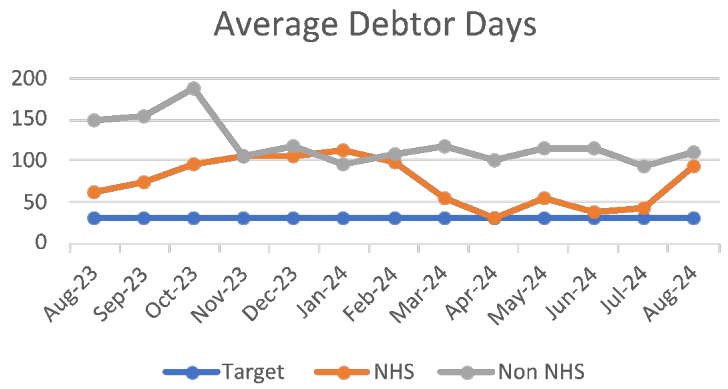
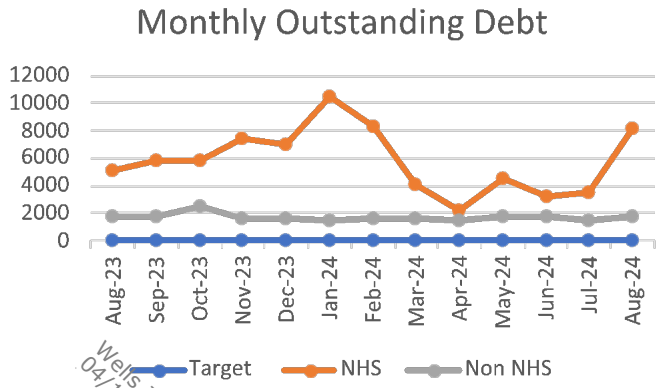
BEST USE OF RESOURCES – CASH

We are driving this measure because

To ensure that all income due to the Trust is invoiced in a timely manner, to enable the collection of the debt to improve the Trust cash flow.





Performance and Actions

The Trust terms of credit for invoiced income is 30 days from date of invoice.

For month 5, the average days for invoices outstanding are 94 days for NHS and 111 for Non-NHS.

The Non-NHS debtor days is distorted by accounts that have been sent to EDR (external debt recovery) and accounts/customers that have a repayment plan – 182 invoices, which is 19% of the total.

Debt that is over 90 days totals £2.111m (555 invoices, which includes the 182 invoices as above).

Non-NHS oldest invoices are £100k for Breast Unit which is under query, but progress is being made to resolve. £249k at month 5, (£228k mth 4) relates to invoices being chased under EDR, £41k (£85k at mth 4) for Private Patients where collection is in progress or in dispute and DMC Health Care pathology £51k.

Risks

If income is not invoiced regularly or with adequate supporting information, the Trust/SBS will face challenges in collecting the debt and therefore a negative effect on cash flow.

The Trust has monthly meetings with the SBS Collections team, who have been implementing changes in the way the debt is collected and have assured us that there will be an improvement in the next quarter. It is also to be noted that Trust staff also contact customers trying to resolve queries etc. to ensure that the debt is collected.
We continue to work with SBS to ensure they are actively chasing and recovering outstanding debtors as per the SBS contract.

What the charts tell us

Average Debtor Days – 94 days for NHS and 111 days for Non-NHS – this is the time from when the invoice is raised to when it is paid by the customer. Due to the Trust not paying other NHS bodies, they in turn are not paying us. We are working with Trusts to get agreements in place to pay each other at the same time to ensure minimum impact on cash flow and to clear old invoices from the Trust ledger.

Monthly Outstanding Debt – at month 5, the amount of outstanding debt is £9.893m (month 4 - £5.031m), NHS Debt has increased significantly in August due to an invoice raised to the ICB for Community Diagnostics Hub for 2024/25 for £3.356m, which has been paid in September.

Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Aug-24 data

Performance Against Target (Status)
- Meeting Target
- Not Meeting Target

Activity Performance Only
- Over 5% above Target
- 5% above to 2% below Target
- More than 2% below Target to 5% below Target
- Over 5% below Target

Type	Item	Description
Pass/Fail		The system is expected to consistently Fail the target
Pass/Fail		The system is expected to consistently Pass the target
Pass/Fail		The system may achieve or fail the target subject to random variation
Trend Variation		Special cause variation - cause for concern (indicator where HIGH is a concern)
Trend Variation		Special cause variation - cause for concern (indicator where LOW is a concern)
Trend Variation		Common cause variation
Trend Variation		Special cause variation - improvement (indicator where HIGH is GOOD)
Trend Variation		Special cause variation - improvement (indicator where LOW is GOOD)

Example

Data Quality Assurance Questions

		Overall KPI Rating Key
S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?	No Assurance
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?	Limited Assurance
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?	Reasonable Assurance
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?	Substantial Assurance

Worcestershire Acute Hospitals NHS Trust

Quality of care, access and outcomes		Responsible Director	Standard	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Latest Month Numerator	Latest Month Denominator	Year to Date (v Standard if available)	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	75%	72.8%	73.7%	76.7%	69.7%	71.5%	63.1%	69.5%	76.9%	73.4%	80.0%	78.3%	80.8%	-	2,236	2,769	78.0%		76.2%				
	2 Week Wait all cancers	Chief Operating Officer	93%	68.5%	81.5%	95.0%	95.6%	85.7%	87.9%	88.9%	86.0%	86.0%	89.0%	85.4%	93.0%	-	2,654	2,854	88.4%		78.4%				
	Urgent referrals for breast symptoms	Chief Operating Officer	93%	86.5%	96.6%	99.0%	93.7%	80.0%	77.8%	32.0%	16.8%	35.0%	27.4%	30.0%	67.0%	-	71	106	39.6%		67.0%				
	Cancer 31 day diagnosis to treatment	Chief Operating Officer	96%	89.5%	87.7%	84.7%	90.0%	90.9%	87.2%	88.5%	87.2%	85.3%	87.1%	85.6%	82.4%	-	375	455	84.9%		92.4%				
	Cancer 31 Days Combined (new standard from Oct 23)	Chief Operating Officer	96%	88.6%	89.4%	86.9%	89.4%	89.7%	87.3%	90.5%	87.5%	84.5%	86.8%	87.4%	83.6%	-	583	697	85.4%		91.9%	Jul-24			
	Cancer 62 days urgent referral to treatment	Chief Operating Officer	85%	51.8%	46.1%	52.6%	49.0%	42.3%	42.3%	44.1%	50.6%	57.9%	54.4%	60.4%	67.5%	-	193	286	60.5%		62.5%				
	Cancer 62-Day National Screening Programme	Chief Operating Officer	90%	51.4%	48.4%	45.7%	58.8%	83.3%	44.4%	67.8%	61.9%	65.8%	59.4%	66.2%	70.6%	-	24	34	65.6%		65.6%				
	Cancer consultant upgrade (62 days decision to upgrade)	Chief Operating Officer	85%	98.4%	95.2%	71.4%	78.2%	77.8%	78.1%	81.9%	79.5%	82.7%	77.2%	82.6%	84.6%	-	85	101	81.8%		78.2%				
	Cancer 62 days Combined (new standard from Oct 23)	Chief Operating Officer	85%	60.9%	59.3%	55.1%	57.5%	54.1%	51.4%	56.7%	58.4%	63.6%	60.9%	66.9%	71.3%	-	304	427	65.9%		67.7%				
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	Plan	300	321	391	389	379	409	366	141	159	176	145	151	186									
Urgent and emergency care	% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	83.6%	84.8%	84.0%	84.3%	82.9%	82.6%	82.3%	84.7%	85.6%	85.5%	85.4%	87.2%	87.4%	2,942	3,368	86.4%		92.2%	Feb to Jan			
	A&E Activity (any type)	Chief Operating Officer	Plan	17,957	18,427	18,564	17,403	16,960	17,647	17,190	18,537	18,677	19,875	19,293	19,351	18,672			95,868						
	Ambulance handover within 30 minutes	Chief Operating Officer	98%	62%	57%	48%	56%	53%	53%	55%	64%	64%	60%	64%	71%	65%	2,479	3,816	65%		73%	July			
	Ambulance handover over 60 minutes	Chief Operating Officer	0	863	1,046	1,272	1,064	1,166	1,072	1,029	869	836	922	784	639	784			3,965		12%				
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	Plan	99.6%	96.5%	98.8%	99.9%	99.9%	115.8%	110.8%	112.4%	130.2%	119.2%	103.7%	123.6%	113.7%	4,332	3,812	117.8%						
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	>40%	38%	38%	39%	39%	37%	43.8%	41.3%	41.9%	42.2%	41.7%	38.2%	35.2%	28.8%	1,218	4,231	37.5%		36%	Feb to Jan			
	A&E - % of patients seen within 4 hours (any type)	Chief Operating Officer	76%	66.5%	64.6%	63.1%	62.5%	59.6%	60.5%	61.0%	68.0%	64.4%	66.3%	67.9%	66.2%	67.8%	12,653	18,672	66.6%		75%	Jul-24			
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer	-	14.8%	16.0%	19.0%	16.0%	17.0%	19.3%	18.5%	15.8%	16.6%	16.3%	15.4%	14.5%	14.8%	1,872	12,628	15.7%		16%	Feb to Jan			
	A&E - Time to treatment	Chief Operating Officer	-	128	151	155	152	167	161	166	143	158	150	146	145	136			150		01:41				
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	<15 minutes	16	17	19	16	16	16	16	14	14	15	15	15	15			15		00:22	Feb to Jan			
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	0	300	256	211	203	260	316	304	301	248	271	307	270	335			1,431						
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	3%	7.0%	6.6%	6.7%	6.8%	7.1%	6.7%	7.2%	7.5%	6.8%	7.4%	7.5%	7.5%	7.7%	975	12,628	7.2%		8%	Feb to Jan			

