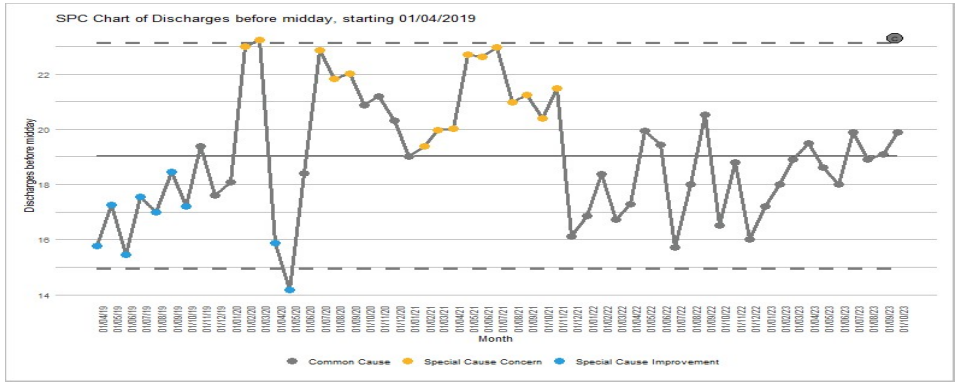
OUR OPERATIONAL PERFORMANCE – PATIENT FLOW

We are driving this measure because

Hospital flow is a significant contributor to overcrowding in the Trust' Emergency Departments and consequently on the safety of the Emergency Department. Improving these measures will support reduction in ambulance handover delays as well as reducing the time take patients stay in the Emergency Department. Most importantly, reducing the length of time patients are not in their usual place of residence (by reducing the length of stay) reduce the risks associated with functional hospital decline; and will enable those patients who need a bed in our hospitals to access the most appropriate bed in a timely manner.

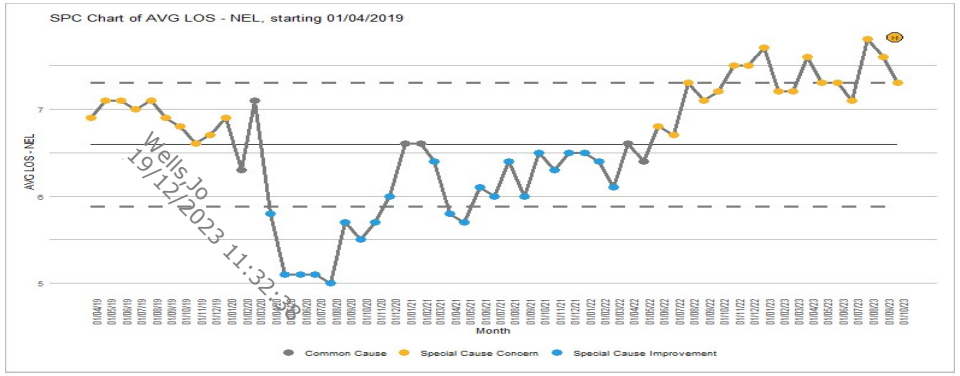
Assurance **Variation**

This metric is **not changing significantly.** It shows the level of natural variation you can expect to see. The target (33%) lies below the process limits so we know that the **target will not be achieved** without change**.**



Assurance **Variation**

This metric is **deteriorating.** There is no target for this metric.



Performance and Actions

Discharges before midday showed no significant change in October 2023. There has been no sustained improvement in the percentage of discharges before midday, which is impacting on the Trust's ability to deliver effective hospital flow and ensure timely admission for patients from the Trust's Emergency Departments (and other emergency admissions).

The length of stay for non-elective admitted patients has continued to rise since August 2020. Since August 2022 in particularly, the non-elective length of stay has increased by one day, contributing towards less hospital flow and capacity pressures. Medicine in particular; has a non-elective length of stay in excess of nine days compared to a national average which is nearer six days.

The Hospital Flow Delivery Group has been established to oversee delivery of this programme as the top operational priority for the organisation. Chaired by the Chief Operating Officer, with others executive and Divisional leadership membership.

- Internal Professional Standards relaunch
- Site Management arrangements including Electronic Bed Management System
- Consultant of the Week model
- Implementation of Trust Winter plan schemes
- Criteria Led Discharge

Risks

- Industrial Action
- Patient Acuity
- Clinical engagement

What the charts tell us

2,953 patients were discharged from G&A beds and 580 (19.6%) were before midday. The average LOS for a non-elective patient was 7.4 days; when you exclude patients for a zero LOS, this increases to 7.9 days.

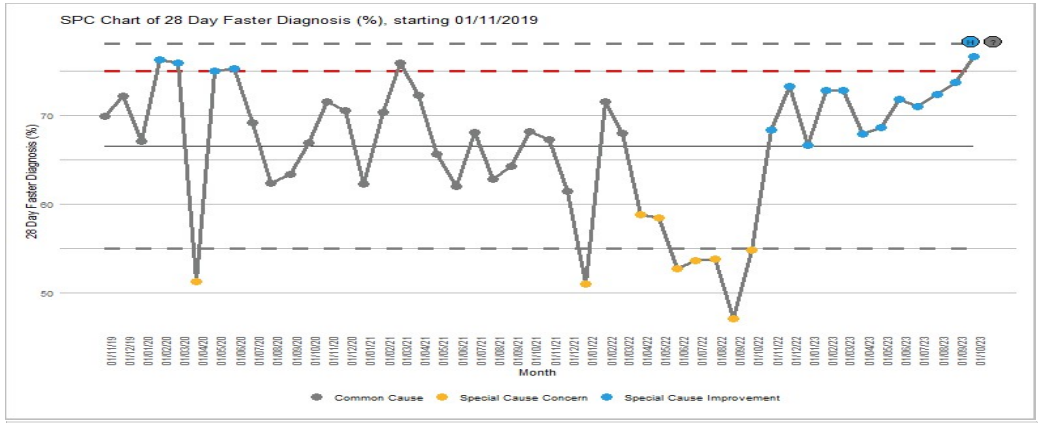
OUR OPERATIONAL PERFORMANCE - CANCER | 28 DAY FASTER DIAGNOSIS STANDARD

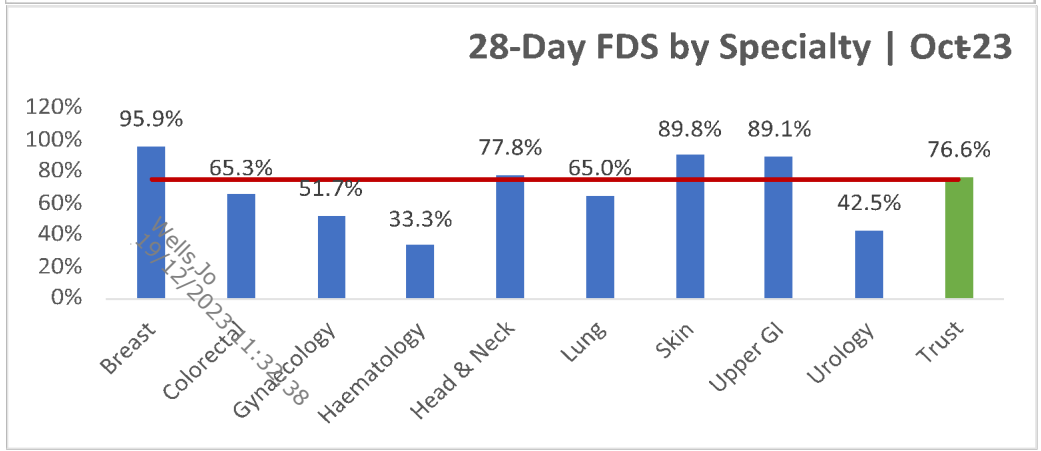
We are driving this measure because

Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer within their lifetime. There are three key timeframes in which patients should be seen or treated as part of their pathway. Two key measures are monitored in these slides. 75% of patients referred for suspected cancer should receive a diagnosis within 28 days (Faster Diagnosis Standard) and 85% of patients with a cancer diagnosis should start their treatment within 62 days.

Assurance **Variation**

This metric is **improving.** The target lies within the process limits so we know that the **target may or may not** be achieved**.**





Performance and Actions

There were 2,675 new GP referrals for suspected cancer in October 2023. This is the fourth lowest referrals in a month in 2023, and 160 fewer than Oct-22.

Trust **unvalidated** performance against the 28-day Faster Diagnosis Standard is currently 76.6%. This is above the NHSE milestone performance of 70.8% and above the national standard of 75%, which is expected to be achieved by the end of the financial year.

Updates and Actions

- IST visit in early November focussing on cancer. Initial feedback and recommendations received and action plan in place in response
- Additional Regional Cancer monies ring-fenced allocations following successful bid – supporting Urology and colorectal, alongside trust wide diagnostics.
- Use of 28-day and 62-day pathway analyzer to support evidence base of action planning
- Recovery Action Plan meetings chaired by Deputy Chief Operating Officer, with new terms of reference
- Review of urgent suspected referral proformas – December 2023
- NHS England support for Best Practice Pathway implementation expected January 2024
- Review of cancer administration post MDT
- Additional support remains in place to support diagnostic elements
- Revised pathway in gynaecology – expected impact from December 2023

Risks

- Lack of capacity in Dermatology to see and treat the demand.
- Ongoing impact of industrial action.
- Histology, radiology and urological diagnostic capacity remain an issue.

What the charts tell us

Performance is above the 75% target in Oct-23 having improved significantly from Nov-22 onwards. However, there are 5 specialties who continues to work towards achieving the cancer waiting time standard.

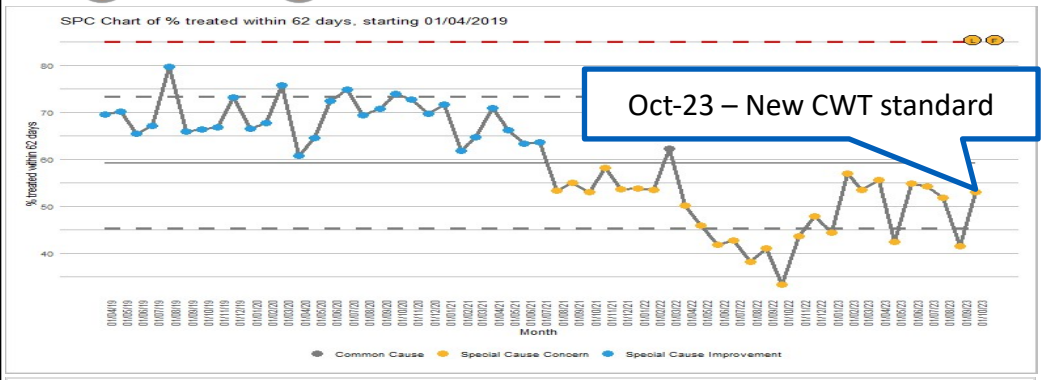
OUR OPERATIONAL PERFORMANCE - CANCER | 62 DAY START OF TREATMENT STANDARD

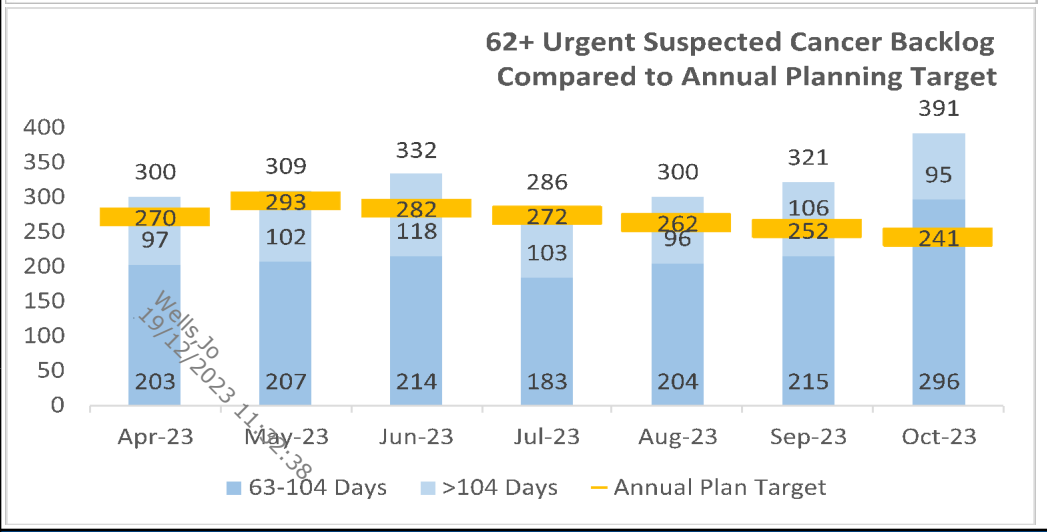
We are driving this measure because

Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime. There are three key timeframes in which patients should be seen or treated as part of their pathway. Two key measures are monitored in these slides. 75% of patients referred for suspected cancer should receive a diagnosis within 28 days (Faster Diagnosis Standard) and 85% of patients with a cancer diagnosis should start their treatment within 62 days.

Assurance F **Variation** L

This metric is **deteriorating.** The target lies above the process limits so we know that the **target will not be achieved** without change.





Performance and Actions

NEW The Trust unvalidated position for 62 days cancer waiting time performance in October 2023 is currently 54% with 143 patient breaches. Note that this is the first-time reporting against the new standard for 62 days which includes screening and consultant upgrade patients (previously reported separately).

At the end of October there were 391 patients waiting over 62 days (against a planned position of 241). Of those patients waiting, 95 were waiting over 104 days. The Trust target for the end of the 2023/24 is to have no more than 190 patients waiting more than 62 days, with a target of 0 patients waiting more than 104 days.

The increase in the 62-day backlog continues to be driven by the increased backlog in skin pathways due to service fragility – with a backlog of 108. Whilst the backlog of Urology remains high at 161, this is a significant reduction against its peak of more than 250.

- Many of the drivers for performance align to the FDS performance. In addition, there are challenges with treatment capacity in some specialties driven by a combination of access to appropriate theatre capacity and clinical vacancies.
- Divisional teams leading weekly waiting list meetings for all patients over 62 days in initial phase, with daily oversight of the longest waiters
- Revised improvement trajectory for 62-day backlog and 62-day performance being developed – Trust remain committed to delivery of 62-day backlog reduction to 190
- Each specialty has a recovery action plan in place to address the drivers of performance to support the Trust to deliver more timely treatment to patients referred on a suspected cancer pathway. These are overseen by the Deputy Chief Operating Officer, with specialty specific groups in place for greater oversight of most challenged specialties.

Risks

- Lack of capacity in Dermatology to see and treat the demand
- Ongoing impact of industrial action
- Histology, radiology and urological diagnostic capacity remain an issue
- Waiting times at Tertiary Centres

What the charts tell us

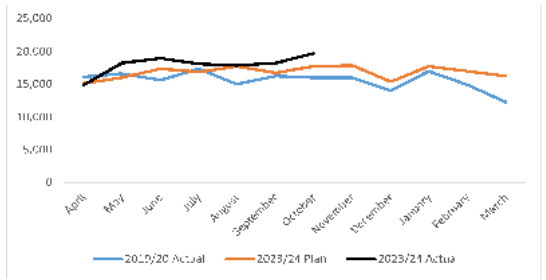
Performance against the cancer waiting times standard has never achieved the 85% target and was been 50% for 12 of the last 24 months. The introduction of the new methodology is noted on the graph.

OUR OPERATIONAL PERFORMANCE - ELECTIVE RECOVERY

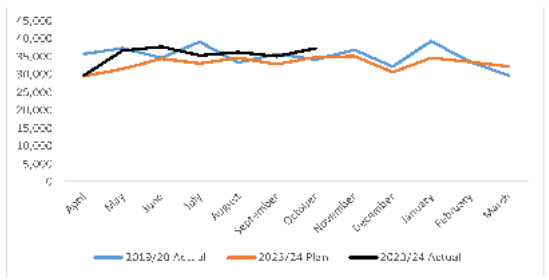
We are driving this measure because

Elective recovery is a key priority to ensure that patients can access the treatment they need in as timely a manner as possible. To reduce the impact of waiting for non-urgent, consultant-led treatment, the Trust made a commitment to deliver a maximum wait of 65 weeks by the end of the 2023/24 as part of our journey to recovering the 18-week Referral to Treatment standard as set out in the NHS constitution; and put in place annual activity plans to enable this.

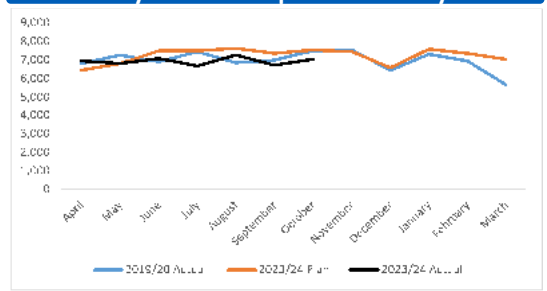
Outpatient New Activity



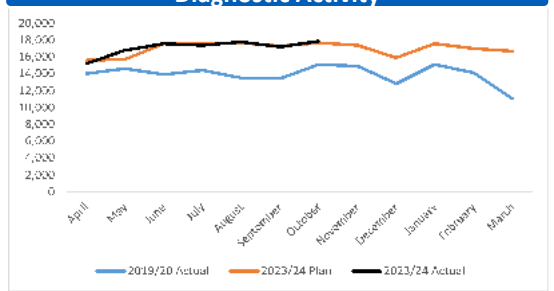
Outpatient Follow-up Activity



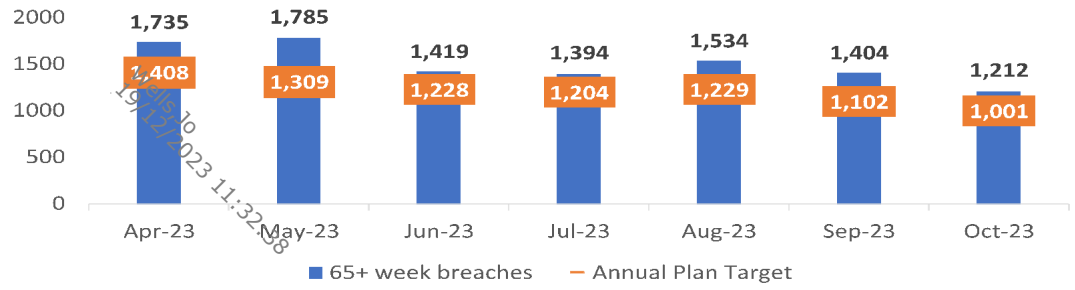
Day Case and Inpatient Activity



Diagnostic Activity



RTT 65+ Week Breaches Compared to Annual Plan Target



Performance and Actions

In October 2023, the Trust delivered 19,855 new outpatient appointments (12% above plan) and 38,022 follow up appointments (8.7% over plan). Inpatient and day case activity was 6.3% under plan, with day case activity 330 spells under plan and elective inpatients under plan by 147.

Factors impacting the shortfall in elective activity include:

- Delayed opening of additional theatre capacity at the Alexandra Hospital site – capacity fully open in December 2023
- Ophthalmology – driven by workforce vacancies. Increased in activity expected from September and October, with further consultant start dates in January 2024.
- ENT and Oral & Maxillofacial surgery – workforce availability and impact of medical outliers on surgery beds at Worcestershire Royal site

As at end of September there were 1,211 patients waiting over 65 weeks, including 100 over 78 weeks and 3 over 104 weeks. At the time of writing, the forecast for end of November is 1 104-week waiter.

Actions

- Ongoing validation of RTT waiting list in line with national guidance. Digital solution implementation in November will increase coverage.
- Recovery plans overseen by Divisions, with Divisional actions overseen via PRM and Elective and Cancer Delivery Group
- Continued use of additional capacity (waiting list initiatives, insourcing and outsourcing, mutual aid) – further work to do to maximise return on investment and demonstrable impact of sustainable improvements in waiting times
- Focus on productivity to maximise throughput through core capacity in theatre and outpatients
- NHS England Theatre Review – end of November to support going further on theatre productivity
- Reinforcement of theatre booking policy to ensure maximal use of capacity
- Use of locums to cover hard to fill vacancies

Risks

- Urgent care demand impacting physical capacity and staffing
- Ongoing Industrial action
- Workforce challenges
- Medical outliers in surgical beds

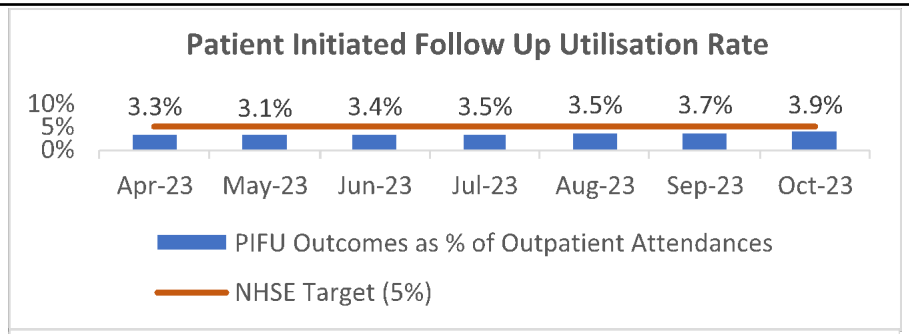
What the charts tell us

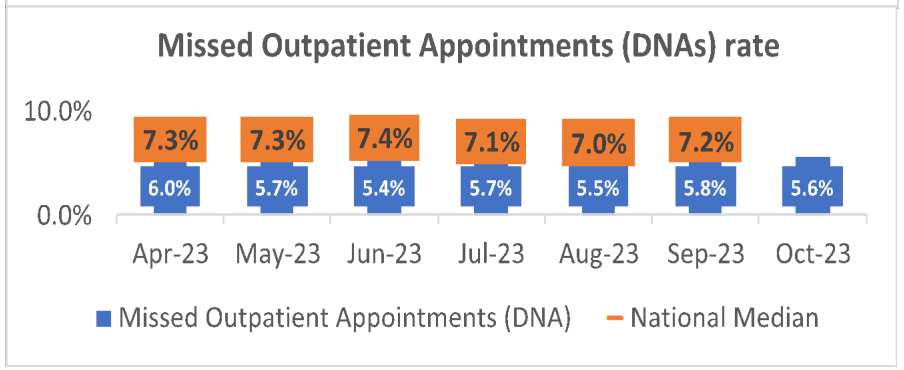
Outpatient New activity is above plan by 2,118 appointments and follow-ups were higher than plan, by 3,055 appointments. This was ~3,200 more than Oct-19 (22 vs 23 working days). Day case and elective inpatient activity remains below plan and overall diagnostic activity is 324 above plan in Oct-23.

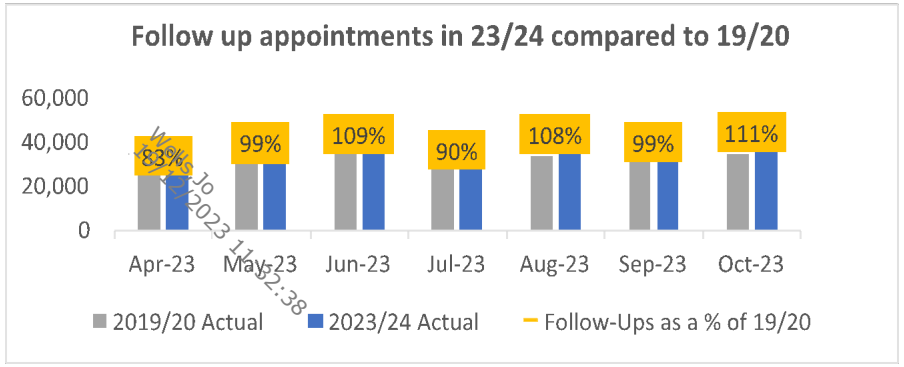
OUR OPERATIONAL PERFORMANCE - OUTPATIENT TRANSFORMATION

We are driving this measure because

Transforming and modernising how we deliver outpatient services so patients can be seen more quickly and interact with services in a way that suits their lives. This in turn, enables faster diagnosis and treatment to support Trust delivery of Referral to Treatment times as well as ensuring patients have more control and greater choice over how and when they access care.







Performance and Actions

Outpatient Transformation encompasses a broad remit. The focus in this report is on those elements that form part of annual plan expectations and immediate operational delivery, rather than the broader Trust Outpatients Transformation Programme. Of note is the expectation that the Trust delivers a reduction in follow-up activity to no more than 75% of 2019/20 activity.

Performance in Patient Initiated Follow Up (PIFU) remains static at 3.9%, which is under the 5% national target. However, a large percentage of specialties are delivering PIFU more than the national median at a specialty level.

Trust wide DNA rate in October was 5.6% percentage points below the national median though at a specialty level there is some variation.

Actions

- Divisional plans to achieve 85th percentile performance of PIFU
- Revision of information shared with primary care to support both referral avoidance and streamlined pathways for patients who are referred (reducing follow ups) – known as common conditions
- Review of follow up waiting lists for PIFU pathway opportunities aligned to national best practice and clinical risk
- Specialty Deep dives by Trust's Outpatients Transformation Programme lead to identify further opportunities for pathway transformation including one-stop clinics, referral guidance for primary care to support direct access
- Trust has recently been inducted into cohort two of the GIRFT Further Faster programme to support going further and faster in outpatient opportunities. This will be aligned to the specialty deep dive process to ensure single Trust approach
- Implementation of digital validation in line with national guidance

Risks

- Clinical engagement
- Capacity to implement changes alongside day-to-day operational delivery
- Finance available to invest in people and technical solutions
- Size of follow-up waiting list limits opportunity to reduce follow-ups

What the charts tell us

PIFU – YTD monthly average we discharge / transfer 1,750 patients; to achieve 5% this needs to be increased to ~2,600. **DNAs** remain below the national median with ~2,900 OP appointments a month currently being missed due to DNA. **Follow-Up reduction** – although not yet at the NSHE 75% ambition, we have delivered fewer appointments in four of the seven months YTD.

OUR QUALITY & SAFETY

Dr Christine Blanshard

Chief Medical Officer / Deputy CEO

Trust level mortality indicators remain within an expected range. There is work ongoing to review the care of patients who experience protracted waits in our Emergency departments and in ambulances out side of our hospitals in order to identify themes of potential harm.

Sepsis 6 performance, although remaining non compliant, does not show any special cause variation. The transition to sepsis screening through the EPR is ongoing, with further analysis of data required to identify where improvement actions should be targeted.

Performance against the best practice tariff for Fractured Neck of Femur remains below target. Focussed work is required in order to remediate this, which will be undertaken with CMO oversight.

Compliance with antimicrobial stewardship remains on target at 90.22% for the 11th consecutive month.

We were compliant with all in-month targets in Oct-23 except E-Coli., which is also showing special cause variation of concern but are not currently compliant with any of the year to date targets. With regards to COVID we have 6 active outbreaks, and 4 in monitoring phase as of 9/11/23 and the baseline for COVID inpatients remains above previous levels. There are also CPE (1 active and 2 monitoring) and D&V (1 active) outbreaks.

Sarah Shingler

Chief Nursing Officer

The number of HAPUs for Oct-23 dropped to 25, bringing the current total for 2023/24 to 155. This is still below the total for the same time period in 2022/23. Our total HAPU's as a % of Emergency Admissions decreased to 0.70% in Oct (from 0.81% in Sep) Staff are now required to complete the new essential to role PUP training as improved divisional training %'s have been identified since launch of E Learning.

We have seen a total of 63 new formal complaints received within Oct-23 with 28 (44%) called within 5 days to discuss the complaint. The Trust had 165 complaints still open at the end of Oct, of which 23 have been reopened and of these 165 complaints, 90 have breached 25 days (17 of which have been reopened).

The Surgery Division accounts for 68 (75.6%) of the complaints which have breached 25 days, 12 of which have been reopened and of the 68 Surgery complaints which have breached 25 days, 22 (32.3%) have also now breached 6 months (3 of which have been reopened). The support to the Surgery division continues with a trajectory to enable 80% of the backlog complaints being responded to by end of November 2023. Finally, the compliance with complaints closed within 25 days dropped this month to 43.94%, and this is the 16th consecutive month that the target (80%) has been missed.

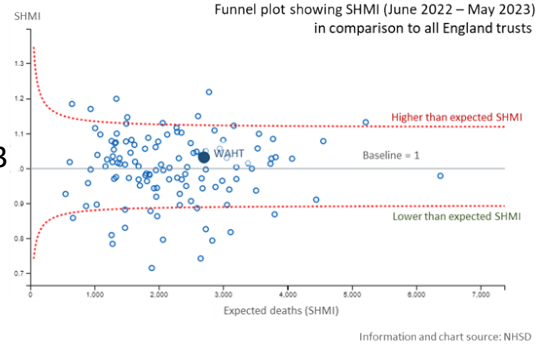
OUR QUALITY & SAFETY – LEARNING FROM DEATHS

We are driving this measure because

Learning from Deaths provides the opportunity to identify any processes which may be changed to enhance the overall levels of care offered to the patients.

Performance

What does the data tell us?



Summary Hospital-level Mortality Indicator (SHMI)

- The Trust's SHMI is in the **'As Expected'** banding for both Worcestershire and Alexandra sites. (Jun-22 to May-23 published by NHSE 12th Oct 2023

Hospital Standardised Mortality Ratio (HSMR)

- The Trust's HSMR alert level is Green.
- The Trust score of 103.57 is above our Midland Peer Group (102.38). (Aug-22 to Jul-23, published by HED, last accessed 09/11/2023).

Crude Mortality Rate

There are several methodologies which are used to calculate Crude Mortality – each of which must be interpreted in the context of the algorithm used to calculate the metric.

- HSMR crude mortality rate is 2.79%, which is lower than our Midland Peer Group (3.19%).
- SHMI crude mortality for elective admissions 1% which is in line with the NHS average.
- SHMI crude mortality rate for non-elective admissions 4.3% which is above the England average (3.5%).

Trust Data

- The overall number of deaths in the Trust (Inc. ED) rose in Oct-23 but is lower than in Oct-22.
- Deaths in ED also rose in Oct-23 and was higher than in Oct-22. October's figure was the 3rd highest in the last 12 months.
- The number of SJR's dropped in Oct-23 to 4 – all of which were completed within 30 days of the MCCD being issued.
- In the last 3 months there have been no completed SJRs indicating overall poor care (i.e. scores of 1 or 2)

Actions

1. Governance teams to encourage SJR completions by directorates
2. Governance teams to give assurance that Mortality and Morbidity meetings are properly configured
3. Continual engagement with ICB to work with peer organisations to understand whole system picture of mortality and influence local priorities
4. Engagement with Medical Examiner's office to ensure all relevant deaths are subject to SJR

Risks

1. Lack of SJR completion risks poor scrutiny of deaths and difficulties identifying improvement opportunities

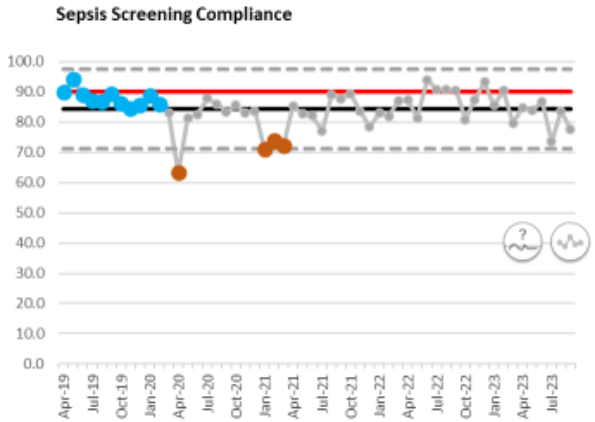
What the charts tell us

Mortality metrics are not a quality-of-care indicator. A higher number of deaths should not immediately be interpreted as indicating poor performance, but as a flag that further investigation is required. Care must also be taken when comparing mortality indicators between Trusts, for example SHMI makes no adjustment for the severity of the condition the patient is in hospital for (https://files.digital.nhs.uk/E8/1AE28E/SHMI%20FAQs.pdf).

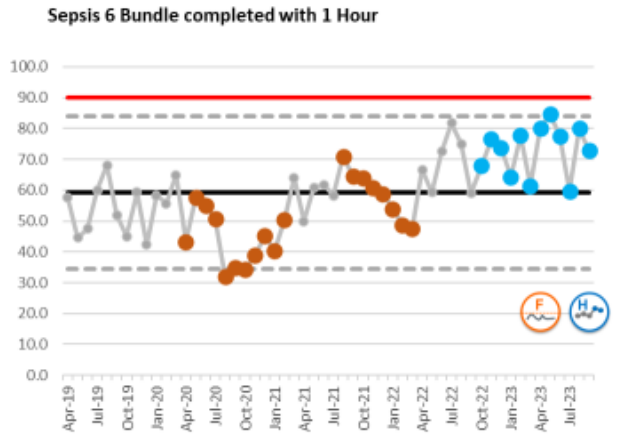
OUR QUALITY & SAFETY – SEPSIS 6

We are driving this measure because

Sepsis with shock is a life-threatening condition affecting all ages. NCEPOD 2015 highlighted sepsis as being a leading cause of avoidable death that kills more people than breast, bowel and prostate cancer combined.



This metric is **not changing significantly**. It shows common cause variation. The target (90%) lies within the process limits so we know that the target **may or may not** be achieved.



This metric is **improving.** The target (90%) lies above the process limits so we know that the **target will not be achieved** without change**.**

Performance and Actions

- Our performance against the sepsis bundle being given within 1 hour has dropped in Sep-23 to 72.9% and remains non-compliant with the 90% target.
- The Sepsis screening compliance also dropped in Sep-23 to 77.6% and did not achieve the target.
- Antibiotics provided within 1 hour increased in Sep-23 to 94.9% and achieved the target.
- Two of the remaining five elements of the Sepsis Six bundle also achieved the target; Oxygen and IV Fluid Bolus.
- Urine (87.8%), Lactate (81.1%) and Blood Cultures (86.5%) failed to achieve the target.
- The SEPSIS document on EPR went live in October, and the data is currently being examined with a view to moving reporting away from the Gap audit.

Action

- Meeting with sepsis lead for EPR to review sepsis module undertaken 24th October 2023
- Analysis of EPR data to be undertaken
- Further workshop with governance leads planned for this month

Risks

Ambulance offload delays 3908
Crowding in Emergency Departments 4843, 4963, 4964
Insufficient staffing to deliver safe, timely care 3698, 4192

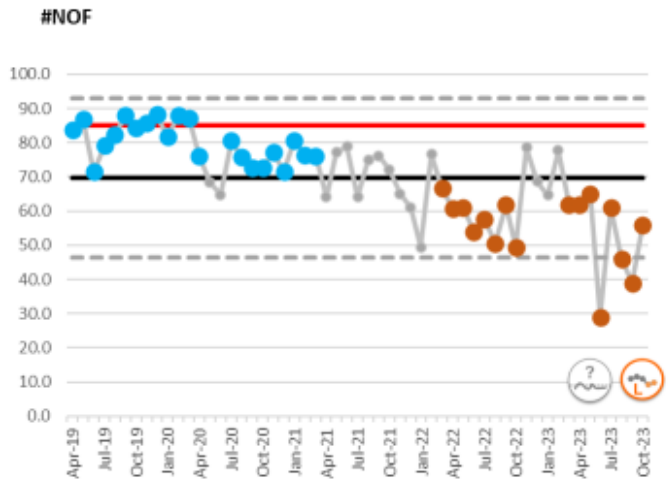
What the charts tell us

The Trusts Crude Mortality Rate for the period Aug-22 to Jul-23 for the diagnostic group of Septicemia (except in labour) is 26.37% (In-hospital 16.63% & and Out of hospital 9.74%).
The Trust has the 9th lowest rate in the Midlands (out of 22 Trusts)

OUR QUALITY & SAFETY – FRACTURED NECK OF FEMUR

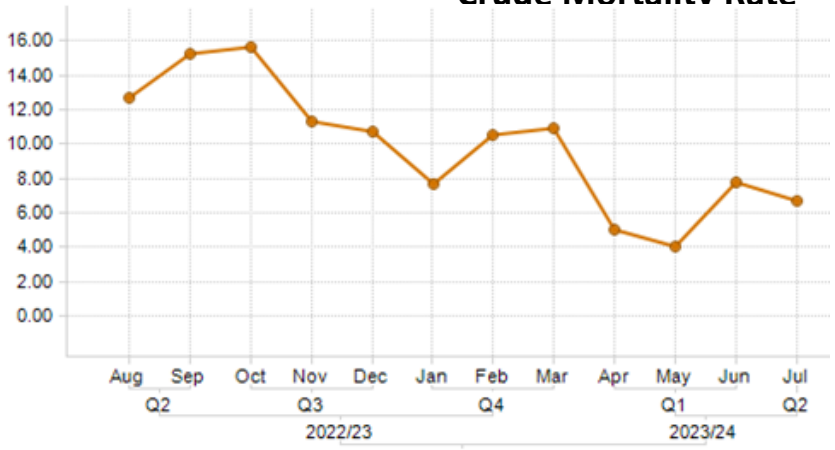
We are driving this measure because

Prompt surgery and appropriate involvement of geriatric medicine has benefits in terms of improved patient outcomes, increased number of independent individuals and reduced mortality, shorter length of stay and more cost-effective care.



Compliance with the standard of surgery within 36 hours is showing special cause variation of concern for the last 8 months.

Crude Mortality Rate[1]



[1] Source: HED – accessed 09/11/2023, data unchanged from last IPR.

Performance and Actions

- #NOF compliance increased to 56% (BPT), and 56% (All) in Oct-23, up from 36% and 39% respectively in Sep-23.
- The #NOF target of 85% has not been achieved since Mar-20.
- There were 61 (BPT) and 79 (All) #NOF admissions in Oct-23.
- There were a total of 27 (BPT) and 35 (All) breaches in Oct-23.
- The primary reasons for BPT delays were;
  - 40.7% (11 patients) due to theatre capacity
  - 37.0% (10 patients) due to bed issues
  - 25.9% (7 patients) due to medically unfit patients.
- The average time to theatre in Oct-23 was 39.5 hours (BPT) and 41.0 hours (All), down from 49.8 and 50.5 hours respectively in Sep-23.

Actions

The T&O trauma quality improvement plan will be reviewed with the divisional and directorate management teams in order to progress the outstanding actions.

Risks

Theatre and bed capacity continue to be the biggest risks to the effective delivery of the #NOF pathway

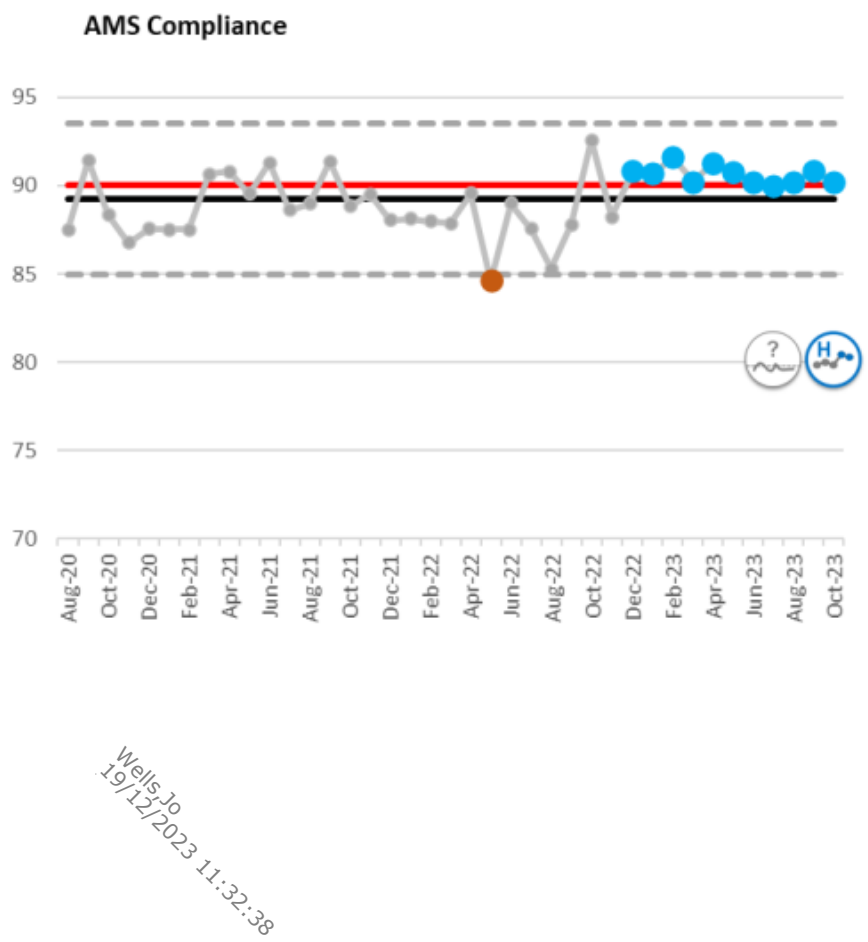
What the charts tell us

The Trusts Crude Mortality Rate for the period Aug-22 to Jul-23 for the diagnostic group of #NOF is 9.99% (In-hospital 3.60% & and Out of hospital 6.39%).
The Trust has the 4th lowest rate in the Midlands (out of 22 Trusts)

OUR QUALITY & SAFETY – ANTIMICROBIAL STEWARDSHIP

We are driving this measure because

We need an approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness and using Start Smart The Focus principles to reduce the risk of antimicrobial resistance (AMR) while safeguarding the quality of care for patients with infection.



Performance and Actions

- A total of 388 audits were submitted in Oct-23, compared to 292 in Sep-23.
- Antimicrobial Stewardship overall compliance dropped slightly in Oct-23 to 90.22% (from 90.87%) but still achieved the target for the 11th consecutive month.
- Patients on Antibiotics in line with guidance or based on specialist advice increased to 96.32% in Oct-23 and achieved the target.
- Patients on Antibiotics reviewed within 72 hours dropped in Oct to 90.57% but still achieved the target.
- Of the 8 elements of the audit, 3 have failed to reach the target this month.
- Achieved 15% against the CQUIN target (<40%) for Q2 for IV to oral switches of antibiotics where clinically appropriate to do so

Actions

- Divisional AMS clinical leads will continue to promote participation in the Start Smart Then Focus monthly audits and identify actions to drive improvement in quality (KPIs)
- Continuing to monitor the compliance with antimicrobial guidelines and antimicrobial consumption with a view to achieving reduction targets specified in standard contract for Watch and Reserve categories.
- Focusing on learning from C diff case reviews where antibiotics may be implicated & developing actions pertaining to AMS (and Prof Wilcox's report)
- Promoting IV to oral switches of antibiotics, and reducing length of course.
- Successfully recruited to the AMS lead pharmacist post (commencing Feb/March 24)
- Promoting antimicrobial resistance through information shared during Word Antimicrobial Resistance Week (18th to 24th November 23)

Risks

- Limited resource available for AMS support until newly appointed AMS lead pharmacist starts Feb/March 24
- Operational pressures prevent necessary attention to AMS

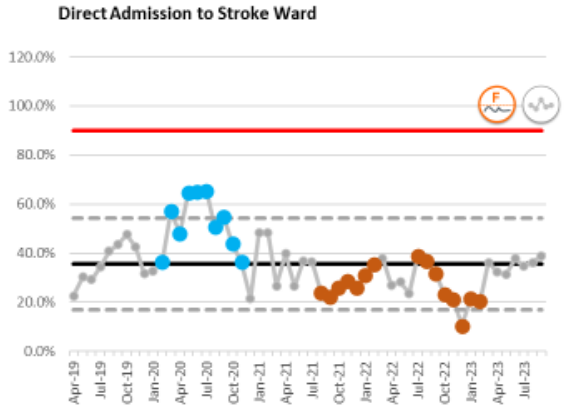
What the charts tell us

This metric has shown special cause variation of improvement for the past 11 months.