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks)	Chief Operating Officer	**92%**	50.3%	50.5%	53.2%	56.3%	55.6%	56.6%	56.0%	54.3%	54.8%	55.9%	56.1%	55.9%	56.0%	34,632	61,862			58.8%	Jul-24						
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		61,008	59,842	58,046	58,058	59,242	59,900	61,458	61,753	61,740	62,118	62,152	61,348	61,862					7,620,000							
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	5,152	4,399	3,593	3,194	2,968	2,746	2,672	2,536	2,204	2,089	1,980	1,891	1,804					290,326							
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	1,534	1,404	1,211	1,064	1,048	891	766	587	472	464	402	357	300					50,860							
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	61	88	100	119	125	109	68	27	13	14	4	0	0					2,738							
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	4	3	3	1	0	0	0	0	0	0	0	0	0					107							
	GP Referrals (electronic referrals ONLY. Includes RAS even if rejected)	Chief Operating Officer	**2019/20**	8,878	8,670	8,873	8,970	7,206	9,156	9,374	8,711	9,438	9,533	8,546	9,787	8,699			46,003									
	Outpatient Activity - New attendances (% v 2019/20)	Chief Operating Officer	**2019/20**	118%	113%	126%	124%	107%	110%	120%	136%	118%	112%	119%	123%	129%	19,393	15,072	120%									
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	101%	109%	113%	111%	98%	105%	104%	103%	106%	88%	84%	101%	93%	19,393	20,943	94%									
	Total Outpatient Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	111%	103%	117%	113%	102%	104%	116%	123%	113%	108%	110%	113%	117%	56,810	48,565	112%									
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	103%	108%	111%	113%	103%	111%	111%	107%	119%	99%	92%	111%	98%	56,810	57,959	103%									
	Total Elective Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	106%	96%	95%	100%	101%	105%	107%	129%	110%	104%	109%	115%	114%	7,856	6,875	110%									
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	95%	91%	94%	101%	99%	101%	102%	104%	94%	98%	94%	112%	93%	7,856	8,452	98%									
	BADS Daycase rates (3 months to month end)	Chief Operating Officer	**Actual**	85%	85%	85%	85%	87%	88%	87%	86.6%	85.0%	83.8%	-	-	-	4202	5015	-		81%	Dec						
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	83%	82%	81%	84%	81%	82%	81%	82%	82%	83%	82%	83%	82%			82%		78%	February						
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	**85%**	87%	85%	84%	88%	84%	84%	83%	85%	84%	86%	85%	86%	84%			85%		82%							
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer	-	40	66	55	63	45	59	40	57	37	49	40	38	42			164		21,053	Q4 23-24						
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	**Plan**	105.2%	101.5%	108.5%	109.4%	112.4%	117.0%	115.0%	117.6%	115.2%	119.4%	114.9%	111.0%	112%	7,179	6,397	114%									
	Diagnostic Activity - Endoscopy	Chief Operating Officer	**Plan**	100.1%	79.7%	89.4%	104.2%	91.3%	92.0%	96.0%	84.5%	115.5%	111.9%	96.8%	109.5%	103%	1,402	1,361	107%									
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	**Plan**	87.7%	86.1%	89.3%	91.9%	102.6%	97.0%	86.0%	89.3%	99.6%	104.7%	96.2%	100.6%	116%	2,721	2,338	104%									
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<15%**	18.9%	22.5%	14.2%	15.8%	18.4%	25.2%	19.5%	25.8%	27.4%	29.7%	34.3%	31.1%	34.7%	4,242	12,219			22.4%	Jul-24						
Maternity	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	85%	88%	84%	85%	86%	87%	88%	87%	83%	88%	86%	87%	86%	364	421	86%									
	Caesarean section rate for Robson Group 1 women (rolling 6 month)	Chief Medical Officer	**TBC**	5.4%	5.8%	5.6%	5.1%	4.4%	4.4%	4.4%	4.7%	5.5%	6.5%	7.2%	-	-					8.6%	Jun-24						
	Caesarean section rate for Robson Group 2 women (rolling 6 month)	Chief Medical Officer	**TBC**	56.8%	58.2%	59.2%	59.6%	60.0%	59.5%	59.6%	59.2%	59.3%	60.1%	60.7%	-	-					61.0%							
	Caesarean section rate for Robson Group 5 women (rolling 6 month)	Chief Medical Officer	**TBC**	82.3%	81.9%	81.9%	82.4%	81.7%	81.4%	81.3%	81.8%	82.9%	82.3%	83.3%	-	-					83.1%							
	Maternity Activity (Deliveries)	Chief Nursing Officer		387	392	393	357	358	396	372	413	372	410	356	384	422			1,944									
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	**<4%**	5.3%	5.5%	5.6%	5.8%	5.8%	5.5%	4.8%	5.0%	4.8%	5.2%	5.3%	5.0%	5.2%	3,064	58,728	5%		6.9%	Jul-24						
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	89%	89%	88%	89%	89%	90%	91%	91%	89%	90%	89%	88%	89%	34905	39265	89%									
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Chief Operating Officer	**v 2019/20**	108%	99%	112%	109%	100%	101%	114%	118%	110%	106%	106%	109%	112%	37,417	33,493	109%									
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	104%	107%	110%	114%	106%	114%	114%	110%	126%	105%	97%	118%	101%	37,417	37,016	109%									
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	18%	18%	18%	18%	18%	18%	18%	17%	16%	17%	15%	16%	15%	8,193	55,121	17%		18%	Feb to Jan						
Prevention long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer	-	9%	5%	8%	8%	7%	9%	9%	7%	7.3%	7.8%	7.3%	6.0%	6.4%	27	422	6.9%									

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	93%	95%	96%	96%	96%	97%	96%	96%	96%	96%	95%	96%	95%	760	801	96%		92%				
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	51	52	70	65	63	75	102	82	69	67	59	56	48			299		3,848	Jul-24			
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	7.7	7.3	7.4	7.9	7.5	8.1	8.2	8.1	7.8	7.9	7.7	7.5	7.2	20933	2909	7.6		4.4	Feb to Jan			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	2.9	3.7	3.4	3.4	3.5	3.0	3.7	3.2	3.3	3.1	3.3	2.8	3.1	1418	459	3.1		3.1				
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	10%	12%	16%	15%	15%	14%	14%	12%	12%	13%	14%	12%	12%	92	773	13.0%		23.1%	Dec			
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	6.2%	7.3%	6.5%	6.6%	7.2%	7.1%	7.9%	8.5%	7.5%	8.2%	7.2%	6.9%	6.9%	835	12066	7.5%		7.5%	Jan to Dec			
	Mortality SHMI - Rolling 12 months (new methodology introduced Dec-23 onwards)	Chief Medical Officer	**100**	102.9	104.3	103.9	104.5	105.8	104.0	103.0	103.5	102.8	-	-	-	-				As expected					
	Never Events	Chief Nursing Officer	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0			0						
	MRSA Bacteraemia	Chief Nursing Officer	**0**	1	0	0	0	0	0	1	1	0	0	0	0	0			0						
	MSSA Bacteraemia	Chief Nursing Officer	**17**	5	2	0	4	5	2	4	2	3	3	3	5	5			19						
	Number of external reportable >AD+1 clostridium difficule cases	Chief Nursing Officer	**78**	15	10	7	14	8	8	15	9	11	10	14	17	16			68						
	Number of falls with moderate harm and above	Chief Nursing Officer		3	5	6	3	1	4	2	5	3	6	5	13	10			37						
	Serious Incidents	Chief Nursing Officer	**Actual**	15	4	1	0	0	2	1	0	1	1	0	0	0			2						
	VTE Risk Assessments	Chief Medical Officer	**95%**	93.5%	92.7%	92.4%	93.6%	91.0%	93.3%	93.0%	92.2%	96.3%	96.0%	97.0%	96.87	97.04	11556	11909	97%						
	WHO Checklist	Chief Medical Officer	**100%**	98%	96.1%	97%	97%	98%	98%	97%	98%	98%	98%	99%	98%	98%	1722	1750	98%						
	Stroke: % of high risk TIA patients seen within 24 hours	Chief Medical Officer	**60%**	87%	76%	86%	85%	86%	83%	61%	66%	45%	62%	69%	83%	84%	364	528	69%						
	Stroke: % of patients meeting thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	44%	45%	67%	50%	50%	50%	75%	75%	33%	57%	57%	43%	55%	6	11	51%						
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	**80%**	74%	74%	79%	70%	81%	77%	75%	82%	78%	69%	73%	73%	64%	45	70	71%						
	Number of complaints	Chief Nursing Officer	**2022/23 (747)**	64	71	63	71	51	88	77	75	80	66	73	72	70			361						
	Number of complaints referred to, and investigated by, Ombudsman	Chief Nursing Officer	**0**	0	0	1	0	0	0	0	0	0	0	0	0	0			0						
	Complaints resolved within policy timeframe	Chief Nursing Officer	**85%**	76%	64%	44%	42%	62%	63%	82%	69%	48%	62%	73%	61%	62%	44	70	66%						
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	**95%**	90%	87%	86%	87%	84%	74%	71%	77%	76%	75%	75%	78%	82%	2118	2598	77%		79%				
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	**95%**	97%	96%	97%	98%	96%	94%	93%	94%	94%	94%	94%	95%	96%	5160	5369	95%		95%	Apr-24			
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	**95%**	84%	89%	94%	70%	94%	33%	94%	100%	100%	88%	92%	86%	78%	39	50	86%		93%				
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**20%**	25%	22%	17%	21%	14%	23%	23%	23%	22%	23%	21%	22%	24%	2598	10975	22%						
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	39%	35%	30%	36%	25%	35%	37%	37%	35%	37%	38%	39%	44%	5369	12097	39%						
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	5%	2%	3%	6%	12%	1%	9%	1%	4%	9%	8%	20%	10%	50	515	9.9%						

People		Responsible Director	Standard	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6%**	10.2%	9.8%	9.4%	9.7%	8.5%	9.6%	8.4%	8.8%	8.6%	9.0%	7.9%	8.6%	7.9%			8.4%					
	Appraisals - Non-medical	Chief People Officer	**90%**	78.4%	81.0%	79.0%	79.0%	80.0%	79.0%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	4,553	5,673	80.0%					
	Appraisals - Medical	Chief People Officer	**90%**	91.0%	91.0%	92.0%	94.0%	96.0%	93.0%	93.0%	93.0%	94.0%	96.0%	94.0%	93.0%	94.0%	519	552	94.2%					
	Mandatory Training	Chief People Officer	**90%**	89%	88%	88%	88%	88%	90%	90%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	76,517	84,350	91.0%					
	Overall Sickness	Chief People Officer	**4$%**	5.6%	5.7%	6.2%	6.0%	6.3%	6.3%	5.9%	5.8%	5.9%	5.6%	5.3%	5.5%	5.0%	10,427	207,599	5.5%					
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**11.5%**	12%	12%	11%	11%	11%	11%	11%	11%	11%	11%	10%	10%	10%	603	5,872	10.6%					
	Vacancy Rate	Chief People Officer	**7.5%**	11%	10%	9%	8%	8%	8%	7%	7%	10%	9%	9%	9%	8%	598	6,722	9.1%					