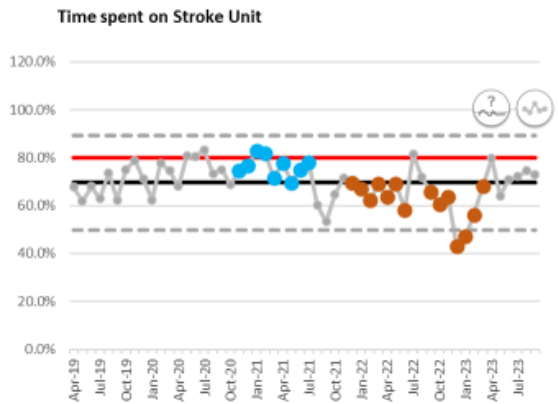
OUR QUALITY AND SAFETY – STROKE

We are driving this measure because

All Stroke patients should be admitted to our ward within 4 Hours / 90% Stay on Stroke Ward / Specialty Review Within 30 Minutes



This metric shows common cause variation. The target (90%) is above the upper control level meaning the **target will not be achieved** without change.



This metric shows common cause variation. The target (80%) lies within the control limits so we know that the **target will be met inconsistently.**

Wells Jo 19/12/2023 11:32:38

Performance and Actions

Performance

Internal figures for Sep-23 compared to Aug-23 show all metrics remaining at same levels, except;

- 80% of patients spend 90% of time on the Stroke ward **dropped** to Level E (from D)
- Median % of days as an inpatient on which physiotherapy is received **increased** to Level C (from D)
- Compliance (%) against the therapy target of an average of 27.3 minutes of physiotherapy across all patients **increased** to Level C (from D)
- Median number of minutes per day on which SLT is received **increased** to Level B (from C)
- Compliance (%) against the therapy target of an average of 16.1 minutes of speech and language therapy across all patients **dropped** to Level C (from B)
- Percentage of applicable patients who have mood and cognition screening by discharge **increased** to Level A (from B)

Actions

- The Acute Stroke Unit remains ring-fenced for stroke and neurology patients. To facilitate flow, 2 boarding spaces have been created on the ward. One of these boarding spaces remain free to ensure that there is a bed available at all times to give thrombolysis to a patient if required and bring the patient straight up to the ward from ED.
- Patients are alerted to the stoke team from WMAS, the stroke team are able to assess the patient much sooner. The stroke team are able to meet the ambulance when it arrives at WRH.
- The stroke team continues to assess patients alongside the therapy teams, if appropriate, to prioritise discharging patients directly home from ED/AMU. Ongoing investigations are then
- requested on an outpatient. This ensures that ASU beds are only used for those patients who are not medically fit for discharge.
- There is currently a band 7 SLT vacancy within ASU. The recruitment is currently underway led by therapy services.

Risks

4025 Risk of Stroke patients not receiving timely assessment, diagnosis and treatment due to workforce challenges and vacancies
4214 Risk of poor patient flow due to lack of inpatient rehabilitation beds & Community Stroke Team capacity
5274 Risk of patient harm in Stroke services due to insufficient and unsafe clinical workforce due to industrial action
5283 Risk of patient harm due to no provision for thrombolysis calls out of hours following withdrawal from South West network

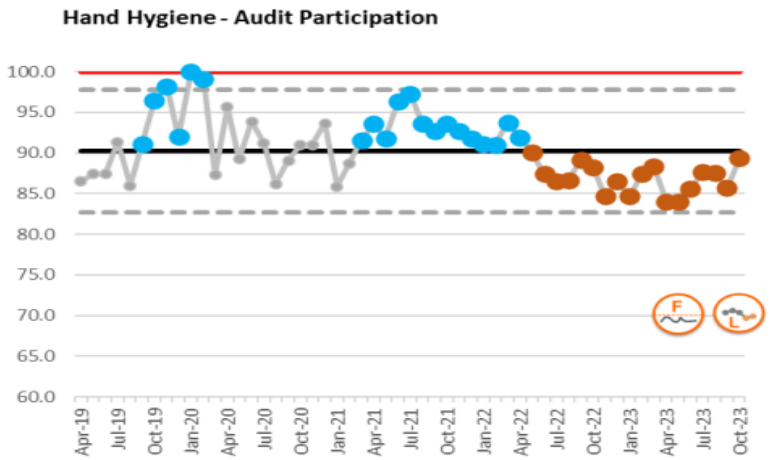
What the charts tell us

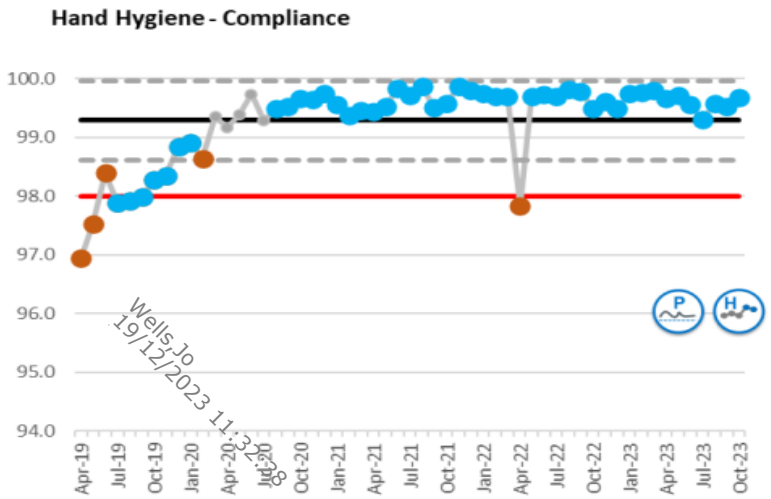
CT within 60 minutes and TIA within 24 hours are both showing common cause variation

OUR QUALITY & SAFETY – INFECTION PREVENTION AND CONTROL

We are driving this measure because:

There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.





Performance and Actions

- We were compliant with all in-month targets in Oct-23 except E-Coli.
- We are not currently compliant with any of the year to date targets.
- E-Coli is showing special cause variation of concern.
- There are currently 6 active COVID outbreaks, and 4 in monitoring (09/11)
- Baseline for COVID inpatients remains above previous levels
- There are also CPE (1 active and 2 monitoring) and D&V (1) outbreaks.

- All of the high impact intervention audits were compliant in Oct-23.

	Oct (Actual vs Target)	Year to Date (Actual vs Target)
C.Diff	7/7	73/45
E-Coli	10/7	64/42
MSSA	0/1	20/11
MRSA	0/0	2/0
Klebsiella	4/4	18/14
Pseudomonas	0/1	9/7

Actions

Hand Hygiene – compliance reviewed at TIPCC W&C and surgery division have worked with clinical areas to improve compliance and report increase in participation numbers for October.

Ecoli – Divisions due not have visibility of the data, there are currently no themes and trends. IPC working on how we inform of cases. High level themes for causative factors relate to urinary tract infections and hepatobiliary which is expected due to the nature of the organism.

CPE – No cases of CPE in the Laurels since Aug 23. Avon 3 noted to be In outbreak – no new cases for a month. CPE found in floor scrubbers, task and finish group underway to establish risk and mitigations to enable NEW floor scrubbers to be reinstated across the Trust.

Line Management Prevention of BSI– PVD pack audit has taken place, results under review and further training/awareness about availability of packs is required, managed through Line management improvement group.

Risks

Capacity: Level 4 actions impact on IPC actions as planned meetings involving clinical staff have been cancelled.

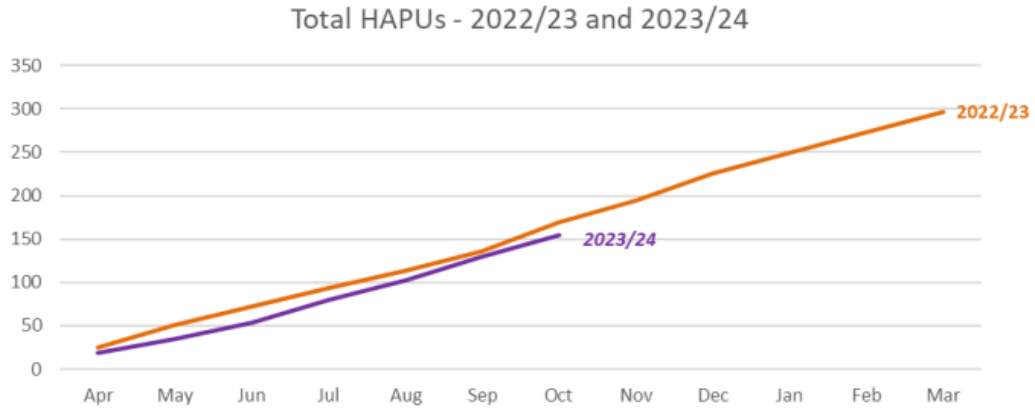
What the charts tell us

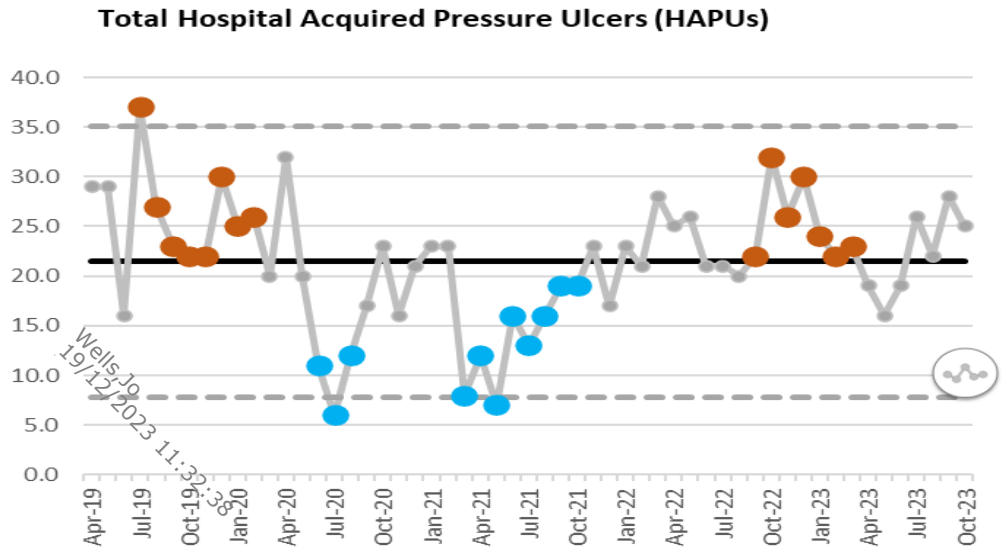
- Hand Hygiene Compliance has exceeded the target for the (98%) for the past 18 months and is showing special cause variation of improvement.
- However, Hand Hygiene Audit participation (see SPC) is still not compliant with the target (100%) and is showing special cause variation of concern.

OUR QUALITY & SAFETY – PRESSURE ULCERS

We are driving this measure because

In support of WAHT Quality and Patient safety plan priorities to improve on our progress achieved in reducing the number of causative hospital acquired pressure ulcers (HAPU).





Performance and Actions

Total HAPU's

- The number of HAPUs for Oct-23 dropped to 25, bringing the current total for 2023/24 to 155.
- The total is still below the same time in 2022/23.
- Total HAPUs as a % of Emergency Admissions decreased to 0.70% in Oct (from 0.81% in Sep)

HAPU's causing Harm

- There were zero HAPUs causing harm in Oct-23.

Actions

- Continue to support divisions with Educational Training programmes training for all health professional
- CQUIN 12 continues . (Documentation of a full pressure ulcer risk assessment (within 6hrs) using a validated scale, such as Waterlow in progress to support Quality and improvement.
- staff to complete new essential to role PUP training as improved divisional training %'s identified since launch of E Learning.

Risks

- 5306 (Risk score 10) TV SSKIN bundles not being completed adequately / accurately: raised with EPR team, unable to support with mandatory fields until phase 3.
- 4571:If patients are inappropriately referred for assessment this may delay specialist input for complex patients leading to serious harm .
- Due to increased patient acuity and vacancies in team timely reviews will be impacted.

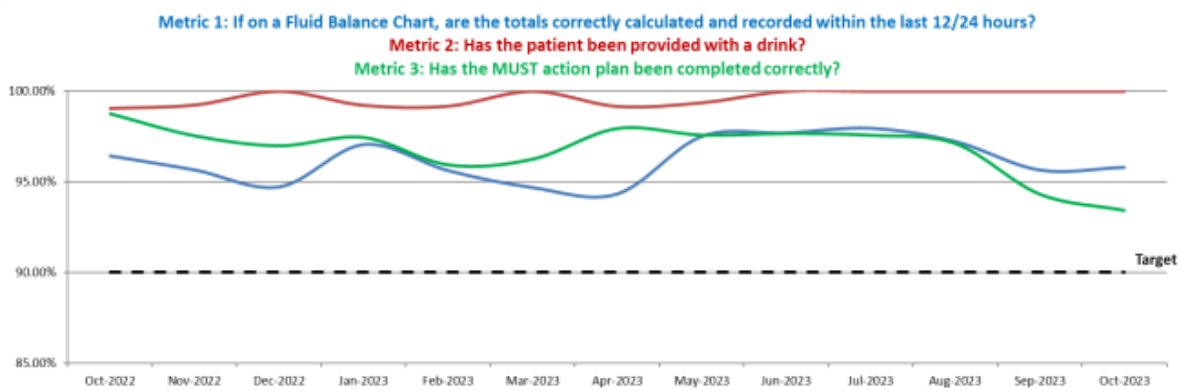
What the charts tell us

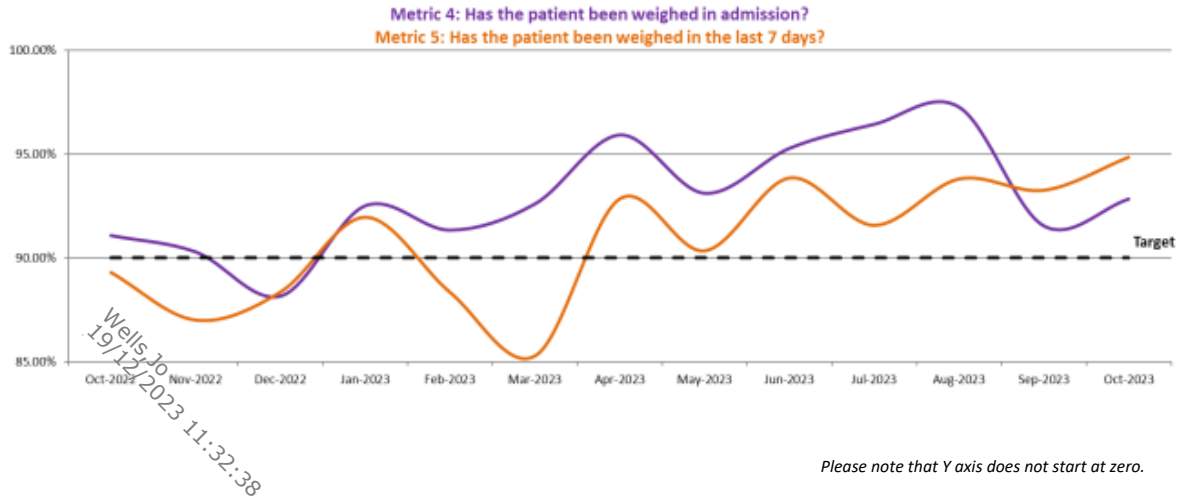
Total Hospital Acquired Pressure Ulcers is showing common cause variation.

OUR QUALITY & SAFETY – NUTRITION AND HYDRATION

We are driving this measure because

Nutrition and hydration is a vital area for high quality care of our patients. We need robust governance and assurance processes to ensure we are meeting, or working to meet, the standards set by NHSE.





Please note that Y axis does not start at zero.

Performance and Actions

- Metrics 1, 2 and 3 have all been compliant for the last 13 months.
- Metric 4 has been compliant for 12 of the past 13 months.
- Metric 5 has been compliant for 8 of the last 13 months, including the last 7 consecutive months.
- Note that as part of the Fundamentals of Care project, the data for some of these metrics will be collected from Sunrise (as they become available) rather than the Quality Check App.
- This will result in a much larger cohort.

Actions

- NGT training and practice plan formed between Nutrition Nurse and Practice Development team to improve training compliance and standards and identify how to improve ward based processes in placing NGTs. Actions developed and agreed for ongoing reporting to N&HSG.
- Ongoing development of Food and Drink Strategy. This has been slower than aimed for due to the working group having additional time demands which has slowed their progress on the tasks assigned to them.

Risks

- 5268 Risk of harm to patients requiring parenteral nutrition due to lack of dietetic staffing trust wide. 5260 Non timely access to nutritional management for patients trust wide.
- 4898 Risk of harm to patients requiring parenteral nutrition due to insufficient pharmacy levels to safely manage demand.

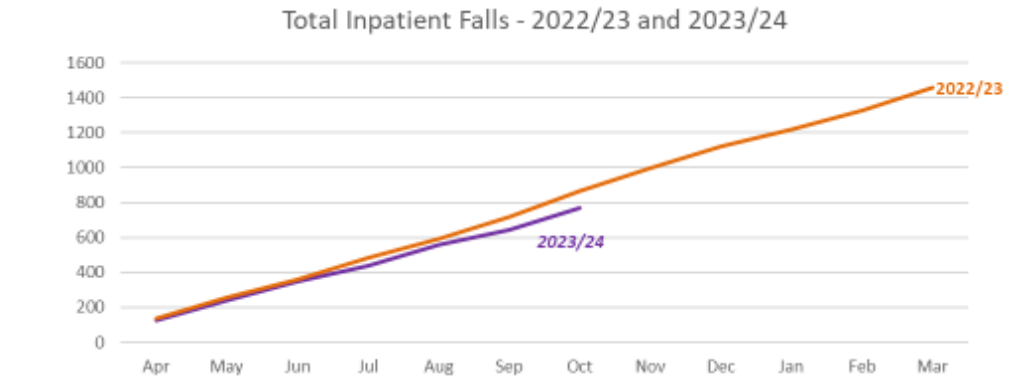
What the charts tell us

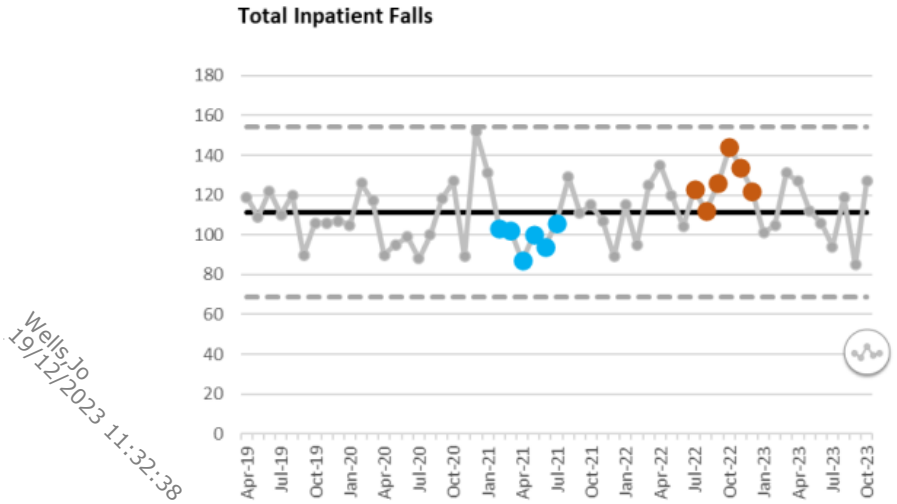
All Metrics were above the target of 90% in Oct-23.

OUR QUALITY & SAFETY – FALLS

We are driving this measure because

Falls and falls related injuries are a major cause of disability and the leading cause of mortality due to injury in older people in the UK. Falls are associated with increased length of stay, additional surgery and unplanned treatment.





Performance and Actions

Total Inpatient Falls

- The total monthly number of falls increased in Oct-23 (127) to the highest level since Apr-23.
- Of these 127 falls the harm caused was: 42 Insignificant, 79 Minor, 4 Moderate & 2 Severe.
- We remained below the national benchmark in Oct-23 with 5.39 Total Falls per 1,000 Bed Days (national target 6.63).

Inpatient falls resulting in Serious Harm

- There were 0 SI falls in Oct-23.
- This means there have been a total of 2 SI falls to date in 2023/24.

Actions

- Continue to monitor all falls, including falls with harm weekly, identifying hotpot areas where quality improvement projects (QIP) may be required.
- Encourage registered staff to complete the national falls e-learning available on ESR and revisit essential to role criteria to support compliance.
- Trial new falls governance process on wards 9 & 12, using the PSIRF model before Trust wide launch.

Risks

n/a

What the charts tell us

The total number of Inpatient falls is below the same time last year and is showing common cause variation.

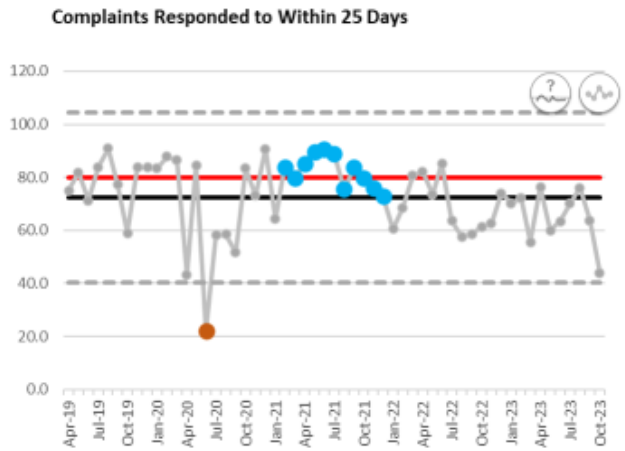
OUR QUALITY & SAFETY – COMPLAINTS

We are driving this measure because

We are aware from public feedback that a prompt, real-time, comprehensive service for the public using the Complaints services can be effective in resolving the majority of complaints, queries or outstanding concerns.