Finance and Use of Resources		Responsible Director	Standard	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional	SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	-£2,672	-£201	-£2,331	£2,279	-£4,897	-£5,562	-£4,361	-£3,361	-£7,799	-£4,672	-£5,283	-£5,507	-£5,253			-£28,514					
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-4.6%	-0.3%	-4.1%	3.7%	-8.7%	-9.8%	-7.5%	-4.7%	-14.0%	-7.8%	-9.1%	-9.8%	-9.0%			-9.9%					
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£1,816	£863	-£3,822	£528	-£5,177	-£7,277	-£6,677	-£4,954	£971	-£836	-£635	£7	-£75			-£568					
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	32.0%	529.0%	-64.0%	77.0%	-6.0%	-31.0%	-53.0%	-47.0%	-11.0%	22.0%	14.0%	0.0%	1.0%			2.0%					
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£1,082	-£1,145	-£2,603	-£1,772	-£2,195	-£2,510	-£2,741	-£1,323	-£643	-£193	-£297	£610	£512			-£78					
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	-£3,717	-£3,456	-£3,272	-£3,581	-£3,049	-£3,505	-£3,098	-£3,158	£3,186	£3,406	£2,965	£3,121	£2,961			£15,639					
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	10.2%	9.8%	9.4%	9.7%	8.5%	9.6%	8.4%	8.0%	8.6%	9.0%	8%	9%	8%			8.0%					
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£632	£2,138	-£2,607	-£2,467	£757	£401	-£925	£25,631	£0	£0	-£2,314	-£832	-£118			-£3,264					
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£5.121m	£4.723m	£7.736m	£1.019m	£1.303m	£7.862m	£20.333m	£11.384m	£1.125m	£1.712m	£1.182m	£1.617m	£6.732m			-					
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	86.1%	86.6%	80.0%	79.4%	88.2%	83.1%	88.5%	95.6%	95.1%	87.9%	83%	64%	70%			-					
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	94.4%	91.3%	82.6%	78.6%	88.2%	85.9%	89.8%	93.3%	87.4%	89.3%	71.5%	41.1%	54.2%			-					

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	Perinatal Safety Report August 2024
Status of report:	**☒Approval ☐Position statement ☒Information ☒Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Lara Greenway – Matron Neonatal Services Justine Jeffery – Director of Midwifery Amrat Mahal – Director of Nursing – Women & Children's Division Susie Smith – Maternity & Neonatal Governance Lead
Documents covered by this report:	• NHSE (2020) Perinatal Surveillance Model • NHSR Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme

1. Purpose of the report

The purpose of the paper is to provide a monthly update on key maternity and neonatal safety initiatives which will support the Trust to achieve the national ambition. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety.

The report will inform 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 also present the evidence required for the NHS Resolution, Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme

2. Recommendation(s)

Quality Governance Committee are invited to:

1. **Note** and **discuss** the content of the report,
2. Receive **Assurance** that our maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.

3. Chief Officer/Executive Director Opinion[1]

The CNO offers assurance to QGC and the Board that the maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.

Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☐ *Focus on Flow*	☐ *Think/Act as a Lead Provider*
☒ *Governance*	☐ *Improve Staff Experience*
☐ *Home First Mindset*	☐ *Tertiary Partnerships*
☐ *4ward Improvement System*	☐ *Leadership and Structures*
☐ *Elective Care: No Delays*	☐ *Strategic 'Big Moves*

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	No					

	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	August
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-abouts	√	√	√	√	√	√	√	√	√	√	√	√
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

1. Introduction/Background

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). This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety and will provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the LMNS Board. The key performance indicators for this month are presented below and RAG rated as appropriate:

Summary of Key Safety Indicators

Metrics	Target	Current position	Previous month
Booking completed by 12+6	90%	86.3% ↓	87.4%
Term admissions	6%	3.54%	5.9%
PMR (MBRRACE 2021)	<5.19 per 1000 births (rolling)	3.37	3.18
Stillbirth rate (MBRRACE 2021)	<3.54 per 1000 births (rolling)	1.90	1.91
NND rate (MBRRACE 2021)	<1.65 per 1000 births (rolling)	1.26	1.27
Maternity and Neonatal Moderate or above incidents	-	2	2
Maternity PALS	-	7	11
Neonatal PALS		0	0
Maternity Complaints	-	4	5
Neonatal Complaints		0	1

Summary of Key Workforce Performance Indicators

Metrics	Target	Current position	Previous month
Sickness rate (MWs)	4%	3.75%	4.27%
Turnover rate (rolling) (MWs)	11.5%	9.79%	8.92%
Vacancy rate (MW)	7%	10%	10%
Sickness rate (MSWs)	5.5%	11.89%	7.12%
Turnover rate (rolling) (MSWs)	11.5%	13.64%	18.12%
Vacancy rate (MSW)	7%	14%	14%
Sickness rate (RNs)	4%	2.78%	4%
Sickness rate (NNs)	4%	8.19%	4%
Turnover rate (rolling) (RNs)	11.5%	9.96%	5.43%
Turnover rate (rolling) (NNs)	11.5%	13.28%	8.14%
Vacancy rate (RN)	7%	0.37%	0.78%
Vacancy rate (NN)	7%	3.35%	1.06%
Shifts staffed to BAPM	100%	91.94%	98.39%
Supernumerary shift leader (NNU)	100%	96.77%	100%
QIS trained	70%	69.7%	69.7%

Summary of Key Training Performance Indicators

Metrics	Target	Current position	Previous month
PROMPT – Human Factors & Maternity Emergencies	90%	83% ↑	81% ↑
PROMPT – Neonatal Basic Life Support	90% (including Doctors and Neonatal Nurses)	88%↑	87% ↑
Fetal monitoring	90%	96% ↑	95% ↔
Maternity Trust Mandatory training (non-medical)	90%	88% ↔	88%↑
Maternity Trust Mandatory training (Obstetricians)	90%	74% ↓	79% ↑

Maternity PDR rate	90%	67% ↑	65%↔
Neonatal PDR rate	90%	79.69%	89.39%
Neonatal Trust Mandatory Training (non-medical)	90%	94.1%	94.54%
Neonatal Trust Mandatory Training (medical)	90%	80.66%	83.99%

2. KPI Booking by 12+6 weeks' gestation

The KPI for booking by 12+6 weeks' gestation has not been met this month. The work around maternity self-referral is progressing slowly – an agreed implementation date is not confirmed as this is reliant on the enactment of the admin review as well as input and a work schedule being agreed with informatics and the digital team.

3. Perinatal Mortality Rate (PMR)

The national average rates for stillbirth and neonatal rates, published by MBRRACE (2021 data) in Autumn 2023 have identified an increase 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 newly updated figures for 2022 births are expected in October 2024.

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 rates for the Trust for the last 12 months are below, and can be compared to the national and group rates:

	National rate	Group rate (other Trusts with 4000+ births)	Trust rate (rolling from 01.09.23 – 31.08.24)
Stillbirths	3.54	3.18	1.90
Neonatal deaths	1.65	1.08	1.26
Extended perinatal mortality	5.19	4.25	3.16

As can be seen from the table above, we are below the national rates for both metrics, and just above the group rate for neonatal deaths. The graph below shows a decreasing trajectory in our perinatal mortality rates. As always, it is always important to note that these figures will change when they are reviewed and adjusted by MBRRACE. Small in month variations (including an increase or decrease in the number of live births) can have a significant impact on the overall numbers and rate/trajectory.

The Trust board is required to have oversight of all deaths reviewed and consequent action plans. The quarterly perinatal mortality reports are discussed with the Trust Executive and Non- Executive Board level safety champions and included in the Safety Champion agenda.

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

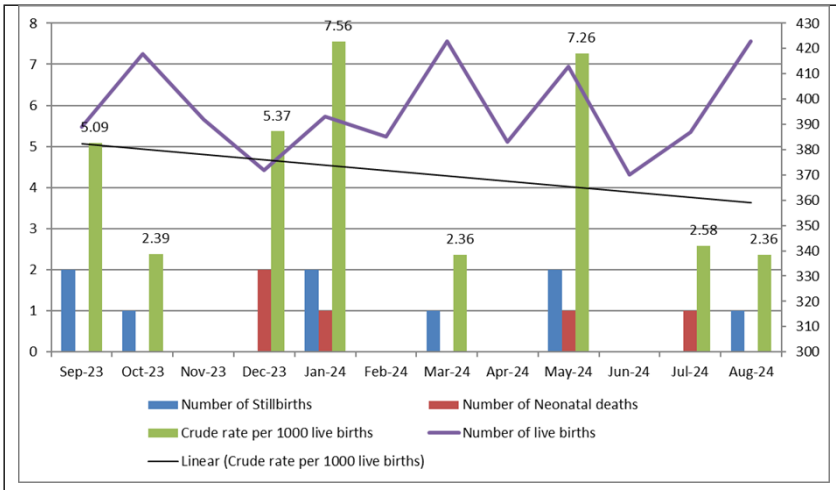


Figure 1. WAHT Perinatal Mortality Rates

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	Comparator group average rate	Term babies-therapeutic hypothermia/ HIE
		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	4843	17	3.21	5	1.12	1	YES – stabilised and adjusted		4
2023	4781	10	2.09*	10	2.09*	1	NO		3 (1 also NND)
2024	3177	6	1.89**	3	0.94**	0	NO		2

*crude rate ** year to date

Key:

Rate suppressed due to small numbers
Rate over 15% lower than comparator group average
Rate 5 to 15% lower than comparator group average
Rate within 5% of comparator group average
Rate over 5% higher than comparator group average

3.3 Perinatal Mortality Summary for August 2024.

In August there was one stillbirth; there were no neonatal deaths. Additional detail will be shared in the Perinatal Incident report shared with Private Trust Board.

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 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
MI036767	January 2024	Yes	Draft report and comments returned – now with family for factual accuracy.
MI037490	May 2024	Yes	Investigation underway

MNSI Quality Review Meetings

The Trust continues to undertake a pilot with MNSI for improving the process of working with the Trust; the Governance Lead and the Link Investigator meet every 2 weeks to share any issues/concerns/updates, and the DOM and MNSI Team Leader meet once a month to discuss emerging themes, trends and safety concerns. This continues to be working well so far and will be evaluated in due course.

5. Incidents reported moderate or above in Maternity and Neonates in August 2024.

There were two incidents reported in August 2024 – one relates to a baby born with an undiagnosed anomaly, and the other relates to a retained placenta.

Further details are presented in the Perinatal Incident report.

6. Maternity and Neonatal Training Compliance

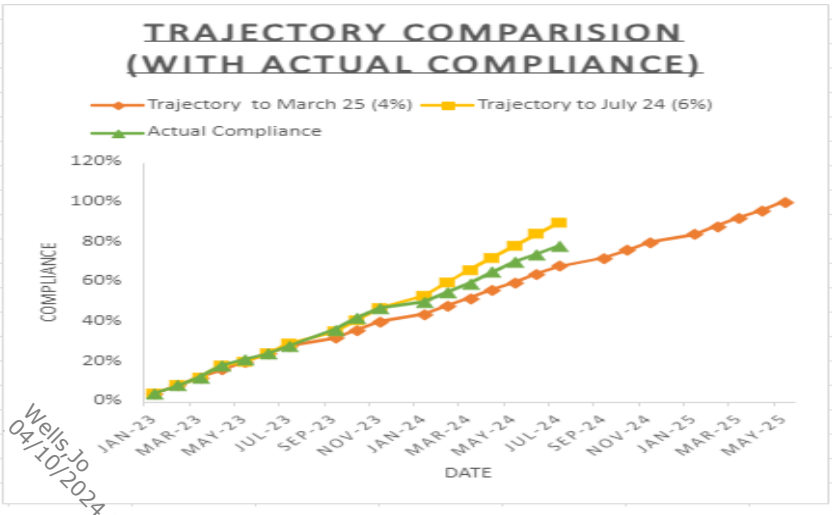
The maternity and neonatal teams have individualised role-specific training but there is some MDT cross over training, in particular in regard to neonatal resuscitation.

Course	Staff Group	Compliance	Previous month	Comments
Maternity Mandatory Training – (3 yearly)	Midwives	78% ↔	78% ↑	
Maternity Mandatory Training – (3 yearly)	MSW/MCA	71% ↔	71% ↑	
Annual Saving Babies Lives training	Midwives	94% ↔	94% ↔	
Annual Saving Babies Lives training	MCA/MSW	62% ↔	62% ↑	
Annual Saving Babies Lives training	Obstetricians	69% ↔	70% ↔	
Annual fetal monitoring training	Midwives	94% ↔	94% ↓	
Annual fetal monitoring training	Obstetricians (all on rota)	97% ↔	97% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	Midwives	95% ↔	95% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	MSW's	82% ↔	82% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	Obstetricians (all on rota)	79% ↑	68% ↔	
PROMPT training (Human Factors/MDT Obstetric Emergency	Anaesthetists (all on rota)	76% ↔	78% ↔	
Neonatal Life Support	Midwives	95% ↔	95% ↑	
Neonatal Life Support (NLS 4yearly)	Neonatal Nurses	100%	100%	
Neonatal Life Support (NLS 4yearly)	Neonatal Drs	90.6% ↑	80%	
Neonatal Resuscitation Update (annual)	Neonatal Nurses	80% ↑	79%	Next update 10.10.24
Neonatal Resuscitation Update (annual)	Neonatal Drs	97.9% ↑	97%	
Trust Mandatory Training	Obstetricians	74% ↓	79%↓	
Trust Mandatory Training	Midwifery Staff	88% ↔	88%↑	
Trust Mandatory Training	Neonatal Nurses	94.1%	94.54%	
Trust Mandatory Training	Neonatal Drs	80.66%	83.99%	

Figure 2. Training Compliance

Maternity specific training:

The expected trajectories for compliance to meet the Core Competency framework V2 are presented below, however in year 6 MIS there is no compliance target, just an expectation that Trust's continue to work towards this. It was hoped that the Trust would be able to demonstrate 90% compliance by end of July 2024 but this has been affected by staff members not being able to attend due to sickness and requirement to cover ward areas to ensure safe staffing.



Neonatal training:

Mandatory training compliance for medical staff has reduced slightly from the previous month. Junior medical staff are employed under different training programmes and currently their training compliance is not transferrable. The Divisional Director is working with the CMO to identify a solution to capturing this training data within the Trust. The directorate team continues to work with line managers to improve their position. Junior doctors change on the first Wednesday of August/December/April (GP/FY1 & 2), and the first Wednesday of August, December/April (Paediatrics) - every year. Neonatal nurses have maintained 94% compliance with their mandatory training.

PDRs for non-medical staff have shown a decline however local data demonstrates higher compliance. Data entry onto ESR has been identified as a cause and the Division is working with the corporate team to rectify this.

All rotation doctors receive an annual neonatal resuscitation update at induction or within 3 months of starting. Nurses receive their annual neonatal resuscitation update by attending the Neonatal study day. The next Neonatal Training Day is scheduled for 10th of October, which will improve the nursing compliance for resuscitation update. Clinical Educators within neonates and maternity are working together to combine this training that will be accessible through PROMPT. NLS compliance for medical staff has increased following the changeover of doctors in August.

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 1)

There were 416 births in August. The escalation policy was enacted on 28 occasions to reallocate internal staff which is an increase on the previous month. The community and continuity teams were asked to support on three occasions.

The vacancy rate has remained the same for midwifes and MSW/MCAs – there are additional midwifery staff commencing by the end of November. The rolling turnover rate for midwives remains below Trust target further however for non-registered staff remains high. Sickness absence rates for midwives is now below the Trust target. Rates for non-registered staff have increased in month.

The supernumerary status of the shift leader was not achieved (NHSR compliant) and 1:1 care in labour was achieved in August.

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.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a

Community Midwifery	78%	100%	n/a	n/a
Antenatal Ward/Triage	91%	94%	90%	84%
Delivery Suite	93%	97%	51%	90%
Postnatal Ward	92%	94%	83%	85%
Meadow Birth Centre	60%	56%	81%	65%

7.2 Obstetric Medical Staffing including Consultant attendance

Consultants

We have 23.5 WTE Consultants in post. 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 appointed a new Substantive Consultant on 12th August and have a further ATR approved for a Maternal Medicine post to fill the PAs we have lost secondary to the increase in SPA and external roles. There are 4 Consultants planned to have elective surgery during the next 4 months so we have gone out for locum Consultants to fill these vacancies and approached our post CCT Registrar to act up for some on calls and Caesarean section lists. We are also ensuring our Speciality Doctor is competent to manage the Pre-term Prevention Clinic independently.

Registrars

The registrars work a 1:9 on call rota. We currently have 19.4 WTE in post (funded for 19.6 WTE), with 16.8 WTE on the on-call rota.

Our on-call vacancies are being filled internally and with previous employers of the department.

We have a clinical fellow (planned to go up to the middle tier rota) currently working on the junior tier rota and have a Urogynaecology Clinical Fellow starting in post on 23rd September.
We have gone out to advert for a Post CCT Clinical Fellow post and have also recently advertised a further Clinical Fellow post which we are hoping our MTI will apply for.

We have recently converted 2 of our Clinical Fellow posts onto permanent contracts and are in the process of doing the same with 3 further Clinical Fellows.

We have submitted an application for a Urogynaecology Subspeciality Training post which will be a joint position with Leicester. If successful it is envisaged that they will commence at WAHT in August 2025.

Medical staffing is on our risk register.

Junior Grades

The junior tier works a 1:10 on call rota. We currently have 14.8 WTE (1 WTE is the Clinical Fellow who will move up to the middle tier rota), giving us a vacancy of 2.2 WTE.

We have a Physicians Associate working 40hrs/wk who is leaving in October 24. We are currently implanting some guidance for our PA following publication of the BMA document in April 2024.

Consultant Attendance

In August, Consultant presence was achieved in 5 of the 7 cases (71%) mandated by the RCOG and Action 4 of CNST.

The two cases where it was not met were for Caesarean sections with a BMI >50 (BMI 50.08 AND 50.66). Both Caesareans were uneventful with normal blood loss.

A reminder was sent to all Registrars and Consultants about the need to attend Caesareans for a BMI over 50 and the RCOG Consultant attendance requirements re-circulated.

Compensatory Rest

There were no episodes/situations in August where a consultant did not meet the required 11 hrs Compensatory Rest.

7.3 Neonatal Staffing

7.3.1 Neonatal Nursing

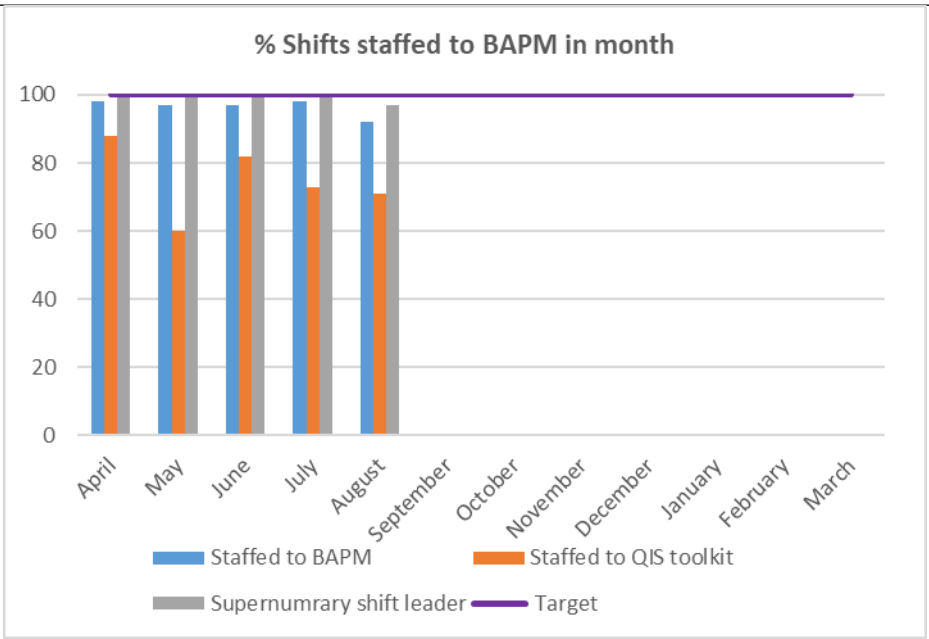
Safe neonatal nurse staffing is monitored by taking the following actions:

- 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

In August 91.94% of shifts were staffed to BAPM. There was a shortfall of 3 shifts due to the acuity & capacity on the Neonatal Unit. 70.97% of shifts in August were staffed to QIS, this was due to high acuity. 11 of the 18 shifts were short by < 1 nurse. The supernumerary status of the shift leader was not achieved on 2 shifts throughout August. This was due to the acuity requiring an additional QIS. The shifts were escalated to Bank & Agency but did not fill. All shifts however remained safe, and no staffing incidents were reported.