Performance

- In total there were 63 new formal complaints received within Oct-23 with 28 (44%) called within 5 days to discuss the complaint.
- The Trust had 165 complaints still open at the end of Oct, of which 23 have been reopened.
- Of these 165 complaints, 90 have breached 25 days (17 of which have been reopened)



- The Surgery Division accounts for 68 (75.6%) of the complaints which have breached 25 days, 12 of which have been reopened.
- **Of the 68 Surgery complaints which have breached 25 days, 22 (32.3%) have also now breached 6 months (3 of which have been reopened).**
- Compliance with complaints closed within 25 days dropped this month to 43.94%, and this is the 16th consecutive month that the target (80%) has been missed.

Actions

The Surgical Division have developed an action plan, with trajectories, to enable 80% of the backlog complaints being responded to by end of November 2023. Actions that have been taken:

- Enhanced interim team to handle the backlog of complaints is in place during October and November 2023
- Trajectory to address both backlog and new complaints agreed
- Monitoring and escalation routes agreed and are in place
- Monitoring includes re-adjustment of workload following assessment of weekly performance and any re-opened cases
- Action Plan includes development of a sustainable process to prevent re-occurrence.
- Risk Register entry made on Divisional Risk Register (5204).
- Trajectory and teams' personal goals will be monitored weekly. Escalation to Divisional Team and Executives as required to ensure compliance.
- Best Practice evidence being gathered to support development of future divisional process for complaint handling.
- The backlog of surgical cases is reducing and has continued to do so throughout November

Risks

Reputational Damage, further resource depletion due to ongoing correspondence with extended open cases, distress to patients and relatives

What the charts tell us

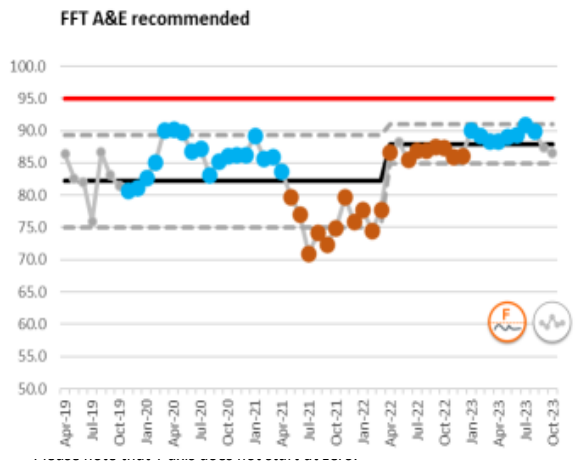
The target is within the common cause variation but performance continues to fluctuate. The SPC chart indicates that more robust processes and / or increased focus / capacity would enable us to meet the target consistently as the target is within the control limits.

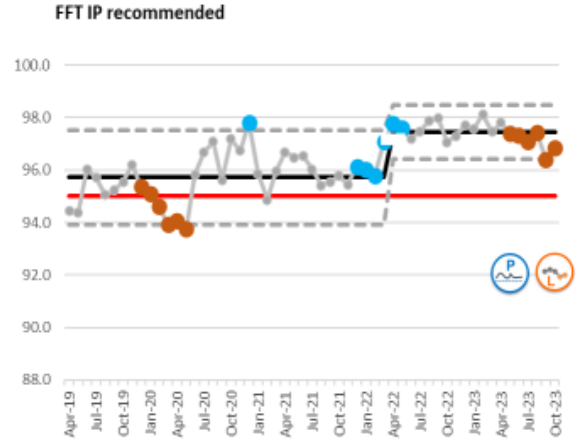
OUR QUALITY & SAFETY – FRIENDS AND FAMILY TEST

We are driving this measure because

Our patients and their carers will be provided with a variety of methods for providing feedback on their experiences of our services, to ensure learning and improvements can be prioritised.

Performance





- Inpatients continues to achieve the 95% recommended target and has been compliant every month since Feb-21.
- Outpatients has met the recommended target every month since Aug-22.
- Outpatients response rate dropped below the target to 9.18%. This is the first time the 10% target has not been met since Mar-22.
- Although A&E have not met the recommended target, they have been above 85% since Apr-22 and benchmarking[1] for Aug-23 shows the highest recommended rate for the Midlands.
- Maternity compliance increased for the recommended rate to 94.12% in Oct-23.
- The response rate for Maternity in Oct-23 increased to 2.94%, which is the highest since Feb-23

Actions

Maternity

Improved reporting is expected to launch in December with new Divisional dashboards to support monitoring, this will include Midlands Peer Group benchmarking, response modes (SMS, online, electronic, paper) and breakdown by speciality.

Actions reported in September continue which include

- The Division continues to monitor the response and recommended rates.
- The card trial will continue as a measure to support an increase in response rates.
- "Anytime" feedback will be promoted across Antenatal services, cards to be handed out on wards and measures in place to ensure those who have experienced long/traumatic births are supported to take feedback home to support reflection.
- Postnatal approach to encourage "on the day of discharge" feedback and a clear processes for collection of cards.

Badgernet is not FFT compatible – this method is therefore not currently being promoted to families.

A and E

- The FFT poster with QR code has not yet launched – the poster will offer an alternative way for people to feedback about experiences of care. The poster can also be used in additional areas. A Children and Young People poster is in development.
- FFT feedback will work alongside the new patient voice and engagement app

The Big Quality Conversation survey is live until 7th January 2024 and provides an additional method for people to share experiences of care at the Trust.

Risks

A&E to be reviewed as moving to new department on the Worcester site in October 23 – potential for FFT feedback percentages reduction/increase – to be monitored.
Maternity – Following the trial and review, if FFT paper feedback does not increase percentages for feedback, the Trust will need to consider other data collection methods alongside West Midlands Peer Group actions taken to increase response rates.

What the charts tell us

A&E is showing common cause variation, and as the target is above the upper control limit compliance with the target is unlikely without a change in process.
Although consistently meeting the target, the Inpatient recommended rate has been showing special cause variation of concern for the last 6 months.

OUR WORKFORCE

Tina Ricketts

Director of People and Culture

Agency costs remain our biggest challenge. Whilst agency costs (as a percentage of gross pay costs) has reduced by 0.26% to 9.39% this month, this is still above our target of 6%. This month saw the dual running of the ED Department following the opening of the new department. The primary reasons for agency bookings are vacancies, sickness, additional capacity, specialing for falls risk, and maternity cover. Our agency reduction plan is focused on enhanced recruitment and improved management of sickness absence.

On a positive note, our annual staff turnover has reduced to 11.34% which means that we have achieved our target of 11.5% for the first time since November 2021. Vacancies have however only reduced in month by 10 wte to 653 wte, this is mainly due to an increase in the staff in post of 62 wte being offset by the growth in establishment.

Our gross vacancy rate on ESR has reduced again from 9.53% to 9.31% compared to 11.78% for the same month last year. This is a direct result of the increased recruitment activity. To meet our workforce plan we need to recruit a further 68 wte new starters by 31st March 2024 and we are on track to do this as we are 0.91 wte ahead of plan at month 7.

Cumulative sickness absence (rolling 12 months) is unchanged 5.81% which is due to last October and this October being very similar. This is clearly above our revised target of 4%. Monthly sickness absence has increased by 0.54% to 6.21% which represents a 0.56% increase on the same period last year. There have been large increases in Corporate, Urgent Care and Surgery with primary reasons being stress/anxiety. Sickness due to stress and anxiety (S10) accounts for 29.63% of the total absence in month. Targeted support is being facilitated through Occupational Health and Health Psychology and all long-term sickness absence cases have been reviewed. Sickness absence management will remain a focus at divisional performance review meetings.

We are working to improve our Job planning compliance to above 95% linking job plans to required activity. Unfortunately, the improvement last month has not been sustained and we have dropped to 75% due to the number of job plans that expire in month, and new starters and leavers.

We will continue with getting the basics right this month due to mandatory training compliance remaining at 88% against a revised Model Hospital Benchmark of 89.6%. Non-medical appraisal has improved by 1% to 79% against a target of 90% and a Model Hospital average of 81%. This is equal to the same period last year. Medical appraisal has improved to 92% which is above target.

OUR WORKFORCE – REDUCTION OF AGENCY SPEND

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and reduced cost to the Trust.

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23
9.3%	7.9%	10.3%	10.3%	8.2%	7.1%	9.2%	9.5%	11.1%	9.3%	10.2%	9.8%	9.4%

Assurance

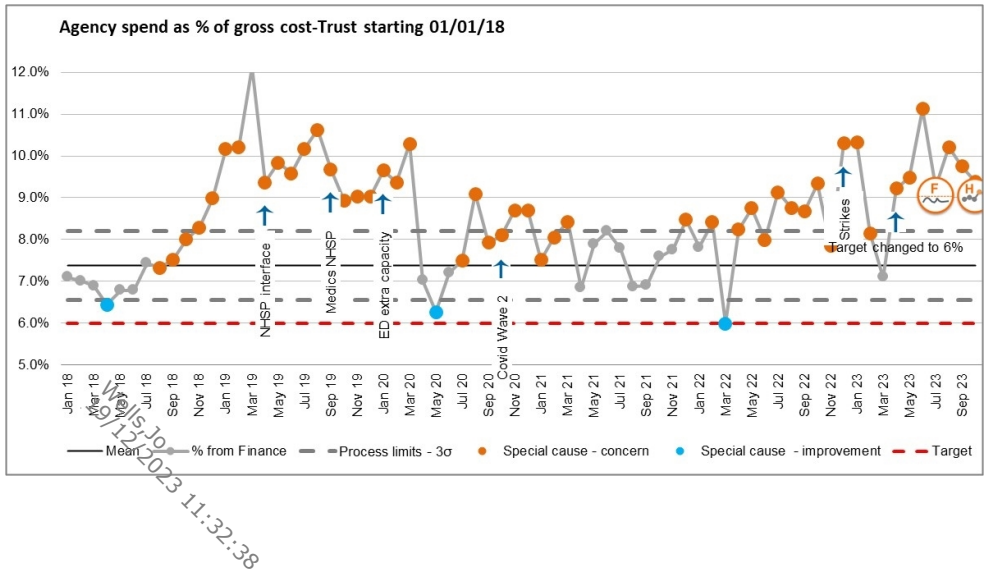
The system is expected to consistently Fail the target

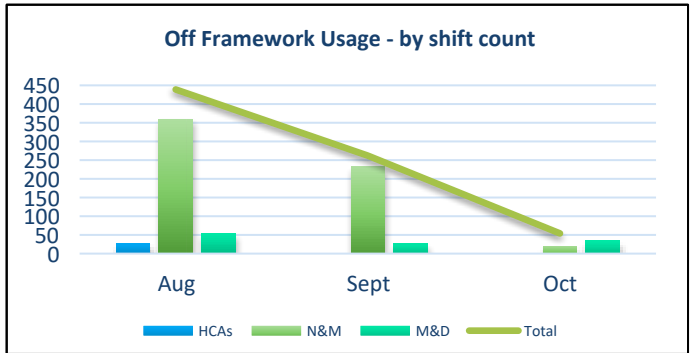
Variation

Special cause variation – Cause for concern (where high is a concern)

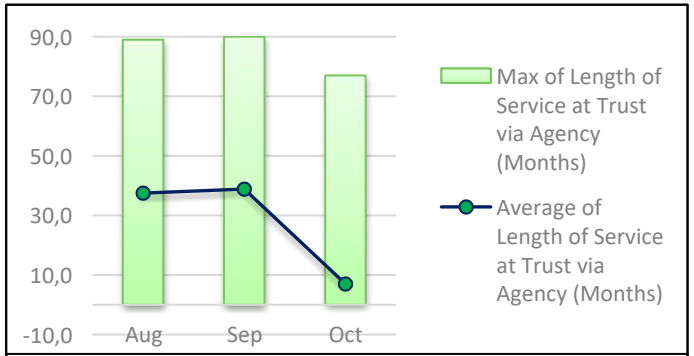
Data Quality Mark

Reasonable Assurance

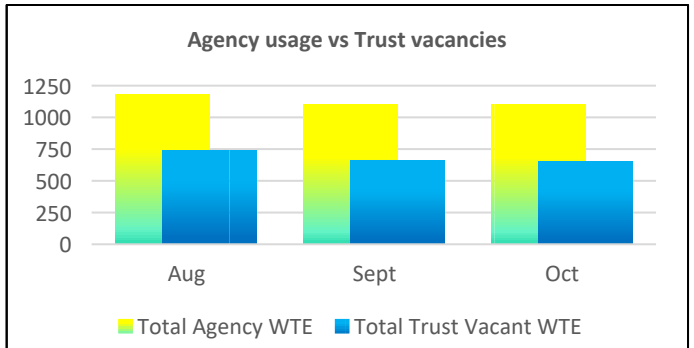




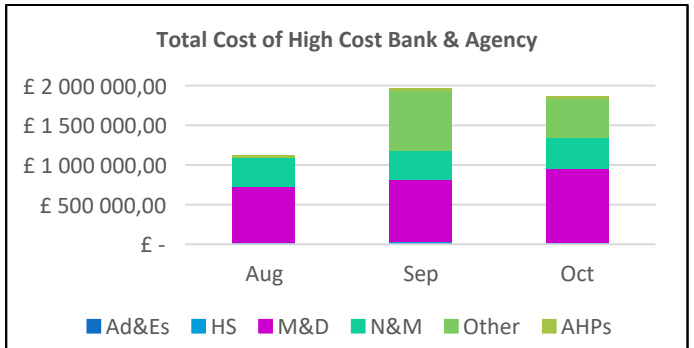
Off-framework usage has decreased very positively over the period, with the majority of reductions being within Nursing & Midwifery



Maximum length of service has begun to reduce in October, with the average length of service dropping drastically in line with worker replacements made, mostly in Nursing & Midwifery



Although agency usage has decreased in line with reduction in Trust Vacancy WTE, the WTE of agency used is almost double the vacancy WTE



The total cost to the Trust of high cost bank and agency workers has increased over the last 3 months, with the majority of these cost increases sitting within M&D and 'Other' categories

What the chart tells us

Agency cost as a % of gross cost has reduced by 0.36% to 9.39% in month. However, this is still above our target of 6% although is broadly the same as October last year despite increased establishment. A number of actions are being taken to reduce temporary staffing costs including our targeted PEP programme, enhanced recruitment plans and improved management of sickness absence.

OUR WORKFORCE - VACANCY

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23
11.8%	11.7%	12.0%	12.0%	11.6%	11.6%	12.6%	12.6%	12.3%	11.6%	10.6%	9.5%	9.3%

Assurance

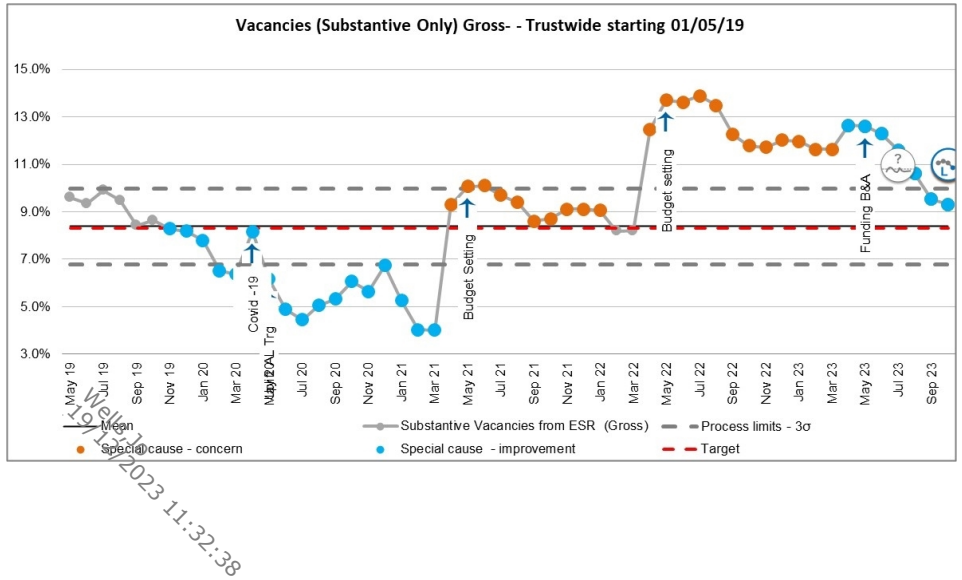
Hit and miss target - Subject to random variation

Variation

Special cause of improving nature or lower pressure due to Lower Values

Data Quality Mark

Reasonable Assurance



Performance and Actions

- **Starters and Leavers** - We have recruited 62 more starters than leavers this month with 154 new starters processed in month (headcount).
- **Time to Hire** – Our time to process checks has improved from 48 in July 2022 to 39 working days this month.
- **Healthcare Support Worker** – We have been actively recruiting HCSWs throughout the year with 44 starting in October (365 new HCSW's in the last 12 months). Our current vacancy rate is 11.67% or 119 vacancies compared to 88 wte last month. This is due to 25 additional posts being added to the establishment. Our retention for HCSWs requires improvement with 248 leavers over the year (22 in September). 86 of the 248 leavers (35%) had less than 1 years' service so we are focusing on early career conversations with new joiners.
- **Nursing & Midwifery** - We currently have 104 wte Registered Nurse vacancies (compared to 148 last month) and 23 wte midwifery vacancies. Our international Nurse recruitment programme is on track to achieve our target of 150 by 31st Match 2024.
- **Allied Health Professionals** – We have 45 wte qualified AHP vacancies (compared to 56 wte last month) and 10 wte support posts. We have struggled to gain traction with our AHP recruitment in the last 12 months with 75 new starters but 70 leavers . 18 of our leavers left due to the preventable reason of work life balance so we are focusing on flexible working opportunities for this staff group. We are working with NHS England to bring in International Radiographers.
- **Medical & Dental**. We have 65 Consultant, 2 Career Grade, and 40 Trainee Grade vacancies. Consultant vacancies have increased due to an 8 wte increase in establishment. We are working with clinical directors on targeted recruitment campaigns and successfully recruited 3 Consultants, 2 Specialty Doctors and 17 Specialty Registrars in October.

Risks

Healthcare support worker retention, hard to recruit medical vacancies and an increasing establishment

What the chart tells us

We are on an improving trajectory other than April 2023 budget setting where business cases were transacted into the establishment.

OUR WORKFORCE - SICKNESS

We are driving this measure because

Due to increased scrutiny and higher sickness levels following the pandemic the Trust aims to reduce sickness levels to provide high quality care, and reduction of agency spend, as well as improving morale of staff.

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
5.7%	5.6%	6.7%	6.0%	5.5%	5.6%	5.4%	5.5%	5.3%	5.5%	5.6%	5.7%	6.2%

Assurance

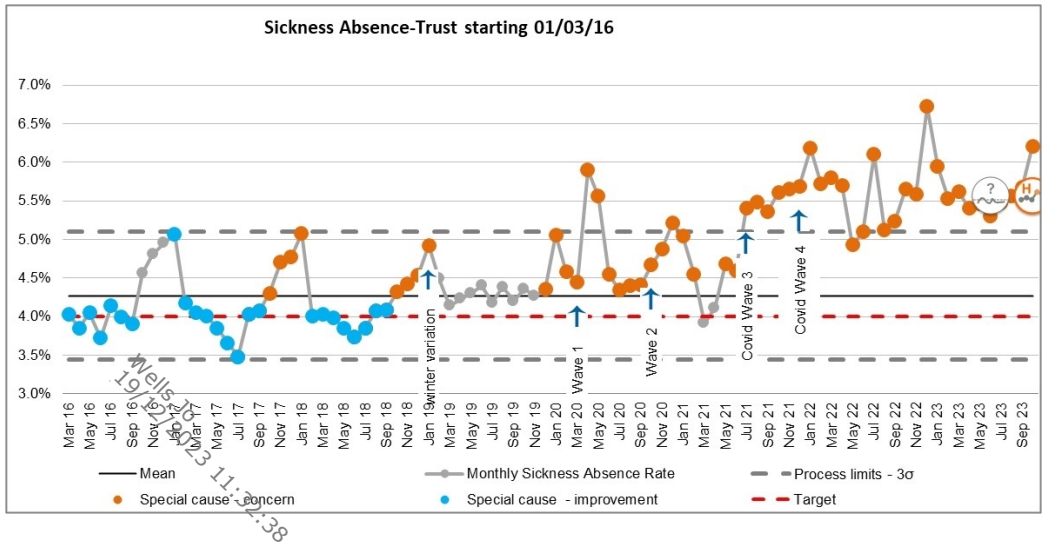
Hit and miss target - Subject to random variation

Variation

Special cause variation – Cause for concern (where high is a concern)

Data Quality Mark

Reasonable Assurance



Performance and Actions

- Monthly sickness rates have increased by 0.54% to 6.21%, which is 0.56% deterioration on the same period last year. Despite some improvement, Urgent Care have had a spike of 1.56% in sickness absence to our highest absence rate at 7.26% primarily in A&E at WRH. Corporate have had the highest increase in month (2.07%) to 8.10%. Estates and Facilities continue to present with high levels of sickness absence: 6.53% in month and 7.78% 12 month cumulative. Digital is the only division who meet the new Trust target of 4%.
- Stress and Anxiety continues to account almost 30% of the in-month sickness absence. Surgery has exceeded 40% of stress related absence again this month. Corporate have now hit 40%, Urgent Care 39% and Women and Children's 37%.
- Long term sickness has increased by 0.05% in month to 3.54%. Short term absence has improved by 0.05%. The highest rates of long-term sickness is in Facilities and Estates (5.26%), Women and Children (3.86%) and SCSD (3.79%). The highest rates of short-term sickness occur in Urgent Care (2.58%), Estates and Facilities (2.53%), and Specialty Medicine (2.51%).
- Our sickness is currently benchmarking poorly against national position in most staff groups with the exception of Allied Health Professionals.
- The health & wellbeing package is reviewed each month to ensure it remains fit for purpose.
- Management of sickness absence will remain a key priority over the coming year and the target has been reduced from 5.5% to 4%.