% shifts to BAPM recommendation

It is important to note whilst the number of qualified in specialty (QIS) is below the BAPM recommended, with on-going nurse recruitment the percentage of compliance will fluctuate. It takes a minimum of 9 months to complete the neonatal foundation course before individuals can be considered for the neonatal critical care course to become qualified in specialty (QIS). The number of nurses qualified in specialty remains at 69.7% in August against the 70% recommended. There are 3 staff allocated to commence the critical care course later this year and there has been recent appointment of nurses already QIS which has improved the overall compliance.

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

Sickness absence rates decreased for the sixth month in a row and is currently 3.8% for registered nurses. There was however an increase in sickness amongst the non-registered from 4% to 11.2%. This gives a total percentage of 5.2% which is just above the Trust target of 4%. Staff continue to be directed to health and well-being support.

7.3.2 Neonatal medical staff

The current on-call rota for out of hours is combined for paediatrics and neonatal. To meet BAPM safe medical staffing there is a need for 8 on-call neonatal consultants and 6 Advanced Neonatal Nurse Practitioners (ANNP) to support the implementation of a separate paediatric and neonatal medical rota.

Currently there is a shortfall of 0.5wte consultant and 5 ANNPs. We have appointed 2 consultants with an advert going out for a 3rd. We have dates confirmed for a locum and substantive consultant commencing September 2024. Following the appointment into the 3rd post there are plans to implement the split rota commencing January 2025.

We have reviewed the case for need for ANNPs and intend to progress this as a future strategy recognising the qualitative benefits. 2 of our clinical fellows have been promoted and we have a favourable deanery fill in the September rotation.

7.3.3 Neonatal AHPs

The Neonatal allied health professionals are now operational via an SLA with the Worcestershire Health and Care Trust and are contributing a measured benefit to our patient's, physiotherapy, occupational therapy, Speech/Language, dietetic and psychology needs.

8. Service User Feedback

8.1 Maternity& Neonatal Voice Partnership

The CQC survey findings have been shared with the MNVP and an action plan has been co-produced, this will be approved in September's Maternity Governance and will be included in the next report.

8.2 Baby Friendly and BLISS Accreditation

The neonatal unit was awarded stage 1 accreditation at the beginning of the year and is aiming to submit action plans for stage 2 by the end of 2024. The maternity unit is now working towards 'GOLD'.

The neonatal unit is also working towards silver BLISS accreditation; with an aim to submit our action plan in September. The Family Integrated Care Lead has presented the action plan to the Division prior to submission.

8.3 Complaints and PALS feedback – Maternity and Neonates

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. There are no themes/trends identified.

Maternity: In In August 2024, 4 formal complaints were received:

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
88897	06/08/2024	Maternity (formerly Obstetrics)	Clinical Treatment	Blood transfusion inappropriate/unnecessary
88940	07/08/2024	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in induction of labour
89833	30/08/2024	Maternity (formerly Obstetrics)	Communications	Communication with patient
89028	09/08/2024	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives

In addition, there were 7 Maternity PALS query received as below, which is a decrease from the 11 received in July 2024.

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
89704	27/08/2024	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
89448	21/08/2024	Maternity (formerly Obstetrics)	PALS - Signposting	Message Directed to Other Department
89202	14/08/2024	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - TELEPHONE
88898	07/08/2024	Maternity (formerly Obstetrics)	Access to Treatment or Drugs	PALS – Access to Services
89103	12/08/2024	Maternity (formerly Obstetrics)	Communications	PALS – Insufficient information given
89570	23/08/2024	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
88753	05/08/2024	Maternity (formerly Obstetrics)	Patient Care	PALS – Food and Hydration – Failure to monitor food intake during period of admission

Neonatal: There were no PALS or complaints received in August 2024.

9. Safety Champion escalations

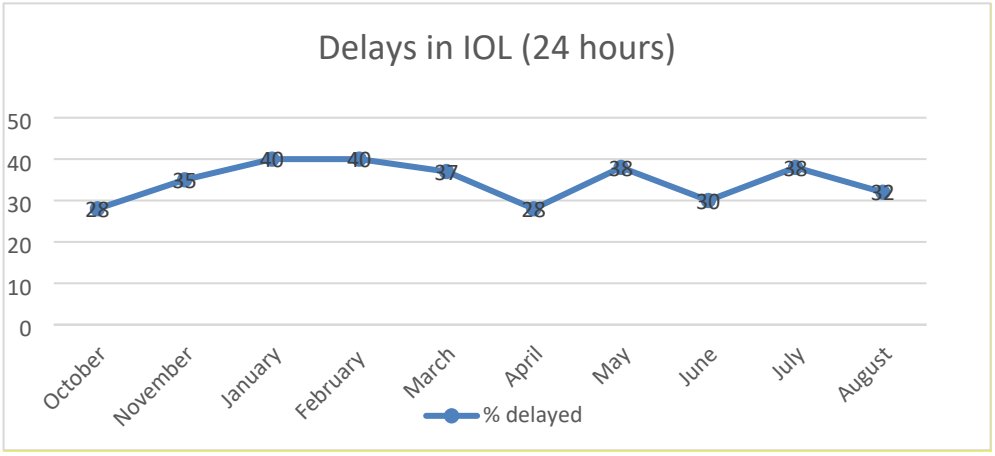
The Safety Champions meeting was scheduled for 30th August, this was cancelled due to declined invitations; this is rescheduled for the following week 5th September 24

9.1 Delays in care

Induction of labour

Delays in induction of labour (red flag) are reported in the national and regional sitreps. Delay in induction of labour is recorded via the acuity tool but this is not reliable and does not reflect the daily position.

The % of women waiting over 24 hours (awaiting ARM) on the IOL pathway are as follows:



Induction of labour pathway remains a focus as delays in care is a significant red flag - a QI project is underway to reduce delays in this pathway.

9.2 Claims scorecard review in conjunction with incidents and complaints

A Q1 report for 2024/2025 report for maternity and neonates will be available in the September report; it had been planned for August but we have now received the detailed information from the legal team regarding the stillbirths claims therefore a deep dive is underway. A further bespoke meeting with NHS Resolution is planned for 24 September 2024 and there will be attendance from the Safety and Learning team, Early Notification Scheme and Maternity Incentive Scheme.

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

The maternity service was rated as good overall. The safe domain remains at 'requires improvement. All actions are monitored via the COSMOS platform and has been presented at the Regulatory Compliance Group (monthly) but this will now be replaced by the ISAG group.

10.1 CQC Rait Tool

Below is a summary of 'Must' and 'Should' Do's by Level of Assurance from the Regulatory Activity Tool (RAIT) produced from the published report 29.11.23

No of Must Do's by LOA		No of Should Do's by LOA		RAIT Tool Attachment
7	2	7	3	MASTER WAHT_RAIT Materni
6		6		
5	2	5		
4		4		
3		3		
2		2		
1		1		

11. Coroner Regulation 28 made directly to Trust

No regulation 28 regarding maternity or neonatal care was made to the Trust in August 2024.

12. In-utero and ex–utero activity

2 IUT transfers out as per the network pathway for <27/40.
1 out to WVT for assistance with ARM.
3 ex-utero repatriations into the unit.
3 ex-utero transfers out for medical reasons & 1 repatriation.
There were no transfer exceptions in August.
The table below summaries the transfers as per network pathway:

Type of Transfer	August		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	0	2	2 out – BWH as per <27/40 gestation pathway
IUT Transfers for non-clinical reasons	0	1	1 out – Hereford for assistance with ARM
IUT Transfers outside of the network	0	0	
Ex-utero Transfers for clinical reasons as per network pathway	0	3	3 out – clinical reasons. 1 to Heartlands & 2 to BCH
Ex-utero Transfers for non-clinical reasons	3	1	3 in – Repatriations from BWH, Coventry & Heartlands. 1 out – repatriation to Hereford
Ex-Utero Transfers out of network for clinical reasons	0	0	
Delays in transfer in/out	0	0	
IUT or Ex-utero Exceptions	0		

13. MSSP Report

Formal confirmation of our exit from the MSSP was received in June 2024. A sustainability plan has been agreed and shared at Trust Board. Progress with the plan will be monitored by the ICB and a quarterly update will be provided via this report.

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

The new MIS Year 6 scheme was published at the beginning of April 24. An action plan has been completed and added to the CCOSMOSS platform to support ongoing monitoring and the collection and storage of evidence. There are a number of changes noted within the scheme in Safety Actions 3,5,6, 7 & 8. A summary position is outlined below with embedded evidence for Trust Board assurance:

Safety Action & Current status		Actions	Evidence for Trust board as prescribed in CNST year 6	Document to follow in yr 6
1	PMRT	• Quarterly reporting in place *NHSR – update 26.6.24 date range moved. Validation commences 1.4.24 for SA1a) & c)*	Q1 24-25 PMRT case report.docx	Q2,3,4 24-25
2	MSDS	No anticipated issues with the data submission		
3	ATAIN	• Quarterly reporting in place *QI project commenced with baseline audit presented in Perinatal Governance June 24, for LMNS update 23rd Oct, full project 11th Dec.*	ATAIN Report Q1 24-25.docx	Q2,3,4 24-25
4	Clinical Workforce	• Safe Staffing report in place • NCCR implementation plan • Audits for Obstetric Medical staff now complete – embedded • Consultant attendance item 7.2 within report • Compensatory rest monitoring log	WMNODN NCCR Unit Implementatior SA4 a) 1& 2 - Short term and Long term Clinical Supervision of Locum and Temp Medical Staffing Report - August24 (	
5	Midwifery Workforce	• Monthly Safe staffing report in place. *SN status of the SL requirement changed in Yr 6 of scheme*	BR+table top (Jan & July 24) BR+ Audit May 22 Item 7 within report	
6	Saving Babies Lives	• Quarterly reports in place LMNS validation quarterly continues on NHSFuture implementation tool. Current level of compliance 83%	6 Element Summary audit Q1.pptx	Q2,3,4 24-25
7	MNVP	Some changes to this year's requirements – additional funding from LMNS and strategic lead planned		CQC Survey Action plan
8	MDT Training	On target	Item 6 within this report	
9	Safety Champions/ Perinatal Safety	• Reporting process in place. • Roles embedded and SC meetings working well. • Perinatal Surveillance guideline updated in line with yr 6 • Claims scorecard Quarterly reporting • Regular Safety champions meeting with Quad/DMT – Notes embedded	MSC meeting notes 23 04 20224.docx MSC meeting notes 07 06 2024 (V2) inclu MSC meeting notes 25 06 2024 (2).docx	Q1,2,3,4 24-25
10	NHSR EN Scheme	Reporting process in place – externally validated.	Item 4 within this report	