Sickness Absence	2023 / 10			
	Trust	Region	Country	National
Add Prof Scientific and Technic	6.10%	4.81%	4.10%	4.07%
Additional Clinical Services	8.99%	7.98%	7.54%	7.61%
Administrative and Clerical	5.96%	4.96%	4.62%	4.64%
Allied Health Professionals	4.30%	4.64%	4.42%	4.43%
Estates and Ancillary	7.53%	7.63%	7.51%	7.66%
Healthcare Scientists	4.23%	3.99%	3.89%	3.80%
Medical and Dental	2.37%	2.06%	1.89%	1.88%
Nursing and Midwifery Registered	6.61%	6.04%	5.62%	5.66%

Risks

Increased cost of bank and agency fill and cultural shift where higher levels of sickness become the norm.

What the chart tells us

The elevated period between May 2021 and December 2022 reflects covid impact in addition to other winter pressures such as Flu. Since the peak in sickness absence in Dec 2022 (6.7%), the trajectory has improved but appeared to be plateauing at about 5.5%. However, there has been a sharp increase in October, primarily in long-term sickness.

OUR WORKFORCE - TURNOVER

We are driving this measure because

To improve retention, maintain staffing levels, improve morale, and enable the reduction of temporary staffing to maintain a high quality of care.

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
13.5%	13.0%	13.5%	13.4%	13.0%	12.1%	12.0%	12.0%	12.1%	11.9%	11.9%	11.6%	11.3%

Assurance

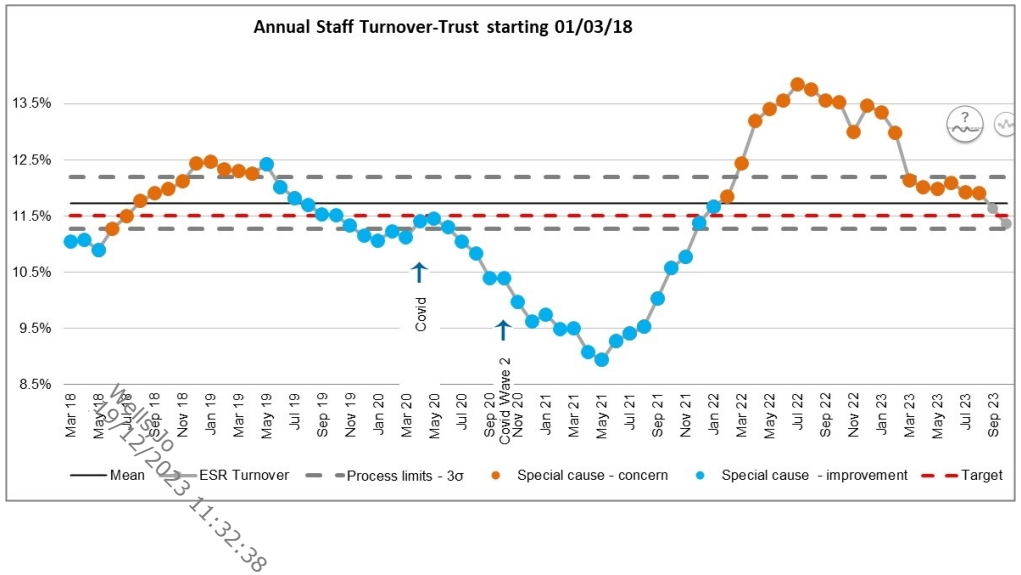
Hit and miss target - Subject to random variation

Variation

Common Cause – no significant change.

Data Quality Mark

Reasonable Assurance



Performance and Actions

Our annual staff turnover has reduced by 0.28% to 11.34% which is 2.19% better than the same period last year. This means that we have achieved our local target of 11.5% for the first time since January 2021.

Our latest performance on Model Hospital for retention rate is 98.3% against an average of 98.4% and peer average of 98.6% (March 2022 rates).

Workforce annual turnover is currently at the lowest level for the past year. Turnover rates for registered nurses is 9.46% and Midwives is 7.37% and we are in Quartile 1 (best) on Model Hospital for these groups (July 2023 data).

The Benchmark Report from ESR however, shows that the Trust has slipped on monthly turnover with all but 2 staff groups worse than average.

We aim to reduce the number of staff leaving due to work life balance during the next year through our focus on flexible working.

Monthly Turnover	2023 / 10			
	Trust	Region	Country	National
Add Prof Scientific and Technic	0.00%	0.70%	0.99%	0.97%
Additional Clinical Services	1.52%	0.85%	1.05%	1.03%
Administrative and Clerical	1.14%	0.93%	0.96%	0.95%
Allied Health Professionals	0.68%	0.76%	0.92%	0.90%
Estates and Ancillary	1.28%	0.86%	0.87%	0.88%
Healthcare Scientists	1.10%	0.84%	0.77%	0.76%
Medical and Dental	2.15%	1.29%	1.86%	1.80%
Nursing and Midwifery Registered	0.92%	0.72%	0.79%	0.77%

Risks

Estates and Ancillary and Admin and Clerical are Quartile 4 (worst) on Model Hospital for turnover. Medical and Dental are Quartile 3.

What the chart tells us

The rolling 12-month position remained consistently within the revised 11.5% target set during the pandemic. Turnover has stabilised in the past 6 months and is on an improving trajectory. We have met our 11.5% target in October.

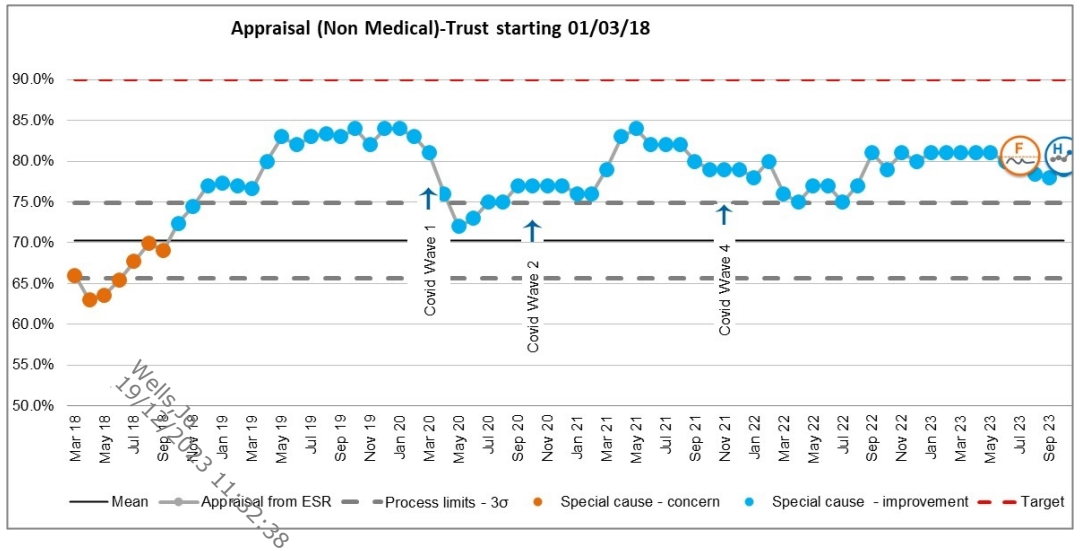
OUR WORKFORCE – APPRAISAL AND JOB PLANS

We are driving this measure because:

To ensure our staff feel heard and valued which will maintain high standards and improve retention.

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
81%	79%	81%	80%	81%	81%	81%	81%	81%	80%	78%	78%	79%

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special Cause Variation where High requires investigation	Reasonable Assurance



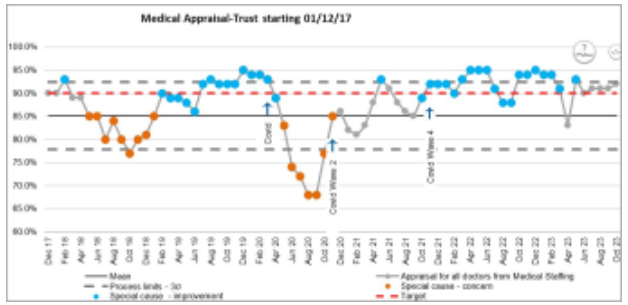
Performance and Actions

Appraisal rates for non-medical staff have improved by 1% to 79% which is the same as last year, against a Model Hospital average of 80.9% (revised 2022/23 rates). We are at Quartile 3 on model hospital.

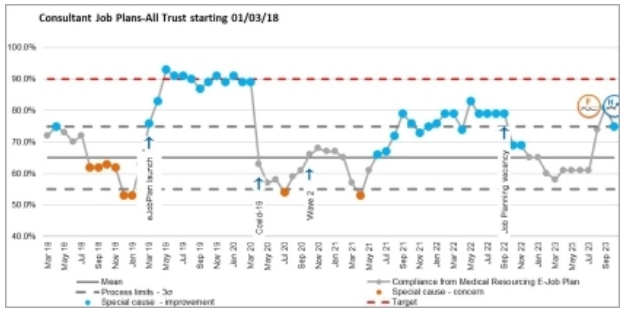
A simplified appraisal form has been launched as well as further guidance on wellbeing conversations with staff.

Divisional leaders have been asked via PRMs to ensure outstanding performance appraisals are completed. The lowest rates are in corporate teams Digital, and Surgery who are all sub-70%.

Medical Appraisal has improved to 92% and has been fairly consistently above target of 90% since December 2021:



Consultant Job Planning compliance has dropped by 6% to 75% this month primarily due to staff in SCSD and Surgery having in month job planning review dates.



Risks

Admin and Clerical staff (particularly those in Corporate Teams) have low levels of appraisal compliance.

What the chart tells us

The rolling 12-month appraisal position remains fairly consistent across the period between May 2021 and July 2023 but then deteriorated, and is below target of 95%.

OUR WORKFORCE – STATUTORY AND MANDATORY TRAINING

We are driving this measure because:

To ensure that all our staff maintain mandatory and essential to roll training which will ensure their safety and maintain high quality of care to our patients

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
88%	88%	89%	89%	89%	89%	90%	90%	90%	90%	89%	88%	88%

Assurance

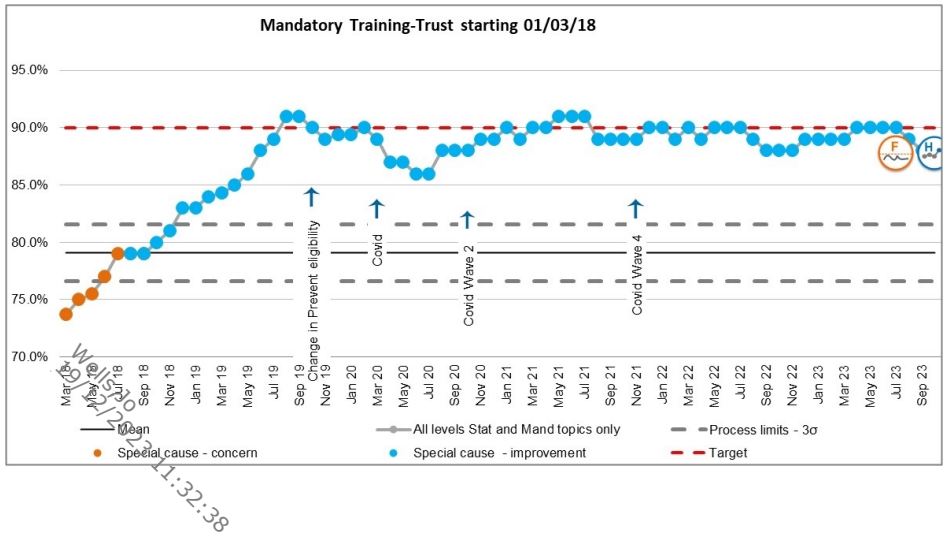
The system is expected to consistently Fail the target

Variation

Special Cause Variation where High requires investigation

Data Quality Mark

Reasonable Assurance



Performance and Actions

Overall mandatory training compliance has remained at 88% against a revised Model Hospital average of 89.6% (2022/23 rates). This is the lowest compliance rate that we have had since November 2022. Urgent Care and Surgery remain outliers at 84% closely followed by Women and Childrens Division. The Medical and Dental staff group remain outliers across all divisions. We have updated the table using the ESR benchmark data which demonstrates that the Trust continues to benchmark well both regionally and nationally from raw ESR data. This would indicate that other Trusts are taking out exclusions in what they send to Model Hospital as ESR reports are raw data:

Mandatory Training	2023 / 10			
	Trust	Region	Country	National
Add Prof Scientific and Technic	82%	81%	76%	77%
Additional Clinical Services	83%	80%	78%	78%
Administrative and Clerical	87%	85%	80%	81%
Allied Health Professionals	89%	81%	79%	79%
Estates and Ancillary	84%	78%	75%	76%
Healthcare Scientists	88%	82%	78%	79%
Medical and Dental	67%	58%	57%	56%
Nursing and Midwifery Registered	87%	79%	75%	75%

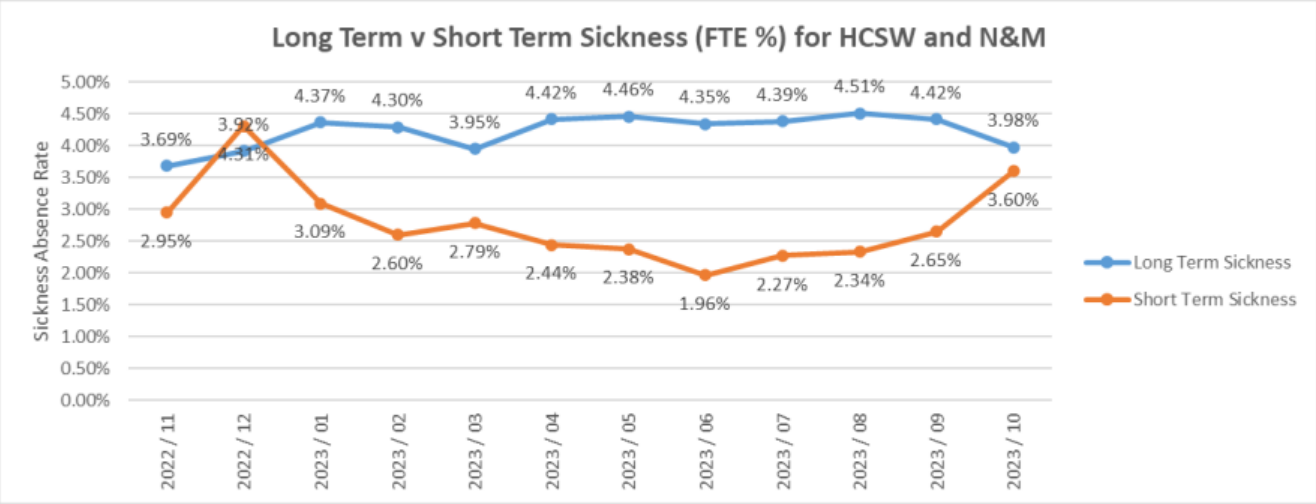
Risks:

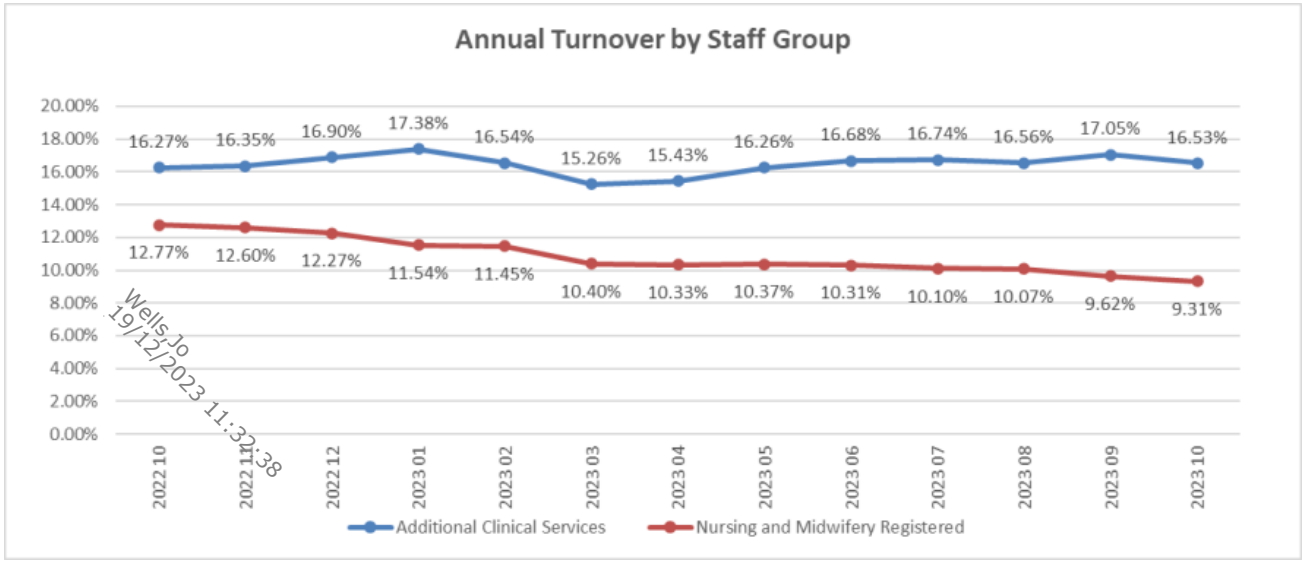
Medical and dental training compliance, and some challenges with legacy IT infrastructure which doesn't consistently support some of the e-learning modules. Escalation to Level 4 means that some training is cancelled.

What the chart tells us:

This is the lowest compliance rate that we have had since November 2022.

WAHT Charts on Sickness Absence and Turnover for HCSWs and Registered Nurses and Midwives





Reason for Absence for Nurses, Midwives and HCSWs	corporate	Digital	SCSD	Specialty Med	Surgery	Urgent Care	Women and Children	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	0.73%	0.00%	4.95%	4.00%	8.00%	4.42%	4.13%	26.24%
S13 Cold, Cough, Flu - Influenza	0.11%	0.00%	3.77%	2.60%	1.30%	1.75%	0.70%	10.25%
S12 Other musculoskeletal problems	0.43%	0.00%	3.57%	1.21%	1.35%	1.46%	1.77%	9.79%
S27 Infectious diseases	0.61%	0.00%	3.24%	1.72%	1.02%	0.36%	0.32%	7.27%
S98 Other known causes - not elsewhere classified	0.04%	0.00%	3.39%	1.20%	0.09%	0.59%	0.95%	6.28%
S30 Pregnancy related disorders	0.00%	0.00%	1.28%	2.04%	0.61%	1.41%	0.36%	5.70%
S25 Gastrointestinal problems	0.25%	0.00%	2.28%	1.23%	0.55%	0.44%	0.39%	5.15%
S11 Back Problems	0.00%	0.00%	1.48%	1.95%	0.80%	0.01%	0.81%	5.06%
S26 Genitourinary & gynaecological disorders	0.12%	0.07%	1.29%	1.52%	0.37%	0.14%	1.07%	4.57%
S16 Headache / migraine	0.01%	0.00%	0.99%	0.41%	1.16%	0.66%	0.30%	3.53%
S28 Injury, fracture	0.00%	0.00%	1.51%	0.45%	0.92%	0.01%	0.54%	3.43%
S17 Benign and malignant tumours, cancers	0.00%	0.00%	0.06%	1.33%	0.39%	0.41%	0.82%	3.00%
S15 Chest & respiratory problems	0.00%	0.00%	0.90%	1.04%	0.26%	0.11%	0.41%	2.73%
S29 Nervous system disorders	0.41%	0.00%	0.44%	0.41%	0.17%	0.05%	0.22%	1.69%
S21 Ear, nose, throat (ENT)	0.00%	0.00%	0.59%	0.42%	0.10%	0.07%	0.19%	1.38%
S19 Heart, cardiac & circulatory problems	0.00%	0.00%	0.57%	0.37%	0.03%	0.37%	0.00%	1.34%
S23 Eye problems	0.07%	0.00%	0.51%	0.48%	0.00%	0.00%	0.00%	1.06%
S31 Skin disorders	0.00%	0.00%	0.02%	0.09%	0.00%	0.48%	0.00%	0.59%
S22 Dental and oral problems	0.00%	0.00%	0.39%	0.10%	0.00%	0.03%	0.00%	0.52%
S24 Endocrine / glandular problems	0.24%	0.00%	0.00%	0.15%	0.00%	0.00%	0.01%	0.40%
S14 Asthma	0.01%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%
Available FTE	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Annual Turnover by Staff Group and Division						
Staff Group	Corporate	Specialty Medicine	Urgent Care	SCSD	Surgery	Women and Children
Registered Nurses	11.48%	11.45%	8.72%	8.78%	8.32%	7.67%
Midwives						7.37%
HCAs/Support Workers	22.46%	16.42%	20.00%	17.44%	11.38%	18.37%

OUR FINANCIAL PERFORMANCE

Neil Cook

Chief Finance Officer

Financial Plan 2023/24
The final plan reflects a break-even plan for the year including £28m (4.2%) of PEP and £20m of Elective Recovery Fund activity. It is important to note that the recurrent underlying position of the Trust continues to run at a greater level of deficit due to the significant level of non-recurrent funding received from the Herefordshire & Worcestershire ICB.

Income & Expenditure Performance
In Month 7 the Trust returned a deficit of £2.3m against a planned surplus of £1.5m, representing an adverse variance of £3.8m. The cumulative deficit to date is £18.9m against a planned deficit of £7.7m, an adverse variance of £11.2m. Key drivers of the variance include:

- Exceptional / Unplanned Items including the costs of industrial action, backdated pay awards and the cost of 1:1 specialist care for high acuity patients totalling £2.9m.
- Slippage on the delivery of Productivity and Efficiency Programmes of £6.3m.
- The impact of excess inflation £1.2m.
- The costs of temporary staffing above normal levels for both high acuity and hard to appoint to vacant posts totalling £2.1m.

The projected outlook for the year is a £34.9m deficit against plan. Financial recovery measures have been instigated including the setup of a Financial Recovery Board to oversee the implementation of revised financial and operational delivery targets for each Division. Wrap around support is being provided to Divisions on this improvement journey which including the use of experienced 3rd party expertise to help co-ordinate and lead the development of a recovery plan.

Capital
The total capital plan submitted for 2023/24 was £30.089m and increased by £800k PDC funding relating to the final part of the RAAC (roofing) scheme in M6. The Trust has also received notification in M7 that the National Diagnostic PDC Scheme is now expected to be £144k of the £350k forecasted. The PFI Lifecycle Replacement forecast has also increased to £4m resulting in a new plan figure of £34.351m. The Trust is on track to spend to this allocation. Going forward however the future expectations of capital spend significantly outstrip the available funds due to the overspend on the UEC programme. This is impacting on the Trusts ability to undertake backlog maintenance and equipment replacement in line with expectations. Discussions are progressing with ICB and NHSE regarding a longer-term solution to support the capital programme in 2024/25.

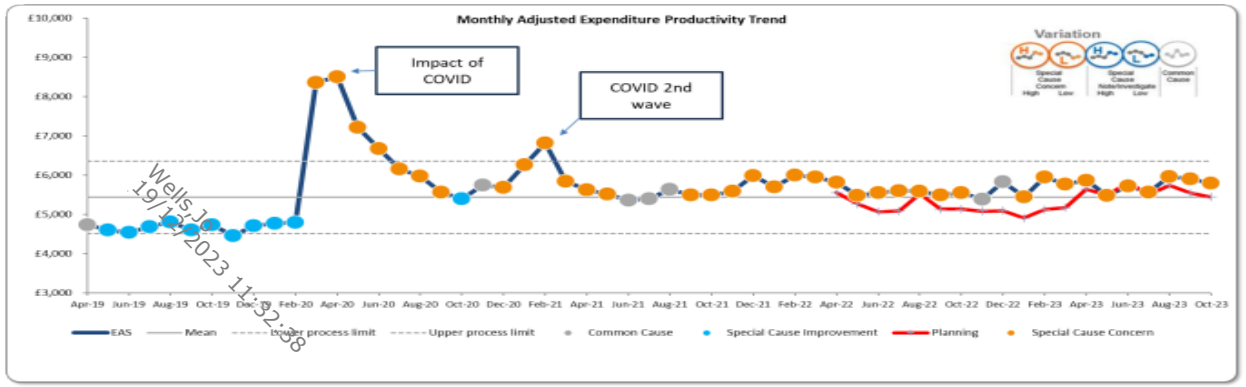
Cash
The external capital financing planned up to and including month 7 was £12.7m. The actual amount received to date is £7.634m for the CDC2 Diagnostic Recovery and Renewal Programme (£692K) and Theatres at the Alex (£6.94m). Better Payment Practice Code (BPPC) performance has fallen in month to 83% based on volume of invoices paid and 80% based on value due to delays with the formal cash application process. We are 5.74% under the BPPC target YTD for Value and 2.59% below target for Volume at 92.41% and 89.267% respectively (92% Volume 89% Value). The Trust has applied for cash support of £3m in December which has been approved. The Trust has also applied for Q4 cash support of £14m.

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

The Income and Expenditure plan reflects the Trust's operational plan, and the resources available to the Trust to achieve its objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

Statement of comprehensive income	Oct-23 Plan £'000	Oct-23 Actual £'000	Oct-23 Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	54,021	54,930	909	367,037	377,205	10,168
Other operating income	2,552	2,576	24	16,849	18,039	1,190
Employee expenses	(32,350)	(34,868)	(2,518)	(230,814)	(241,062)	(10,248)
Operating expenses excluding employee expenses	(20,700)	(22,994)	(2,294)	(146,796)	(159,281)	(12,485)
OPERATING SURPLUS / (DEFICIT)	**3,524**	**(356)**	**(3,880)**	**6,276**	**(5,099)**	**(11,375)**
FINANCE COSTS						
Finance income	40	130	90	580	775	195
Finance expense	(1,280)	(1,278)	2	(8,960)	(8,952)	8
PDC dividends payable/refundable	(803)	(838)	(35)	(5,621)	(5,619)	2
NET FINANCE COSTS	**(2,043)**	**(1,986)**	**57**	**(14,001)**	**(13,796)**	**205**
Other gains/(losses) including disposal of assets	0	0	0	0	(2)	(2)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**1,481**	**(2,342)**	**(3,823)**	**(7,725)**	**(18,897)**	**(11,172)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**1,481**	**(2,342)**	**(3,823)**	**(7,725)**	**(18,897)**	**(11,172)**
Remove capital donations/grants I&E impact	10	11	1	70	38	(32)
Adjusted financial performance surplus/(deficit)	**1,491**	**(2,331)**	**(3,822)**	**(7,655)**	**(18,859)**	**(11,204)**
Less gains on disposal of assets	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**1,491**	**(2,331)**	**(3,822)**	**(7,655)**	**(18,859)**	**(11,204)**



Performance and Actions

At the end of M7 we report an adverse variance of £11.2m.

Exceptional items totalling £2.9m (26%) include direct additional backfill costs identified because of Industrial Action. Other variances include undelivered PEP (£6.2m) and temporary staffing/workforce (£2.1m) with worked WTE c.260 higher in 23/24 than in 22/23 across all staff groups. YTD there is a favourable variance of £1.4m due to the phasing of the plan and over the course of the year will right itself and by the end of the year the variance will disappear.

Note that the additional patient care income is derived from the combined impact of (a) a reduction in the elective variable income target and (b) a revision made by NHSE to the Trust's 19/20 baseline in M6.

The planning assumption for inflation on Drugs cost was 0.9%, YTD at M7 tariff drugs spend 15% higher than 22/23 and Non PbR Drugs spend is 5% higher. Discussions with Pharmacy would suggest most of this increase is activity or prescribing guidance related rather than price related. A Medicines Deep Dive was included in the ICS Finance Forum in September reviewing the in-year cost pressures, risks into 24/25 and any opportunities for savings.

Risks

In response to the rapid National two-week exercise to agree actions to deliver priorities for the remainder of the financial year our financial forecast submission was not compliant with the requirement to break-even as we submitted a deficit of £34.9m against our breakeven plan.

The Trust has appointed a Turnaround Director and initiated a Financial Recovery Plan (FRP), that will further strengthen grip and control over expenditure and savings schemes to reduce the run rate whilst ensuring we maximise use of core capacity to improve productivity and reduce the cost per WAU.

What the charts tell us

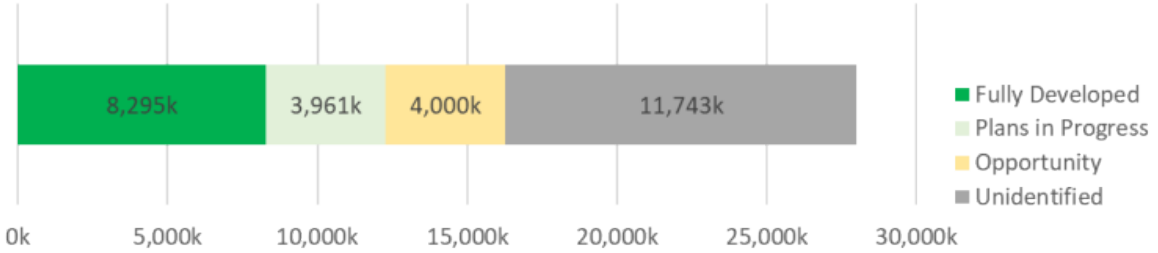
For October our Cost per WAU is 6% higher than plan. This means that we are spending more per unit of activity delivered than was in the operational and financial plan. (Note uncoded activity can impact this position).

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

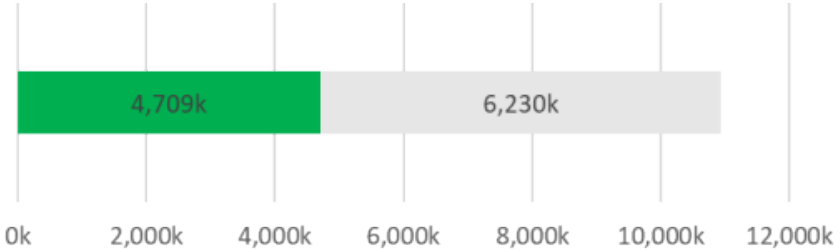
We are driving this measure because

If the Trust fails to identify recurrent Productivity & Efficiency Plans (PEP) and put in place sufficient resources and governance arrangements to drive delivery, then it will not achieve financial sustainability.

Schemes identified vs budgetary target



YTD CPIP achieved vs YTD budget target 7,640k



Performance and Actions

- The Trusts target for 23/24 is £28m. YTD £4,709k has been delivered against the plan £10,939k.
- The reforecast performed at M5 indicated £16,257k of PEP delivery inclusive of high risk schemes. Incorporating recent months actuals and holding the M8-M12 forecast suggests £15,554k –(including £6,426k high risk schemes).
- A further reforecast will be conducted post M7.
- A series of measures approved by FPC designed to contribute to bridging the gap to £28m are currently being implemented.
- A Turnaround Director has been appointed and commenced in post 1 November.

Risks

- If the Trust is unable to deliver the plan target of £28m this will impact on the Trust's ability to deliver a breakeven position at year end.
- The Trust has commenced Annual Planning for 24/25 with Divisions and Corporate teams developing CIP ideas which may impact on the capacity and ability to continue progressing with 23/24.

What the charts tell us

M7 delivered actuals of £696k against a plan of £3,299k and forecast of £1,399k. YTD performance is £4,709k of actuals compared to a plan of £10,939k.

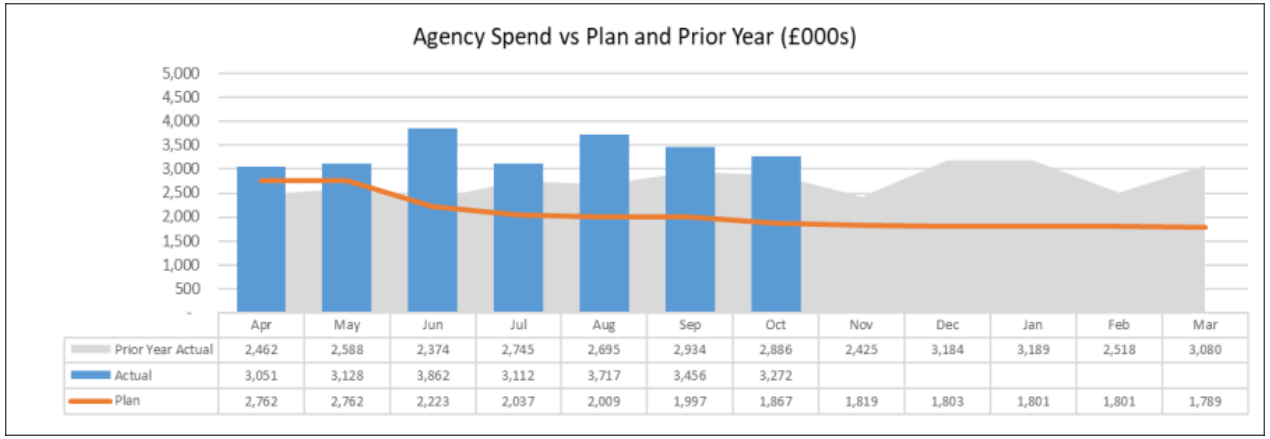
Currently, using the NHSE categorisation £8,295k of schemes are Fully Developed (increasing by £1,173k compared to M6), £3,961k Plans in Progress and £4,000k Opportunity. £11,743k remains unidentified.

The priority is to progress and convert the schemes through the categorisation to Fully Developed and provide assurance that the re-forecast value of £16,257k can be achieved this FY given the high risk nature of £6,426k of the schemes.

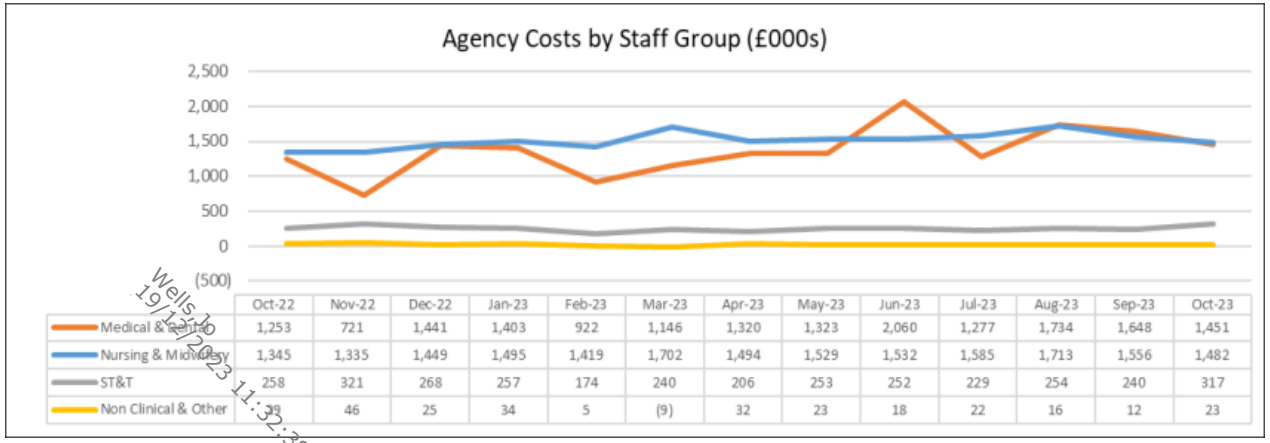
BEST USE OF RESOURCES – AGENCY SPEND

We are driving this measure because

Expenditure on high-cost agency is a significant driver of our financial performance and consequently our financial plan reflects a challenging target to reduce our agency spend to 6% of the pay bill. Delivery of this level of spend reduction is therefore key to achievement of our overall financial plan.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Prior Year Actual	2,462	2,588	2,374	2,745	2,695	2,934	2,886	2,425	3,184	3,189	2,518	3,080
Actual	3,051	3,128	3,862	3,112	3,717	3,456	3,272					
Plan	2,762	2,762	2,223	2,037	2,009	1,997	1,867	1,819	1,803	1,801	1,801	1,789



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Medical & Dental	1,253	721	1,441	1,403	922	1,146	1,320	1,323	2,060	1,277	1,734	1,648	1,451
Nursing & Midwifery	1,345	1,335	1,449	1,495	1,419	1,702	1,494	1,529	1,532	1,585	1,713	1,556	1,482
ST&T	258	321	268	257	174	240	206	253	252	229	254	240	317
Non Clinical & Other	39	46	25	34	5	(9)	32	23	18	22	16	12	23

Performance and Actions

Total agency expenditure in October was £3.3m, a reduction of £0.2m compared with September. This represents 9.4% of total staff costs compared to 9.3% in October last year.

Of the £0.2m favourable movement, £0.2m is on Medical & Dental, the majority of which relates to a switch between bank and agency usage due to the ongoing retrospective correction of temporary medics data. A corresponding increase can be seen on bank spend. There is a further £0.1m favourable movement on Nursing & Midwifery largely driven by a reduction in shifts booked against vacancy cover (c.14 WTE and £92k in month). This has been offset by a £0.1m adverse movement on Scientific, Therapeutic & Technical staff, mainly in Pathology due to increased fill rates and in Oncology due to an increase in vacancies.

By staff group agency spend was £1.5m on Medical & Dental (£0.2m reduction compared to M6), £1.5m on Nursing & Midwifery (£0.1m reduction compared to M6), £0.3m on Scientific, Therapeutic & Technical staff (£0.1m increase compared to M6) and £23k on Non-Clinical staff.

Despite the reductions in spend in month 7, significant operational pressures continue due to high levels of vacancies, sickness, higher rates and increased numbers of patients requiring specialing which is driving costs above our agency target.

Risks

Continued Industrial Action and a lag in delivery of the productivity and efficiency programme (PEP) schemes relating to recruitment will add to the pressure reflected in the Trust's overall financial performance. Emergency pressures continue causing additional capacity to remain open incurring agency costs. Sickness also remains significantly higher than the target impacting our ability to remove temporary staffing.

What the charts tell us

The charts reflect an increasing reliance on temporary staffing some of which can be linked to industrial action and volume of high acuity patients presenting for urgent and emergency care leading to excessive pressure on staff capacity.

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Perinatal Safety Report – October 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 Amrat Mahal – Director of Nursing – W&C Susie Smith, Governance Lead

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

Report to be reviewed by		
Committee/Group	Date	Outcome
W&C Divisional Governance	29th November 2023	
Paediatric Governance	December 2023	
Maternity Governance	15th December 2023	
QGC	30th November 2023	

Recommendations	It is recommended that the Board accept the report and share key components of the report with the Local Maternity & Neonatal System to meet the requirements of: • the Perinatal Quality surveillance model • NHSR Maternity Incentive Scheme (Year 5) • the National Neonatal Critical Care Review (2020) • the British Association of Perinatal Medicine (BAPM) Service standards for hospitals providing neonatal care (2010) and • the DH Toolkit for High Quality Neonatal Services (2009).

Executive summary	The purpose of the paper is to provide a monthly update on key maternity and neonatal safety initiatives which will support WAHT to achieve the national ambition. The report will also present the evidence required for the NHS Resolution, Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme. **Summary of Key Safety Indicators (October 2023)**

Metrics	Target	Current position
Booking completed by 12+6	90%	83%↑
ATAIN	6%	3.5%
PMR (MBRRACE 2021)	<5.19 per 1000 births (rolling)	4.59
Stillbirth rate (MBRRACE 2021)	<3.54 per 1000 births (rolling)	2.71
NND rate (MBRRACE 2021)	<1.65 per 1000 births (rolling)	1.88

Maternity and Neonatal SI reported	-	1
Maternity and Neonatal Moderate or above incidents	-	3 (inc SI above)
Maternity PALS	-	7↓
Neonatal PALS		0
Maternity Complaints	-	3 ↔
Neonatal Complaints		0

Summary of Workforce Key Performance Indicators (October 2023)

Metrics	Target	Current position
Sickness rate (MWs)	4%	5.89%↑
Turnover rate (rolling) (MWs)	11.5%	8.39%↑
Vacancy rate (MW)	7%	7% ↓
Sickness rate (MSWs)	5.5%	10.47%↓
Turnover rate (rolling) (MSWs)	11.5%	19.92%↓
Vacancy rate (MSW)	7%	33%↔
Sickness rate (RNs)	4%	8.91%
Sickness rate (NNs)	4%	4.21%
Turnover rate (rolling) (RNs)	11.5%	6.44%
Turnover rate (rolling) (NNs)	11.5%	8.09%
Vacancy rate (RN)	7%	4.27%
Vacancy rate (NN)	7%	0.49%
Shifts staffed to BAPM	100%	67.7%
Supernumerary shift leader	100%	90.32%
QIS trained	70%	66.5%

Summary of Training Key Performance Indicators (October 2023)

Metrics	Target	Current position
PROMPT – Human Factors & Maternity Emergencies	90%	76% ↑ (in year)
PROMPT – Neonatal Life Support	90% (figures for Drs are currently being calculated)	95% ↑ (in year)
Fetal monitoring	90%	87.5% ↑ (in year)
Maternity role specific MT Midwives	90%	42% ↑ (in year)
Maternity role specific MT – MCA's and MSW's (SBL only)	90%	52% ↑ (in year)
Maternity role specific MT Obstetricians (SBL only)	90%	28% ↔ (in year)
Trust Mandatory training (Non-medical)	90%	83%↔
Trust Mandatory training (Medical)	90%	75%↑
Maternity PDR rate	90%	67%↓
Neonatal PDR rate	90%	87.3%↑
Neonatal Life Support (4 yearly) (non-medical)	90%	100%
Neonatal Life Support (4 yearly) (medical)	90%	(figures for Drs are currently not available)
Neonatal Resuscitation Update (annual) (non-medical)	90%	96.92% ↑
Neonatal Resuscitation Update (annual) (medical)	90%	(figures for Drs are currently not available)
Baby friendly (BFI) update (non-medical)	90%	93.75%↑
Baby friendly (BFI) update (medical)	90%	(figures for Drs are currently not available)
Trust Mandatory Training (non-medical)	90%	93.89% ↑
Trust Mandatory Training (medical)	90%	67.84% ↑

Worcestershire Acute Hospitals NHS Trust

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	There was one stillbirth and no neonatal deaths reported in October 2023. Three moderate or above harm incidents were reported with one noted as a serious incident. There are 4 ongoing HSIB cases: 2 neonatal deaths, 1 Intrapartum Stillbirth and a baby who receive therapeutic hypothermia. Two draft reports have been received by the Trust. Medical and midwifery safe staffing remains positive and minimum safe midwifery staffing achieved on all shifts. Supernumerary status of the shift leader was not met in October however 1:1 care in labour was achieved. Neonatal nurse staffing did not meet BAPM requirements on all shifts and the shift leader was not 100% supernumerary due to vacancies and high sickness in the service. CQC must do's and should do actions progressing – escalation policy due for sign off and essential to role training compliance expected to show further improvement each month – trajectories met. Trust mandatory training and PDRs remain challenging. The maternity services position against COSMOS is improving each month; the greatest progress noted in CNST and Saving Babies Lives compliance in recent months. The Trust is working with the Maternity Improvement Advisor to finalise the sustainability plan so that the service can formally exit the support programme. The sustainability plan will be overseen by the ICB. The suggested level of assurance is 5. An increase in the level of assurance will be recommended when the KPI for workforce and training are met alongside the requirements for maternity bookings BLISS and BFI accreditation in neonates.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*2,4,9,10*

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

Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*

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

CQC Maternity Ratings 2020	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Worcester Acute Hospitals NHS Trust	Requires improvement	Requires Improvement	Good	Good	Requires improvement	Good

Maternity Safety Support Programme														
	Sept	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**Sept**	**October**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2. Findings of review of all cases eligible for referral to HSIB	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	√	√	√	√	√	√	√	√	√	√	√	√	√	√
3.Service User Voice Feedback	√	√	√	√	√	√	√	√	√	√	√	√	√	√
4.Staff feedback from frontline champion and walk-about	√	√	√	√	√	√	√	√	√	√	√	√	√	√
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	√	√	√	√	√	√	√	√	√	√	√	√	√	√
6.Coroner Reg 28 made directly to Trust	√	√	√	√	√	√	√	√	√	√	√	√	√	√
7.Progress in achievement of CNST 10	√	√	√	√	√	√	√	√	√	√	√	√	√	√

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Annual report
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours	Annual report

Meeting	Public Trust Board
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Paper number	

1. Introduction/Background

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the WAHT Trust Board and the LMNS Board of present or emerging safety concerns or activity being undertaken to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020).