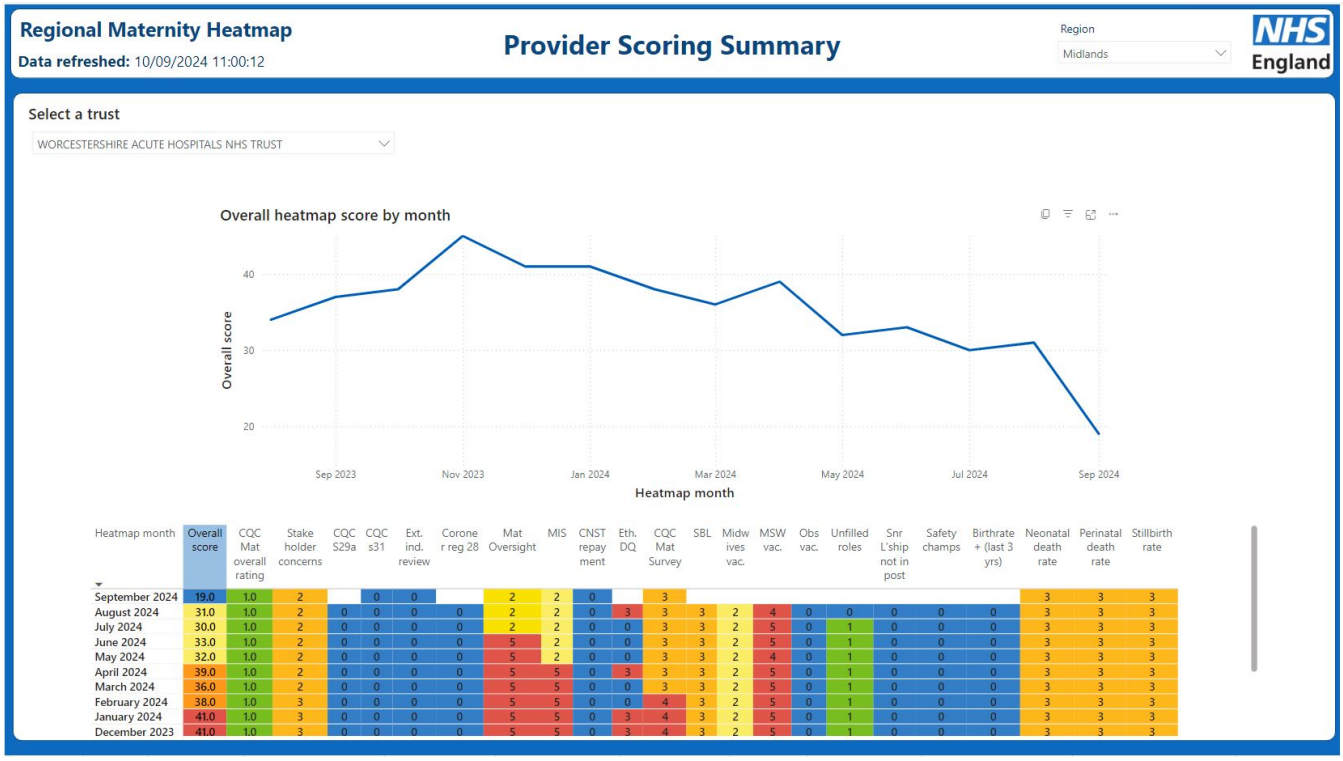
15. Regional Heatmap

The Regional Perinatal Heatmap was introduced in October 2023 and tracks 22 quality and safety indicators. This will read the signs of trusts that require additional early intervention and support. It scores

systems and providers to ensure the right level of support is in place to enable focussed quality improvement to address key challenges.

The heatmap score is used to determine which systems and trusts are encouraged to take up the offer of regional involvement in system-led insight visits to maternity services and additional regional improvement support. It aligns to the themes of the maternity and neonatal single delivery plan and perinatal quality surveillance model.

The Trust position for August is as follows:



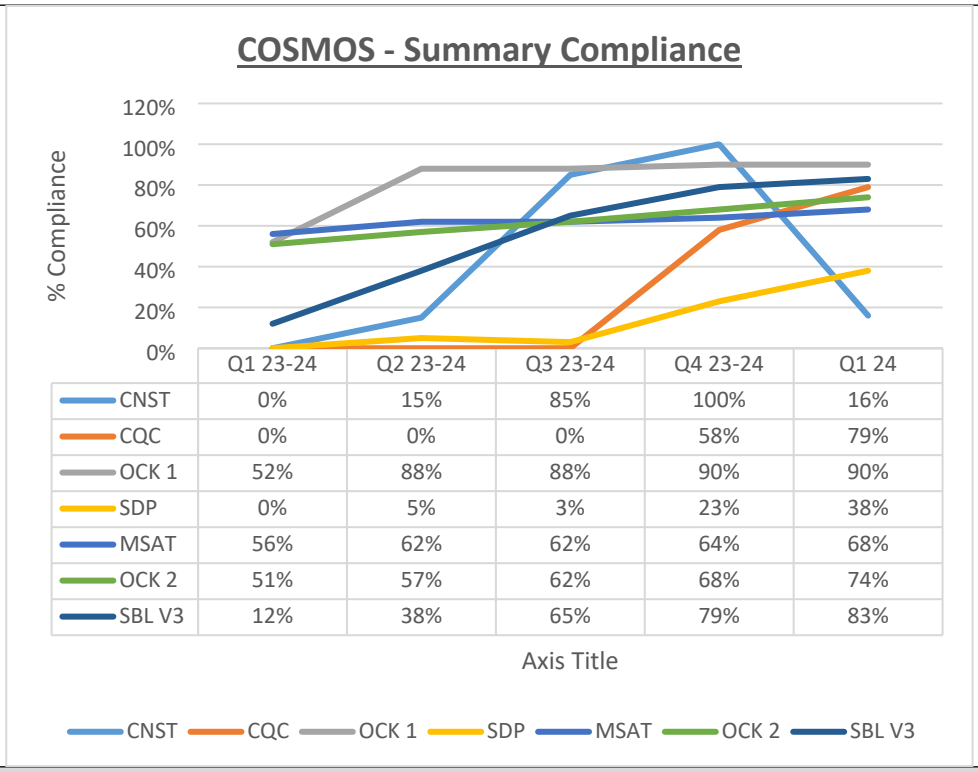
Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
September 2024	19.0	1.0	2		0	0		2	2	0		3									3	3	3
August 2024	31.0	1.0	2	0	0	0	0	2	2	0	3	3	3	2	4	0	0	0	0	0	3	3	3
July 2024	30.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	5	0	1	0	0	0	3	3	3
June 2024	33.0	1.0	2	0	0	0	0	5	2	0	0	3	3	2	5	0	1	0	0	0	3	3	3
May 2024	32.0	1.0	2	0	0	0	0	5	2	0	0	3	3	2	4	0	1	0	0	0	3	3	3
April 2024	39.0	1.0	2	0	0	0	0	5	5	0	3	3	3	2	5	0	1	0	0	0	3	3	3
March 2024	36.0	1.0	2	0	0	0	0	5	5	0	0	3	3	2	5	0	1	0	0	0	3	3	3
February 2024	38.0	1.0	3	0	0	0	0	5	5	0	0	4	3	2	5	0	1	0	0	0	3	3	3
January 2024	41.0	1.0	3	0	0	0	0	5	5	0	3	4	3	2	5	0	1	0	0	0	3	3	3
December 2023	41.0	1.0	3	0	0	0	0	5	5	0	3	4	3	2	5	0	1	0	0	0	3	3	3

The score increased in August as we did not meet the 90% compliance in our ethnicity data. This has been rectified for Septembers submission. The score will reduce by a further 5 points across the next quarter as vacancies are filled. Further score reductions will be achieved if we can evidence compliance against the 10 CNST standards and the local perinatal death rate continues to reduce.

16. CCOSMOSS

CCOSMOS is a local acronym for Clinical Negligence Scheme for Trusts (CNST), CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2, Saving Babies Lives (SBL) and Safety Champions. The recommendations/actions (n=505) from all 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 directorates quarterly progress is presented below:



	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24
CNST	0%	15%	85%	100%	16%
CQC	0%	0%	0%	58%	79%
OCK 1	52%	88%	88%	90%	90%
SDP	0%	5%	3%	23%	38%
MSAT	56%	62%	62%	64%	68%
OCK 2	51%	57%	62%	68%	74%
SBL V3	12%	38%	65%	79%	83%

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.

Appendices

1. Midwifery Staffing Report

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COMMITTEE REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	Nurse safer staffing report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Sue Smith, Deputy Chief Nursing Officer
Documents covered by this report:	

1. Purpose of the report.

This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during August 2024 with numerical data presented for July 2024.

2. Recommendation(s)

Board members are invited to:

1. **NOTE** the content of the report and the assurance levels which are in line with National Quality Board (NQB) and NICE guidance
2. **NOTE** the key points in the executive summary

3. Chief Officer/Executive Director Opinion[1]

Staffing on Paediatrics, Neonates and all Adult in patient areas has been maintained at safe levels throughout August 2024. The Trust remains compliant with NQB safer staffing recommendations.

Acuity and Dependency reviews with all Divisions have now taken place and an acuity and dependency paper, triangulating acuity data, quality and safety measures and professional judgement for all areas is in the process of being approved.

Reduction of agency spend & average hourly rate, remains a focus. We continue to see a consistent reduction of Tiers 3 & 4 and removal of off framework agencies. Focus moving forwards is to look at the promotion of tier 1 over tier 2 and a greater push toward capped rates. Further reduction / removal of agency for Health Care Support workers will also be a priority.

4. Executive Summary

[1] Chief Officer Opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

This report outlines the current position for Nursing, Midwifery and Health Care Support Worker staffing and intends to provide positive assurance regarding:

- The safe staffing position across these staff groups
- The reduction in overall pay costs and bank and agency spend, with a proportionally larger decrease in agency spend.
- The reduction in overall absence rates however noting a small increase in HCA vacancies in July 2024

5. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☒ ***Governance***	☒ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

6. Relationship to the Board Assurance Framework (BAF) and Risk Register

Are there any existing risks on the Datix BAF/Risk Register relating to this report?	Yes
Does this report have an impact on the risk?	No
Do you recommend a new entry to the BAF and/or Risk Register is made as a result of this report?	No
If yes, describe the new risk.	