The report will provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the LMNS Board.

2. KPI Booking by 12+6 weeks' gestation

The KPI for booking by 12+6 weeks' gestation has increased in month to 83% The work around single point of access is in progress with an implementation target date of January 2024.

The table below shows the breakdown, by week of gestation, in September demonstrating that 90% of women are booked by 14 weeks.

Bookings (Count of Women)

	Gestational age at booking (weeks)					
Month	< 10	< 12	< 13	<= 14	< 20	All booked
Oct-23	109	309	384	416	443	462
Total	109	309	384	416	443	462

3. Perinatal Mortality Rate (PMR)

Following the recent MBRRACE publications there are newly published national average rates for stillbirth and neonatal rates, which have increased from previous years. The stillbirth rate is now 3.54 per 1000 births and for neonatal deaths, the rate is 1.65 per 1000 births.

The national extended perinatal mortality rate is 5.19 per 1000 births. Rates are adjusted for a variety of characteristics such as socio-economic deprivation, maternal age, ethnicity etc, which the figures below are not; these are the crude figures. It is important to note that neonatal deaths (up to 28 days' post birth) are counted at place of birth, rather than place of death. This includes for those babies diagnosed with congenital anomalies and complex cases requiring surgery at tertiary centres.

3.1 Local Rates

The crude stillbirth rate for this period is 2.71 per 1000 births which is below the new national rate. The crude neonatal death rate is 1.88 per 1000 births is just above the new national rate. As can be seen from the graph below, the trajectory for perinatal mortality continues to decrease.

It is again important to note that these figures will change when they are reviewed and adjusted by MBRRACE. Small monthly variations (including an increase or decrease in the number of live births) can have a significant impact on the overall numbers and rate. The Trust board is required to have

oversight of all deaths reviewed and consequent action plans. The quarterly perinatal mortality reports should also be discussed with the Trust Executive and Non- Executive Board level safety champions and this has been added to the Safety Champion agenda.

The Perinatal Mortality Rate for WAHT is presented below in *Figure 1*.

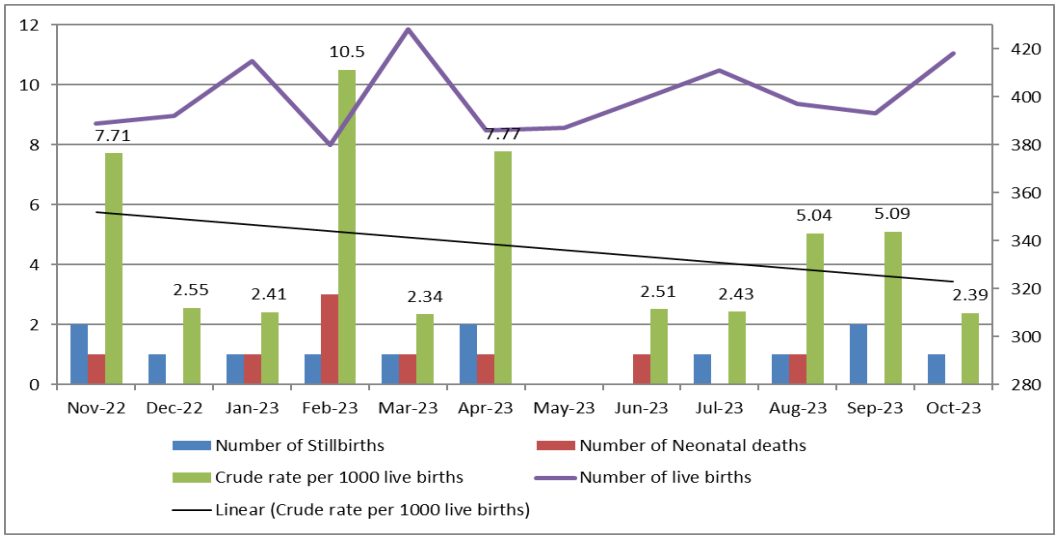


Figure 1. WAHT Perinatal Mortality Rates

3.2 Annual data for stillbirths, neonatal deaths, maternal deaths and babies transferred for therapeutic cooling.

The table below presents the annual local data for stillbirths, neonatal deaths, maternal deaths and babies transferred for therapeutic hypothermia from 2018 and demonstrates that the PMR is consistently within the national average for the last 4 years; 2022 and 2023 figures are crude data. This table also reports term babies transferred for therapeutic hypothermia; it must be noted that not all referrals result in a diagnosis of Hypoxic-Ischaemic Encephalopathy (HIE).

Year	Births	Stillbirths		Neonatal deaths		Maternal deaths	Validated data by ONS & MBRRACE	Term babies transferred for therapeutic hypothermia
		Count	Rate per 1000 births	Count	Rate per 1000 births			
2018	5248	17	3.40	6	1.14	0	YES – stabilised and adjusted	Not available
2019	5200	20	3.05	9	1.29	2	YES – stabilised and adjusted	6
2020	4941	17	3.25	7	1.18	2	YES – stabilised and adjusted	4
2021	4996	16	3.26	6	1.09	1	YES – stabilised and adjusted	4
2022	4847	17	3.51*	6	1.24*	1	NO – due late 2024	4
2023	4014	10	2.49* (year to date)	8	1.99* (year to date)	0	No – due late 2025	2 (1 also NND)

3.3 Perinatal Mortality Summary for October 2023.

There was 1 reported stillbirth in October 2023; this will be reviewed via the PMRT process.

4. Maternity and Neonatal Safety Investigations (MNSI formerly known as HSIB) and Maternity Serious Incidents (SIs)

4.1 Background

The National Maternity Safety Ambition, initially launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. All cases which meet the following defined criteria are reported to MNSI (Appendix 1) and are reported in detail to the Board alongside all maternity Serious Incidents:

All term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

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.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- *Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or*
- *Was therapeutically cooled (active cooling only) or*
- *Had decreased central tone and was comatose and had seizures of any kind*

HSIB became Maternity and Neonatal Safety Investigations in October 2023. They are now hosted by the CQC. Their remit and current processes are the same at present however there are some changes to current practices.

Current MNSI cases:
A summary of the current MNSI cases is below:

MNSI reference	Date of case	DOC completed	Stage of investigation
MI023420	February 2023	Yes	Draft report returned to MNSI
MI023421	February 2023	Yes	Draft report returned to MNSI
MI033054	September 2023	Yes	Investigation ongoing – interviews arranged

We had one case referred to MNSI in October 2023, concerning a baby who required transfer for therapeutic hypothermia. Family consent has been given. Duty of Candour has been completed with this family, and the appropriate paperwork and information shared with them in accordance with the expected timeframe.

MNSI Quality Review Meetings

The maternity governance and leadership team along with the Chief Nursing Officer, continue to attend the MNSI QRM meetings; the next meeting is currently timetabled for December 2023.

5. Incidents reported moderate or above in Maternity and Neonates in October

There was one severe incident (Web206738) (reported as an SI), which concerns a baby transferred for therapeutic hypothermia and has been referred to MNSI. There were two moderate incidents reported; Web206827 concerned a bladder injury at a complex elective caesarean section and Web207292 concerned a baby who required escalation of ventilation secondary to transfer to a Level 3 unit for additional care.

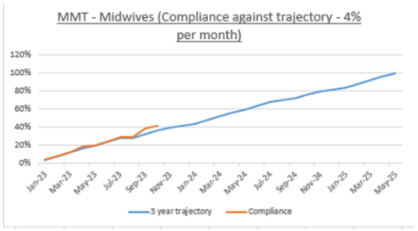
Additional detail will be presented in the Maternity Incident Report at Private Board.

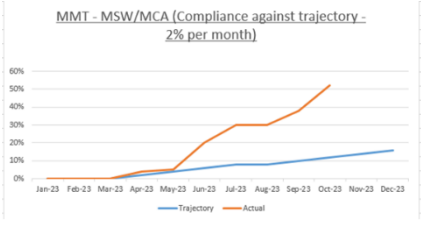
6. Maternity and Neonatal Training Compliance

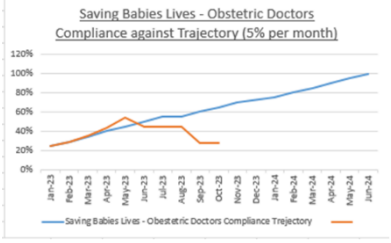
Maternity:

As previously reported, there has been a change in the Maternity Mandatory Training programme to meet the requirements of the Core Competency framework V2. The Saving Babies Lives care bundle training was previously required every 3 years; however, the new NHSR MIS Year 5 and SBLv3 guidance recommends this is now annual; the local programme has been approved through our internal governance processes.

The expected trajectories for compliance (based on previous guidance) are presented below. The compliance is above trajectory for all but the medical staff who have been affected by industrial action, sickness and new starters rotating into post. Ongoing discussions and engagement is in progress with the Rota Coordinator and Clinical Director.







Fetal monitoring training compliance is a slightly improved position with 87% of our medical team now having completed training or shown evidence of completion in a recent previous role. Support and supervision has been offered and the Clinical Director is aware. Where midwives are non-compliant, the matrons have been informed and support offered – escalation has also now taken place to the Deputy Director of Midwifery for additional oversight.

PROMPT training (obstetric emergency skills and human factors training) also continues monthly and is on track plan to achieve 90% compliance for all staff groups by December 2023. Neonatal Life Support training figures are also an integral part of the MIS/CNST scheme. This is included as part of the PROMPT training for midwives.

Neonatal training:

The directorate team continues to work with line managers to set trajectories and improve their position. Junior doctors change on the first Wednesday of August/December/April (GP/FY1 & 2), and the first Wednesday of September/February (Paediatrics)- every year. Mandatory training

compliance for medical staff is an issue as they are employed under different training programmes and currently their training compliance is not transferrable.

Nursing staff have continued to complete their mandatory training achieving 93.89% compliance. Training compliance for medical staff is a challenge as their training compliance is not transferrable at changeover.

Course	Staff Group	Compliance	Comments
Maternity Mandatory Training – (3 yearly)	Midwives	42% ↑	No training in August 2023
Maternity Mandatory Training – (3 yearly)	MCA/MSW (SBL only)	52% ↑	No training in August 2023
Maternity Mandatory Training – (3 yearly	Obstetricians (SBL only)	28% ↔	No training in August 2023 and affected by IA, rotation, sickness etc
Annual fetal monitoring training (K2)	Midwives	88% ↓	
Annual fetal monitoring training (K2)	Obstetricians (all on rota)	87% ↓	
PROMPT training (Human Factors/MDT Obstetric Emergency	Midwives	94% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	MSW's	89% ↑	No training in August 2023
PROMPT training (Human Factors/MDT Obstetric Emergency	Obstetricians (all on rota)	65% ↑	No training in August 2023
PROMPT training (Human Factors/MDT Obstetric Emergency	Anaesthetists (all on rota)	57% ↑	No training in August 2023
Neonatal Life Support	Midwives	94% ↑	
Neonatal Life Support (NLS 4yearly)	Neonatal Nurses	100%	
Neonatal Life Support (NLS 4yearly)	Neonatal Drs	Data awaited	
Neonatal Resuscitation Update (annual)	Neonatal Nurses	96.9%↑	
Neonatal Resuscitation Update (annual)	Neonatal Drs	Data awaited	Data is being collated currently
Trust Mandatory Training	Obstetricians	75%↑	
Trust Mandatory Training	Midwifery Staff	91%↑	
Trust Mandatory Training	Neonatal Nurses	94%↑	
Trust Mandatory Training	Neonatal Drs	67%↑	

Figure 2. Training Compliance

7. Safe staffing

7.1 Midwifery

Safe midwifery staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Unify data
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- 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 (Appendix 2)

There were 413 births in October. 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 to ensure that staffing met acuity.

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service. Again the rates reported demonstrate some improvement in fill rates for registered midwives however there is a reduction in maternity support workers fill rates due to sickness and vacancies. MCA recruitment events are 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	84%	100%	n/a	n/a
Antenatal Ward/Triage	88%	90%	76%	77%
Delivery Suite	88%	90%	57%	88%
Postnatal Ward	86%	91%	77%	58%
Meadow Birth Centre	55%	70%	55%	62%

The supernumerary status of the shift leader was not achieved in October however 1:1 care in labour was achieved in month. Sickness absence rates for midwives increased slightly in month and decreased in the support staff groups.

The vacancy rate has decreased as we welcomed a further 6WTE midwives. The rolling turnover rate for midwives remains below Trust target further however for non-registered staff has remained the same. Further recruitment is planned.

7.2 Obstetric Medical Staffing including Consultant attendance

Consultants

The consultants at WRH work either a 1:10 Obstetric on call or a 1:20 on call depending on whether they are also on the Gynaecology on call rota. There are 8 consultants purely on the Obstetric on call rota and 6 who do both Obstetrics and Gynaecology. We currently have no vacancies but we do have a consultant who is off night on call duty due to health issues pending review.

With the rota structured as it is there is potential for our consultants not to fulfil the compensatory rest period as outlined by the RCOG. In order to address and monitor this we have the following action plan in place:

Compensatory Rest - Monitoring Action Log				
	Action required	Action assigned	Time Scale	Progress
1	Consultant on call days and clinical activity to be reviewed in the next round of job planning in January to see if we can facilitate it.	Clinical Director – Laura Veal	Job planning Nov 23 - Jan 24	
2	The on-call rota template will be reviewed to see if we can amend it to align with the requirements	Clinical Director – Laura Veal	Job planning Nov 23 - Jan 24	
3	Compensatory rest will be audited on a monthly basis	Zoe Marshall	Monthly basis moving forwards (to start in December 23 once process for monitoring decided)	
4	Consultants will be educated on the requirements and the escalation process when they do not receive adequate rest	Clinical Director – Laura Veal	December 23 - Once process for monitoring decided	SOP on Obstetric staffing including compensatory risk shared with all consultants in October and approved through both Gynae and Obstetric Governance - Oct 23

Unfortunately, we have been unsuccessful in recruiting to our fixed term locum post for the third time. We have been successful in raising ATRs for 2 new Substantive posts which will go out to advert shortly with an interview date of the 26th January.

Registrars
The registrars work a 1:9 on call rota. We are currently over established with 23 WTE (funded for 19.6 WTE), with 20 WTE on the on call rota. We have 1 off on long term sick and 1 who has started a period of phased return following an extended period of sickness.

Junior Grades
The junior tier works a 1:9 on call rota. We currently have a 11 WTE, giving us a vacancy of 6 WTE. This enables us to over establish at middle grade level. We have a Physicians Associate starting in November.

Consultant Attendance
In October consultant presence was achieved 100% (7/7) of the time for cases mandated by the RCOG and Action 4 of CNST.

7.3 Neonatal Nursing
The neonatal nursing workforce is funded to BAPM standards. There are currently 3.81wte vacancies (band 5-7) with 0.92wte expected in October. Despite band 6 being out to advert, there have been no applicants therefore the advert has been extended to the end of November.

Currently 66.5% of staff in post is qualified in specialty (QIS) against the recommended average of 70%. There are 2 intakes for the neonatal critical care course each year, one nurse started in October and the second is due to start in December.

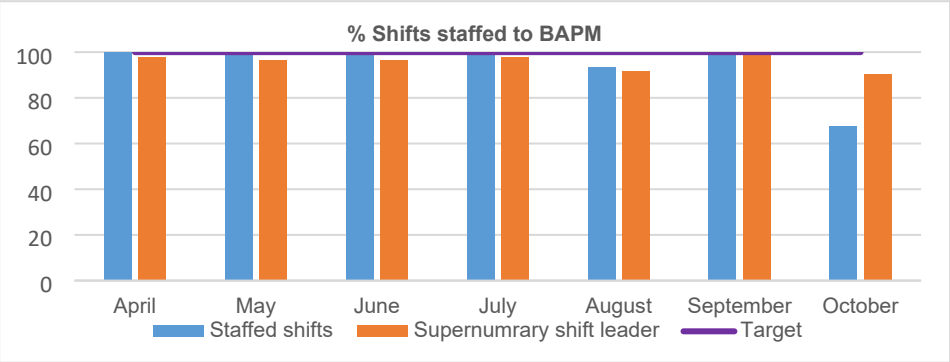
7.3.1 Nursing
Safe neonatal nurse staffing is monitored by taking the following actions:

- Completion of safe staffing on Badgernet – three times day
- Monitoring nurse patient ratios as per BAPM
- Monitoring staffing red flags as recommended by NICE guidance
- Daily safety huddles
- SitRep report and bed meetings three times a day
- Monitoring sickness/absence and turnover rates
- Monitoring recruitment/vacancy rates
- Daily escalation - temporary NHSP and Agency staffing
- Monthly safe staffing report to Nursing Workforce Advisory Group (NWAG)

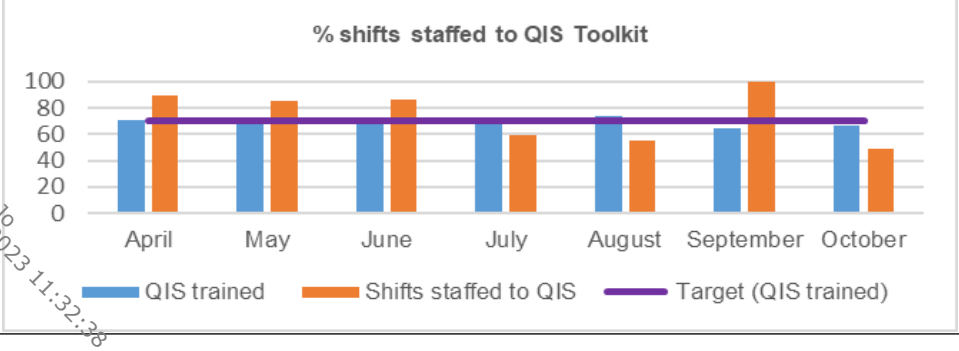
The unit provides the following nurse-patient ratios to meet BAPM:

- 1:1 Intensive Care (IC)
- 1:2 High Dependency (HD)
- 1:4 Special Care (SC)
- Supernumerary shift leader

Acuity and dependency has been extremely high over October with the unit running at full capacity, coupled with a gap in QIS and vacancies we were unable to provide the recommended nurse to patient ratios or meet the supernumerary status of the shift leader (Fig.3). However, with adjustments to nurse-patient ratios all shifts remained safe.



It is important to note whilst the number of qualified in specialty (QIS) is below the recommended (Fig.4), with the on-going nurse recruitment the percentage of nurses QIS will fluctuate due to the appointment of non-QIS staff and it takes a minimum of 9 months to complete the foundation neonatal course before individuals can be considered for the neonatal critical care course.



Escalation plans are in place and during the month there were no safe staffing red flags.

Sickness absence rates have seen a slight increase from the previous month to 8.9% for registered nurses and 4.2% for non-registered nurses, above the Trust target of 4%. HR drop-in sessions took place in October to provide staff with any additional health and well-being support.

7.3.2 Neonatal medical staff

The current on-call rota for out of hours is combined paediatrics and neonatal. There is a requirement for 8 on-call neonatal consultants and 6 Advanced Neonatal Nurse Practitioners (ANNP) to implement a separate paediatric and neonatal medical rota to meet BAPM safe medical staffing.

Currently there is a shortfall of 0.5wte consultant and 5 ANNPs. Some funding has been received from NHSE for obstetric and neonatal medical staff as part of the NHS Long Term Workforce Plan and the Three-Year Delivery Plan for Maternity and Neonatal Services that will support the consultant gap. The directorate are looking at alternative options to support the splitting of the rota which will determine whether a business case is required.

8. Service User Feedback

8.1 Maternity& Neonatal Voice Partnership

The MNVP continues to work with the maternity directorate on a number of action plans in response to numerous surveys. The planned 15 Steps visit to the maternity hub at the Alexandra Hospital took place and we await the final report. The verbal feedback was very positive with signage being the only identified issue on the day.

8.2 Picker Survey

The previously agreed action plan (Appendix 3) has been reviewed to ensure that the actions remain SMART. There has been no further progress on this plan in month.

8.3 Baby Friendly and BLISS Accreditation

The neonatal unit is ready for stage 1 Baby Friendly Initiative (BFI) accreditation with the upcoming assessment arranged for mid-December. The maternity unit has been reaccredited at stage 3 and is now working towards the 'GOLD' standard.

The neonatal unit is also working towards silver BLISS accreditation; however, BLISS have paused the submission of applications until further notice due to the overwhelming number of applications received nationwide.

8.4 Complaints and PALS feedback – Maternity and Neonates

The maternity and neonatal specialities monitor all complaints received on a weekly basis at the QRSM. PALS are handled by the clinical team and Matrons and themes noted and discussed as required.

Maternity: In October 2023, 7 Maternity PALS queries were received as below:

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
77826	09/10/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
78533	31/10/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
78345	23/10/2023	Maternity (formerly Obstetrics)	Clinical Treatment	PALS – Delay or Failure in Treatment/Procedure
77643	02/10/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
78350	24/10/2023	Maternity (formerly Obstetrics)	Trust Admin Policies & Procedures (Incl. Patient Records Management)	PALS – Visiting times/arrangements (Including Protected Mealtimes)
78044	16/10/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
77678	03/10/2023	Maternity (formerly Obstetrics)	Communications	PALS – Patient not listened to

The most common theme concerns communication/communication with patient – on further review however, there are no common themes as the PALS queries concerned requesting debrief appointments, wanting to know about pre-conception clinics, waiting times for induction and access to the ward area.

In addition, there were 3 formal complaints received in October 2023. The complaints are being investigated in accordance with the Trust complaints process.

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
78282	23/10/2023	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives
78326	23/10/2023	Maternity (formerly Obstetrics)	Appointments	Appointment delay (inc length of wait)
77098	10/10/2023	Maternity (formerly Obstetrics)	Clinical Treatment	Birth injury (including fetal laceration at LSCS)

Neonatal: No PALS queries or formal complaints were received in October 2023.

9. Safety Champion escalations

The Safety Champions met on 20th October 2023. There was positive feedback from a recent walkabout at KTC Maternity Hub.

The following issues were raised during walkabouts in the inpatient area:

1. Line care for women receiving enhanced care on DS – the development of a dedicated midwifery enhanced care team is underway
2. New doctor's rota and access – concerns escalated and resolved
3. Availability of a doctor in Triage – monitoring of the situation in place

9.1 Claims scorecard review in conjunction with incidents and complaints

A deep dive into historic claims has been completed (Appendix 4). The top injuries are as follows:

- Fail/delay in treatment (29)
- Fail/delay in diagnosis (7)
- Fail to recognise complication (4)
- Fail to respond to abnormal FHR (4)
- Inadequate nursing care (4)

In part the themes do reflect what is identified locally through complaints and incidents however there is further work planned with NHSR to improve the understanding of the data.

10. HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust

The Care Quality Commission undertook an announced inspection of maternity services on 18th October. The final report is expected in November – no immediate safety concerns were raised.

The directorate have a number of CQC must do's and should do's from the inspection in 2020; the actions are monitored via the Trusts RAIT tool (Appendix 5).

CQC Regulated Activities (NB includes Trust MD /SD)	Applicable to Maternity	Compliance	
		Full	Partial
Must Do's	11	9	2
Should Do's	9	9	0

Of these the maternity directorate has completed 18 actions with 2 actions now partially completed. These are:

1. Appraisal rates (non-medical) – 67% - decrease in month
2. Trust Mandatory Training rates – 83% - slight decrease in month

11. Coroner Regulation 28 made directly to Trust

No regulation 28 was made to the Trust in October 2023.

12. In-utero and e –utero activity

There were 6 IUT transfer out, 4 as per the network pathway (<27/40) and 2 due to capacity on NNU. There were 3 ex-utero transfers out as per network pathway and 4 repatriations back in. There was 1 exception reported due to no capacity within the ODN. The table below summaries the transfers as per network pathway:

Type of Transfer	Oct		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	0	4	3 out to BWH and 1 out to Stoke <27/40 as per pathway
IUT Transfers for non-clinical reasons	0	2	2 out to Telford due to capacity on NNU (Opel status RED)
IUT Transfers outside of the network	0	0	

Ex-utero Transfers for clinical reasons as per network pathway	1	3	29/40 in from BWH 3 out (1 stoke, 1 Heartlands, 1 BWH) for clinical reasons
Ex-utero Transfers for non-clinical reasons	3	0	All repatriations back to WRH
Ex-Utero Transfers out of network for clinical reasons	0	0	
Delays in transfer in/out	2	0	2 repatriation delays in due to capacity & acuity at WRH
IUT or Ex-utero Exceptions	1		1 ExUT exception due to ventilation >48 hours. This was discussed with NTS but no level 3 cots available. NTS & WRH consultant decision to wait until the next day rather than transfer outside Network. Exception report completed.

13. Progress in achievement of NHSR CNST 10 – Maternity Incentive Scheme

The new MIS Year 5 was released nationally at the end of May 2023 and further information is below. The document can be found at this address https://resolution.nhs.uk/wp-content/uploads/2023/05/MIS-year-5-FINAL-31-5-23.pdf. The final declaration submission date is 1 February 2024. The current expected positon is outlined below and evidence presented in appendix 6:

Element	Current Status	Actions
1. PMRT		Quarterly reporting in place. Q1 report presented in Julys report. Q2 was included in October's report.
2. MSDS		Ethnicity issue resolved and MCoC to be included. No issues currently identified and verified externally.
3. ATAIN		Quarterly reporting in place. Q1 report presented in Julys report. Q2 report in appendices.
4. Clinical Workforce		To merge neonatal and maternity safety reports to ensure all workforce data reported monthly and sighted at Board – NCCR implementation plan reported last month. Locum guideline updated
5. Midwifery Workforce		Monthly staffing report presented in appendices SN status of the shift leader not met in July, August, September or October. Agreed action plan in progress.
6.Saving Babies Lives		2nd Validation completed and compliance confirmed above the required 70% to achieve safety action- on track to achieve.
7.MNVP		Chair and Vice-Chair working very hard on additional engagement across Worcestershire and now additional feature in badgernet to ensure each women and birthing person can consent to contact from the MNVP
8.MDT Training		Training plan meeting current trajectory overall – SBL training under close monitoring. Training Policy and TNA was agreed with LMNS in September. Excel calculator from CCFv2 included in CNST appendix.
9. Safety Champions		Information required available within report and appendices.

10. NHSR EN Scheme		Reporting process in place – externally validated.

14. MSSP Report

NHSE have confirmed that the Trust is now in a position to exit the support programme. A sustainability plan has been completed and a separate paper will be presented to Board. The plan will be overseen by the ICB.

15. COSMOS

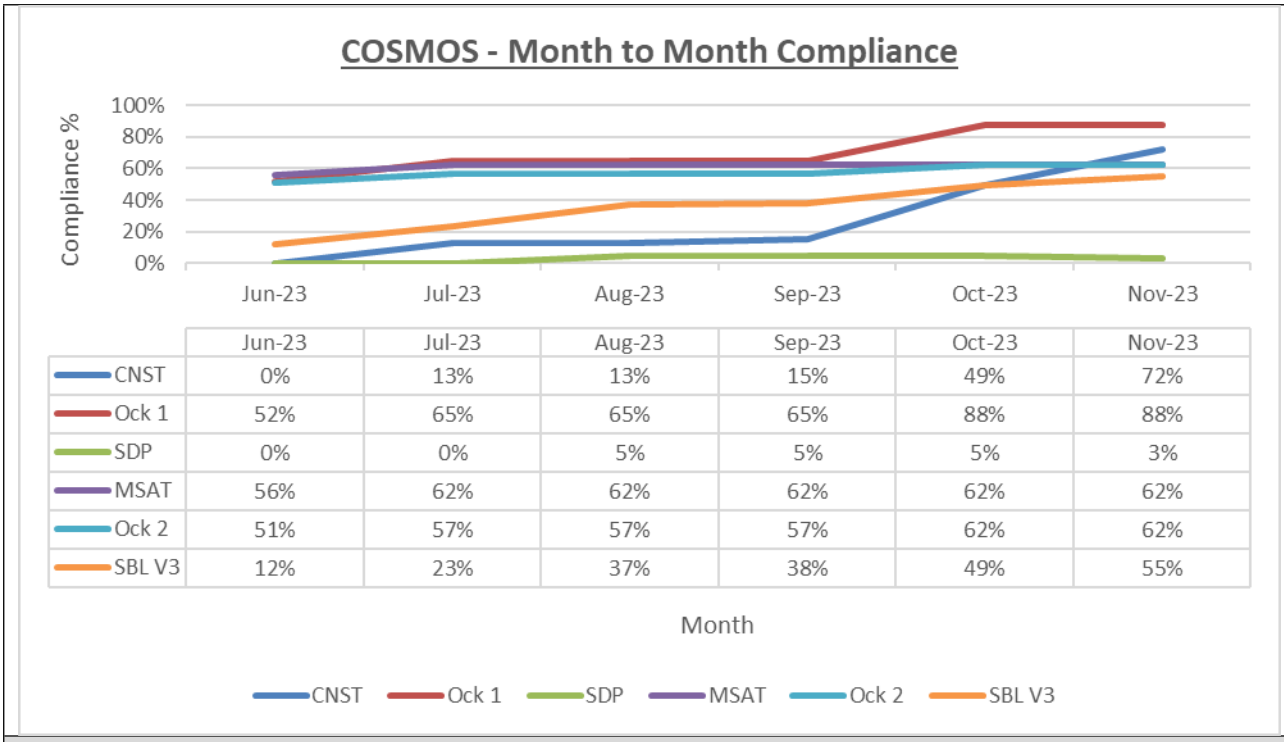
COSMOS is a local acronym for Clinical Negligence Scheme for Trusts (CNST), Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives (SBL). The recommendations/action s(n=532) from all of these national documents have been captured within a TEAMs platform to ensure that the directorate can track the progress of actions completed, communicate with leads and demonstrate monthly position/compliance.

The Single Delivery Plan has distilled a number of actions into one document; the maternity team will focus on the SDP following submission of Q2 SBL to LMNS and Board submission of CNST. The most recent position is presented below.

9th Nov 2023		Compliant	In progress	Overdue	Not Started	Total	Compliance
C	CNST	28	11	0	0	39	72%
O	Ock 1	44	3	2	1	50	88%
S	SDP	2	35	0	26	63	3%
M	MSAT	96	22	21	17	156	62%
O	Ock 2	61	31	2	5	99	62%
S	SBL V3	69	36	0	20	125	55%

The directorates monthly progress is presented below:

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
CNST	0%	13%	13%	15%	49%	72%
Ock 1	52%	65%	65%	65%	88%	88%
SDP	0%	0%	5%	5%	5%	3%
MSAT	56%	62%	62%	62%	62%	62%
Ock 2	51%	57%	57%	57%	62%	62%
SBL V3	12%	23%	37%	38%	49%	55%

Conclusion

This report provides a monthly update on key maternity and neonatal safety initiatives which will support WAHT to achieve the national ambition. The report provides the evidence outlined within the revised perinatal surveillance model and will also assist the directorates to collate evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

Recommendations

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

Appendices

1. Staffing Report

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	21 December 2023
Paper number	

Midwifery Safe Staffing Report October 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	November 2023	
QGC	30 November 2023	Noted for assurance

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

Executive summary

This report provides a breakdown of the monitoring of maternity staffing in October 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 (October 2023)

Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	5.89%↑	10.47%↓
Turnover rate (rolling)	11.5%	7.17%↓	19.92↓
Vacancy rate (MW)	7%	7%↓	33% ↔
Maternity Leave	-	5.61%↑	0%↓
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 413 births in October. 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 to ensure that staffing met acuity.

The supernumerary status of the shift leader was not achieved in October however 1:1 care in labour was achieved in month.

Six new midwives arrived as expected.

There were seven staffing and eight medications (no harm) incidents reported on Datix.

The suggested level of assurance for October is 6. This level assurance is recommended because there is sustained improvement in the midwifery KPIs.

O

ct			
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	**December 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.

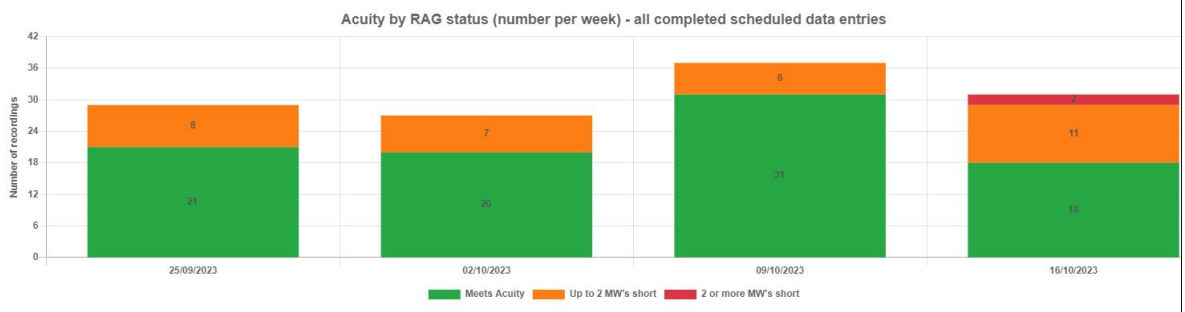
Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 73.8% 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 72% of the time and recorded at 28% when the acuity was not met prior to any actions taken. This is a decrease from the previous month.



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

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=19 occasions) of when staff are reallocated from other areas of the inpatient service; this is an increase in month. In addition, there were nine occasions when the community and continuity teams were deployed and a specialist midwife supported the inpatient area on one reported occasion. There were three reports of staff not being able to take breaks and one report of staff staying beyond their shift time.

Number & % of Management Actions Taken

From 01/10/2023 to 31/10/2023

MA1	Redeploy staff internally	19	58%
MA2	Redeploy staff from community	9	27%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	3	9%
MA5	Staff stayed beyond rostered hours	1	3%
MA6	Specialist midwife working clinically	1	3%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	0	0%
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 three occasion as they were providing 1:1 care; this has increased in month. There were no delays in care reported and 1:1 care was recorded at 100%.

Number & % of Red Flags Recorded

From 01/10/2023 to 31/10/2023

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	0	0%
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	3	100%

Antenatal & Postnatal Wards

The ward acuity tool remains unavailable whilst BR plus complete an upgrade of the tool. The relaunch of the app is planned for November/December.

Staffing incidents

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

1. Delays in IOL pathway
2. Staffing below safe minimum – escalation policy enacted (6)

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 October to offer support to staff and to update staff on current challenges in maternity services. No safety issues or staffing concerns were raised at the last meeting.

Medication Incidents

There were eight medication incidents in October:

- Vaccination stock low and unable to vaccinate as requested in ANC
- Late administration of IVAB's
- Dose given too early (2)
- Drug not signed
- 2nd dose of drug given without prescription
- Incorrect infusion rate
- Incorrect dose of lignocaine given prior to suturing

Monitoring the midwife to birth ratio

The ratio in October was 1:22 (in post) and 1:20 (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. Additional huddles were held in October alongside system huddles for mutual aid. Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

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 some improvement in fill rates for registered midwives however there is a reduction in maternity support workers fill rates due to sickness and vacancies. MCA recruitment events are 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	84%	100%	n/a	n/a
Antenatal Ward/Triage	88%	90%	76%	77%
Delivery Suite	88%	90%	57%	88%
Postnatal Ward	86%	91%	77%	58%
Meadow Birth Centre	55%	70%	55%	62%

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

The national COVID SitRep was stood down in October. A revise national maternity submission is now available and is completed each fortnight.

Vacancy

There are 15 unfilled clinical midwifery posts and 3 unfilled leaderships and specialist roles – vacancy rate 7%. Active recruitment continues. The directorate welcomed a further 6 midwives in October and is expecting a further 8 to commence in November.

Ongoing work continues with international recruitment and 2 WTE international midwives are expected to arrive in the UK in November with the remaining midwife expected in December.

There are 18 WTE MCA vacant posts. Further recruitment is arranged for MCAs.

Sickness

Sickness absence rates for midwives were reported at 5.89% in month. Over the last month there has been a decrease in the sickness absence rate within the non-registered group at 10.47%.

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 7.17% for midwives and at 19.92% for non-registered staff. The retention midwife is working with the team to introduce a number of initiatives to maintain the improvement achieved in retaining staff. The Practice Development Midwife for MSW/MCAs has now commence in post to support and develop the team this 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 cancelled from 31st October as 12 WTE midwives have now commenced in post.
- 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

Conclusion

There was a further decrease 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 28 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 October.

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 15 datix reports submitted no harm was identified.

Sickness absence rates require continued close monitoring and action; ongoing actions are in place to support ward managers and matrons to manage sickness effectively and maintain improvements.

The rolling turnover rate is at 7.17% (MWs) and 19.92% (MSWs & MCA's). The vacancy rate is at 7% for MWs and 33% for MSW/MCA's. There are 8 WTE 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 October is 6. This level of assurance is recommended because there is sustained improvement in the midwifery KPIs but it is recognised that there is a need for more focus on the recruitment and retention of MCAs.

Recommendations

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Public Trust Board
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Paper number	

Addressing the Significant Financial Challenges following Industrial Action

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

Accountable Director	Neil Cook, Chief Finance Officer		
Presented by	Neil Cook, Chief Finance Officer	**Author(s)**	Neil Cook, Chief Finance Officer

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	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendation	Due to a nationally prescribed deadline the Board was asked to approve the submission of a revised financial and operational trajectory for the year to NHSE on the 22nd November. The decision was taken by Chair and Chief Executive in consultation with members of the Board using clause 24.2 of the Trust's Standing Orders and with reference to the information outlined in this paper. The Board is asked to ratify this decision in public. Under section 24.2 of the Trust's Standing Orders: The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Trust Board for ratification.

Executive summary	On 8 November 2023, NHS England wrote to all NHS organisations asking Integrated Care Systems (ICS) to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year following the release of £800m of funds. The Trust is required to submit an approved plan to the Integrated Care Board (ICB) ahead of their Board meeting and ahead of formal submission back to NHSE. Therefore, please find attached a request for approval of the Trust's revised financial and operational plans.

Risks, Implications and Funding			
Which key red risks does this report address?	*State risk numbers*	**Which BAF risk does this report address?**	*BAF, 7, 18 and 20*
What is the impact of this decision on these risks?	*Focus on delivery of safe and effective services for patients over winter along with a continuation of insourcing / outsourcing to drive patient care standards and reduce long waits at the expense of improving productivity back to 2019/20 levels has placed BAF 7 (Finance) at significant risk for which a Financial*		

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	Recovery Plan will be required. A Turnaround Director has been appointed to lead a plan for Financial and Operational Turnaround.
Other risks or implications	*The communication from NHSE asks for all other areas to be deprioritised. Opportunities to stand work down are being considered and a full risk assessment will need to be made to fully understand and adverse implications*
Funding	*The additional funding is outlined in the paper*

Assurance																	
CURRENT **assurance level (x)**	0		1		2	X	3		4		5		6		7		N/A
Rationale for this assurance level	*The Trust has been asked to undertake a significant amount of work in a short space of time to provide assurances on delivery of the 3 priorities outlined in the attached letter at a time of organisational change with new governance and leadership arrangements in place.*																
Actions and timescale to reach next assurance level	*A plan for operational and financial Turnaround will be presented to the next Board outlining arrangements being fast tracked to support delivery of a Financial Recovery Plan.*																
Last reported assurance level	*N/A*				**Anticipated next assurance level**			*Level 3 by the end of the Financial Year*									

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N	X	N/A	
Where is the plan monitored?	*Financial Recovery Board*					
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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Purpose

On 8 November 2023 NHSE wrote to all NHS organisations asking Integrated Care Systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year following the release of £800m (copy attached at Appendix 1).

This paper provides an overview of the requirements laid down by NHSE, the organisation's response and the associated risks with delivery.

Background

The Financial Plans for 2023/24 were originally set on the basis that there would not be any significant ongoing industrial action. The impact of more than 40 days of strikes has had a significant impact on patients and staff and created unavoidable financial costs and reduced levels of elective activity contributing to a loss of productivity.

Recognising the impact of Industrial Action on organisations' financial plans the following has been agreed by NHSE:

- Allocation of £800 million additional financial support to Integrated Care Systems sourced from a combination of additional Treasury funding and a reprioritisation of national budgets.

- A further 2% reduction in the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Elective Recovery Fund (ERF) will no longer be held back pending performance but will instead be allocated in full to IC systems. This secures a level of ERF income and also increases the ability for providers to earn more income should they over achieve on local targets.

Required action for Integrated Care Boards (ICB) and Trust Boards

Finance

ICB and Trust Boards are required to confirm that they will deliver on the original system financial targets for the year and live within the re-baselined ICS allocation. Boards are asked to confirm that they have considered the quality impact assessment of plans and assured themselves of appropriate clinical involvement in decision making. There is an expectation of:

1. Delivery of a break-even position.
2. Fully worked up efficiency plans including the reductions in agency staffing set out at the start of the year.

3. An elective plan that is refocused on driving productivity from core capacity, identifying the insourcing/outsourcing and waiting list initiatives considered necessary within a balanced financial plan focused on the longest waits, urgent elective, and cancer care.
4. An assessment of scenarios where there is no further strike action for November, and for December to March assume both consultants and junior doctors hold strikes 3 days per month, around the middle of the month, and at the same time.
5. Identify flexibility on programme funding.

Operational performance 2023/24

The foundation of the reset is about protecting patient safety, including in maternity and neonatal care, and prioritising Urgent Emergency Care (UEC) so that patients receive the best possible care this winter. The requirement is for formal board sign-off of the commitment to delivering the core elements of these plans for the following headline objectives:

Urgent and emergency care (UEC)

- 4-hour A&E performance as described in winter plans. The expectation is for achievement of 76%. However, the Trust is projecting that it will be non-compliant in returning a best case projection of 73%.

- Average Category 2 performance as described in ambulance service plans. The plan is to reduce from the current year to date average of 43mins to 28mins.

Delivery remains contingent on successful implementation of agreed winter planning initiatives and assumes the opening of an additional 40 beds across the Worcestershire Royal and Alexandra Hospital sites.

Elective and cancer

- The Trust was expected to reduce the 62-day cancer backlog to no more than 190 patients by the end of 2023/24 and set a plan to deliver this. Operational challenges in-year, particularly in Urology and Dermatology, mean the Trust is currently off track against the planned backlog reduction. The skin cancer pathway in particularly is very fragile and reliant on insourced capacity to deliver its services. This capacity will also enable the recovery and sustainability of the cancer 62-day pathway in skin cancer. The expectation is that we will be compliant with the March 62-day backlog reduction target assuming a commitment to continued insourcing in these areas.