Overall Level of Assurance for this Report

Tick ➢ the level of assurance for this report

Full Assurance	☐
Significant Assurance – with minor improvement opportunities	☒
Partial Assurance – with improvements required	☐
No Assurance	☐

7. Supplementary/Supporting Information

1. Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for August 2024

This assessment is in line with Health and Social Care regulations:

- Regulation 12: Safe Care and treatment
- Regulation 17: Good Governance
- Regulation 18: Safe Staffing

2. Content of report

Harms

In August 2024 there were 16 insignificant or minor incidents reported. The insignificant and minor harms reported relating to nursing / midwifery staffing and were largely reported as near misses due to staff absence, rather than patient harm. All incidents were included in NWAG Divisional reports and assurance of mitigation where appropriate has been given. It has previously been noted that there has been an increase in staffing datixes relating to portering and availability of porters, with narrative indicating an impact on patient care. In August only one datix of this nature was reported but monitoring of this will continue.

Safe Staffing

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

"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled'.*
National rates are aimed at achieving 95% across day and night RN and HCA fill.
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where able to do so.

Current Trust Position July 2024 data	What needs to happen to get us there	Current level of assurance
<table><tr><th></th><th>Day % fill</th><th>Night % fill</th></tr><tr><td>RN</td><td>95%</td><td>99%</td></tr><tr><td>HCSW</td><td>102%</td><td>115%</td></tr></table>	This month fill rates remain stable, with registered and non-registered meeting national targets of 95%. Last dip below 95% for RN October 2023. HCSW night fill at 115% is raised but stable for the 5th month and is impacted by areas acknowledged to have both high acuity and high numbers of boarders. This has been discussed in acuity and dependency review meetings during July 2024.	6

Care hours per patient day (CHPPD)

In line with National guidance, in addition to the measurement of unified data (filled and unfilled hours), care hours per patient day (CHPPD) are calculated for each inpatient area and uploaded monthly to NHSE.

The Trust average for CHPPD for July 2024 was **9.5 (increased slightly from 9.1 in June)**. The average national range for CHPPD is **9.1** with a variation of **6.33 to 15.48**, which the Trust falls within.

In July **no inpatient clinical areas** fell below the minimum of 6.33

5 clinical areas were above the maximum variation level seen nationally, these findings are consistent from last month:

- ICU WRH
- ICU AGH
- Meadow birth suite
- NICU
- Ward 1 KTC

All these units are specialised, necessitating staffing to maximum number of beds and acuity rather than actual activity. This will fluctuate greatly each month depending on the patients in each unit at time of measurement at midnight.

Nurse to bed ratio

From the April 24 report there has been no changes to bed state therefore data is unchanged

All adult in patient wards and departments are staffed according to guidance NICE / RCN and where relevant specialist advisory bodies.

Vacancy (Trust target 6%)

July 2024 data

Current Trust Position **WTE** **July 2024 data**	**Previous month** **June 2024**	**Model Hospital data Dec 2023 Benchmarking**	**Current level of Assurance**
RN 6.82% (148.68 WTE) HCSW 10.44% (111.59 WTE)	RN 6.90% (150.46 WTE) HCSW 9.64% (102.99WTE)	RN 9% HCSW 9.3%	5

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

- deploying staff across all wards / departments to ensure safer staffing levels achieved

- employed use of bank and agency workers.

International nurse (IN) recruitment pipeline

The initial target for the year 24/25 is for 50-60 nurses supported by an internal business case, in the absence of assured external funding from NHSE. This number is open to flex however and our NHSP international recruitment partners have been advised.

Domestic and international nursing recruitment

The current 12-month trajectory looks positive with a predicted vacancy rate at Month 12 of 31 WTE RN. This is based on active recruitment drives for both autumn and spring qualifying cohorts and a moderate international pipeline of 50. This is in combination with baseline local recruitment and RNA to RN top ups of existing staff. A graph show showing this can be found in Appendix 1.

The Trust continues to work with the ICS and Heart of Worcestershire College Redditch, to undertake the first pilot cohort of RCN cadets commencing September 24.

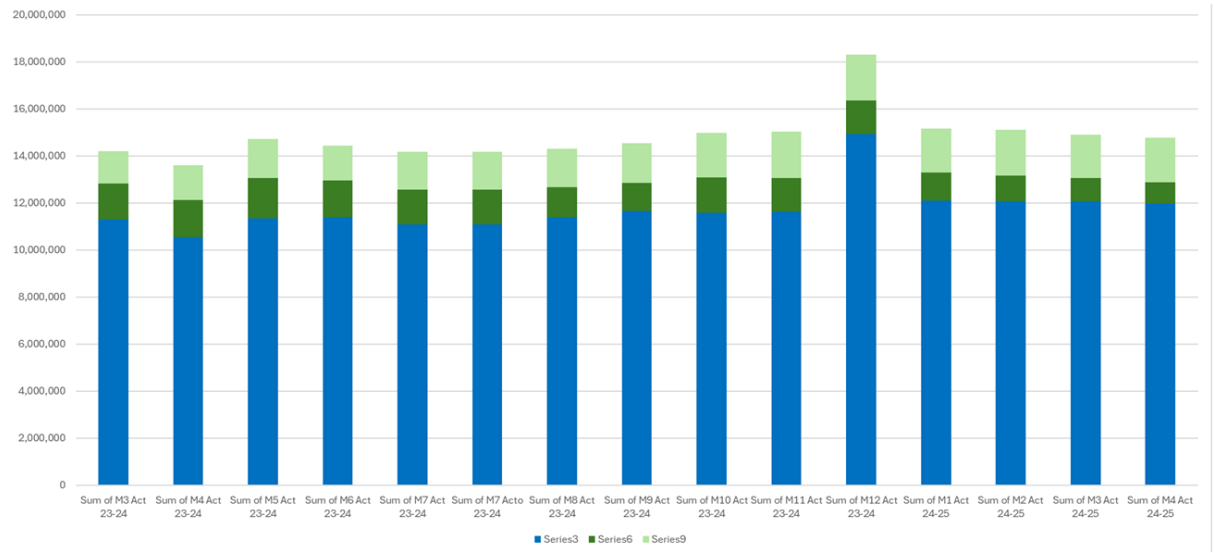
Bank and Agency Usage
July 2024 data

Bank and agency usage, total combined RN & HCSW of 602.69 WTE stable in July (from 600.8 WTE in June).
Triangulated data for sickness / vacancy and maternity leave gives an overall absence of 367.18 WTE for registered (not including midwifery) and 232.29 WTE for unregistered nursing.

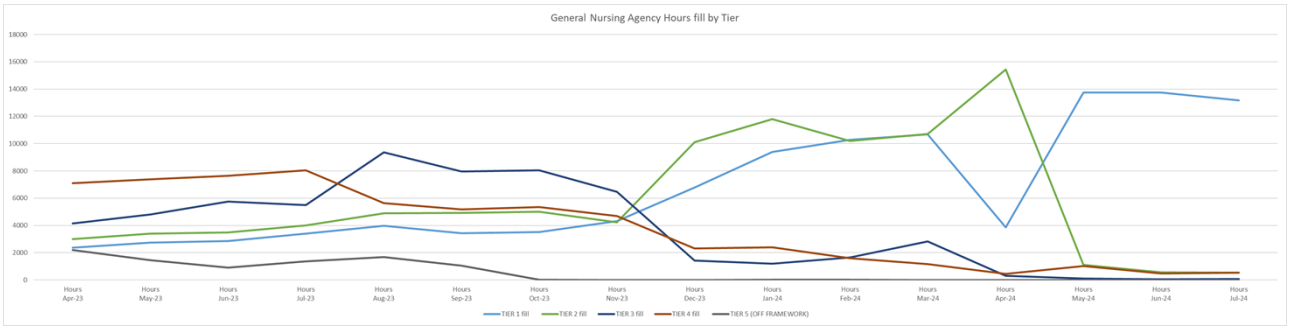
Model Health System (MHS) data shows wards fully established hence the difference from 4.6% (MHS) to 16-24% at WAHT.
Also noting, maternity and sickness are not within headroom cover substantively.

Current Trust Position WTE July 2024	Previous Month June 2024	**Model Health System Data Sep 2023 Benchmarking**	**Current level of assurance**
RN 15.1% (322.94 WTE) (168.33 Bank / 154.61 Agency) HCSW 28.1% (279.75 WTE) (256.97 Bank / 22.78 Agency)	RN 15.5% (333.46 WTE) (165.92 Bank / 167.54 Agency) HCSW 26.8% (267.34 WTE) (240.74 Bank / 26.60 Agency)	RN 4.8% HCSW Not available	5

Graph showing trend of substantive / bank and agency spend



Reduction of agency spend & average hourly rate, remains a focus. The graph below illustrates the consistent reduction of Tiers 3 & 4 and removal of off framework agencies. Focus going forward will look at the promotion of tier 1 over tier 2 and a greater push toward capped rates.



Sickness

June 2024 data (% reflects updated headcount)

Current Trust Position July 24	**Previous Month June 24**	**Model Health System data Feb 2024 Benchmarking**	**Current Level of Assurance**

RN 5.93% (126.48 WTE) HCSW 8.7% (86.7 WTE)	RN 5.49% (117.6 WTE) HCSW 7.39% (73.7 WTE)	RN 5.4% HCA 7.5 %	**5**

Absence (July 2024 data)

- 367.18 WTE RN total absence due to vacancy, sickness and maternity leave (from 360.06 in May & 405.98 WTE in June) versus bank and agency use of 322.94 (down from 333.46 in June).
- 232.29 WTE HCSW total absence due to vacancy, sickness and maternity leave (decreased from 213.69 in June) versus bank and agency usage of 279.75 WTE (increased from 267.34 in June), this is reflective of a slight increase in both the vacancy and sickness for the staff group.

The Trust currently has 92 RNs and 34 HCSWs on maternity leave (stable from June).

3. Summary/Conclusion

Safe staffing

- Staffing on Paediatrics and neonates has been maintained at safe levels throughout August 2024.
- Staffing on all adult areas in patient areas was also safe throughout August 2024.
- Fill rates were stable for August 2024
- CHPPD has increased in August 2024

Pay costs

- **Overal**l nursing, midwifery and HCSW pay costs of £14, 767,041 in July decreased from £14,907,425 in June, this is a further decrease of £140,384 with this being largely attributable to reduction in substantive costs and a larger reduction in agency spend
    - **Substantive** nursing, midwifery and HCSW pay spend of £11,955,517 decreased slightly from £12,071,203 in June 2024.
    - **Bank** spend (registered and unregistered) of £1,889,610 increased from £1,838,324 in June and indicative of agency offsetting.
    - **Agency** spend of £921.914 decreased from £997,898 in July; this is a further decrease of £80,366 in June.
    - **Overall bank and agency**
        - RN ↓15.0%, HCA ↑28.0%
- Throughout July 2024, the Trust has used 202 hrs of 'off framework' agency (Greys) across all registered nursing grades. This was utilised in Occupational Health and for RMN support for a specific situation on Riverbank children's ward. We are working with our agency partners to source robust RMN provision without recourse to off framework solutions.

Overall absence

RN ↑367.18 WTE, HCA↑232.29 WTE

This includes:

- **Vacancy**

➢ RN ↓6.82%, HCA ↑10.44%

- **Sickness**
  - RN ↑5.93%, HCA ↑8.7%
- **Maternity Leave**
  - RN 92 WTE, HCA 34 WTE

Current cover arrangements.
Currently budgets do not contain uplift for maternity leave cover and sickness. Whilst budgeted for, this sits within the bank / agency line so hence is reliant on temporary staffing solutions. Data was requested in August from finance to enable a proposal to be written to incorporate maternity leave into the headroom calculations.

To note: Use of surge capacity continues in the PDU 8 bed overflow area.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	**Midwifery Safe Staffing Report August 2024**
Status of report:	**☐Approval ☐Position statement ☒Information ☒Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Justine Jeffery Director of Midwifery
Documents covered by this report:	• NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • NHSR Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme • NHSE (2020) Perinatal Surveillance Model

1. Purpose of the report

The purpose of this report is to provide assurance that midwifery staffing is monitored and to note actions taken to mitigate any shortfalls.

2. Recommendation(s)

The Board is asked to note how safe midwifery staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of midwifery staffing.

3. Chief Officer/Executive Director Opinion[1]

The report offers assurance to the Board that there are robust processes in place to monitor midwifery staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☒ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

Introduction/Background

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

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
- Sickness absence, vacancy and turnover rates
- Recruitment & retention
- 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.

The summary of the workforce KPIs are as follows:

Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	3.75%↓	11.89%↑
Turnover rate (rolling)	11.5%	9.79%↑	13.64%↑
Vacancy rate (MW)	7%	10%↑	14% ↑*
Maternity Leave	-	4.79%↓	2.99%↑
Midwife to birth ratio (in post)	1:24	1:22	
1:1 care in labour	100%	Achieved	
Shift leader SN	-	Achieved	

*Following change in establishment

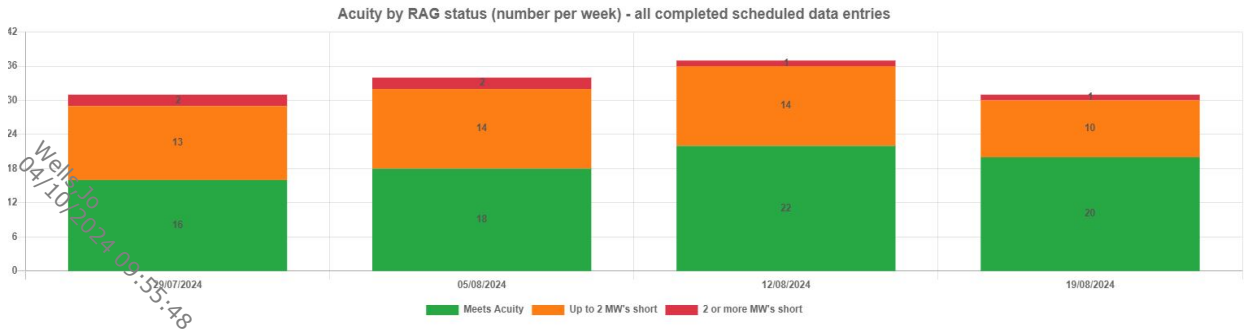
Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 79% of the expected intervals therefore the data presented is now reliable.

The diagram below demonstrates when staffing was met or did not meet the acuity. From the information available the acuity was met in 57% of the time and recorded at 43% when the acuity was not met prior to any actions taken. This is an increase to the previous month and is likely inaccurate due to 40% of the data missing. This indicator is recorded prior to any actions taken. Safe staffing levels were maintained on all shifts in August following the mitigations taken that are detailed below.



The mitigations taken are presented in the diagram below and demonstrate the frequency (n=25 occasions) of when staff are reallocated from other areas of the inpatient service. In addition, there were three reported occasions when the continuity teams were deployed to supported the inpatient area. There were three report of staff not being able to take breaks and no reports of staff staying beyond their shift time. There were two reported concern escalated to the manager on call.

Number & % of Management Actions Taken

From 01/08/2024 to 31/08/2024

MA1	Redeploy staff internally	25	74%
MA2	Redeploy staff from community	1	3%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	3	9%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	2	6%
MA8	Staff sourced from bank/agency	1	3%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	2	6%
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. There were three red flag reported in August – the SL reported that they were not supernumerary during the shift, however they were rostered to be supernumerary at the onset of the shift -this was for a short period of time whilst escalation was initiated.

Number & % of Red Flags Recorded

From 01/08/2024 to 31/08/2024

RF1	Delayed or cancelled time critical activity	1	33%
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	2	67%

Antenatal & Postnatal Wards

The ward acuity tool was relaunch in November. Training has now been completed and the tool was officially relaunched in February. The compliance for completion remains below 80% and therefore the data cannot be reported as it is unreliable. Further work is ongoing with the teams.

Staffing incidents

There was one no harm staffing incidents:

1. Role specific mandatory training cancelled for one midwife

Medication Incidents

There were two no harm medication incidents:

1. Insulin not prescribed
2. Medication not given

Monitoring the midwife to birth ratio

The ratio in August 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 multi professional huddle 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 Deputy Director of Midwifery with an escalation to the Director of Midwifery as required. Additional huddles were held in Aug to maintain safe staffing and manage flow. 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.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	78%	100%	n/a	n/a
Antenatal Ward/Triage	91%	94%	90%	84%
Delivery Suite	93%	97%	51%	90%
Postnatal Ward	92%	94%	83%	85%
Meadow Birth Centre	60%	56%	81%	65%

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.

National Maternity SitRep

The national COVID SitRep was stood down in October. A revise national maternity submission is now available and is completed each fortnight; it is expected that the regional SitRep will be rolled out across England – this is still awaited.

Vacancy

There remains 22 unfilled clinical midwifery posts and 3 unfilled specialist roles – vacancy rate at 10%. Following a successful recruitment event 17 WTE midwives have received offers and are expected to be on boarded by the end of November 2024. Start dates have now been confirmed.

There are 6 WTE MCA posts vacant with plans to recruit.

Sickness

Sickness absence rates for midwives were reported at 3.75% and 11.89% for non-registered staff – midwife sickness now below Trust target. An increase in non-registered staff.

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.

Turnover

The rolling turnover rate is at 9.79% for midwives and at 13.64% for non-registered staff. The PDM for MSW/MCA is currently working with HR to ensure that this group are aware of the Trust offer around Health and Wellbeing and also the development opportunities.

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
- SitRep report completed three times per day
- Monthly 'drop - in' sessions led by the DoM.
- Safety Champion walkabouts

- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

Conclusion

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 25 occasions to maintain safety. The community and continuity of carer midwives were required to support the inpatient team on three occasions.

Three red flags were reported via the acuity app; the supernumerary status of the shift leader at the onset of the shift was maintained and 1:1 care in labour was achieved. Of the three datix reports for staffing and medication incidents submitted, no harm was identified.

Sickness absence rates for midwives are now below the Trust target. Thy have increased for non-registered staff. Ongoing actions are in place to support ward managers and matrons to manage sickness effectively and maintain improvements.

The rolling turnover rate is at 9.79% (MWs) and 13.64% (MSWs & MCA's). The vacancy rate is at 10% for MWs and 14% for MCA's. There are 17 WTE midwives in the pipeline and further recruitment is planned for the 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.

Recommendations

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	Trust Values Proposal
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	People & Culture
If Other, provide details:	
Lead Chief Officer/Director:	**Director of People and Culture**
Author:	Ali Koeltgen, Chief People Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To propose the introduction of a new set of core values for the Trust, co-designed with colleagues, reflecting our commitment to provide a safe and caring environment for colleagues to thrive in and provide the best care to our patients.

2. Recommendation(s)

It is recommended that Trust Board **APPROVE** the introduction of the following named core values:

1. **Compassion**
2. **Openness**
3. **Respect**

It is recommended that Trust Board **APPROVE** the development and co-creation of an implementation plan, detailing the retirement of 4ward signature behaviours, **NOTING** that this plan will be monitored closely by the People and Culture Committee.

3. Executive Director Opinion[1]

The co-creation of an authentic set of Trust values is a fundamental step forward in the development of our Trust culture. Through engagement and testing with over 500 colleagues, across a multitude of locations and professional groups, we are confident that the proposed statements are representative of the values that matter to our workforce.

Subject to Board approval, further work will now take place with our colleagues and engagement groups to build an implementation plan to embed the values into our Trust.

4. Please tick box for the Trust's 2023/24 Objectives the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☒ ***Best services for local people***

☒ ***Best experience of care and outcomes for our patients***

☐ ***Best use of resources***

☒ ***Best people***

Values Proposal

Introduction

Values statements are important to the ethos of the NHS, serving as guiding principles that shape our culture, inform our practices, and influence our interactions with patients and colleagues.

Clearly articulated values provide a framework for decision-making, set expectations for behaviour, and foster a shared sense of purpose amongst our colleagues. The co-creation of this authentic set of Trust values is a fundamental step forward in the development and improvement of our Trust culture.

Values Development Methodology

The following principles and aims were used to guide the co-creation process:

- Create values that are clear, ambitious and co-produced with colleagues.
- Use a 'Toward' methodology – inspire people to the future.
- Work towards the retirement of the '4ward' signature behaviours, whilst learning about what colleagues valued.
- Ensure the process relies on engagement with colleagues and their direct input about the values that matter to them.
- 'Play back' and test the values colleagues tell us are important.
- Create a sense of shared ownership and ambassadorship with colleagues.
- The values development is the start of a multi-year journey to shape and nurture a culture that we are proud of.
- Gather insight on how to effectively embed the values as a fundamental part of our culture.

The proposed values were developed over a series of engagement sessions with representatives from a cross section of professional groups, teams and sites - reaching over 500 colleagues in total.

A representative cross-section of our workforce had the opportunity to contribute by participating in virtual and in-person workshops as well as a series of self-facilitated sessions in a variety of teams. The latter being designed in response for requests to find a way to enable more people to share their view.

Proposed Values

The values development process has enabled us to identify consistency in beliefs, language and meaning. The three core values colleagues told us were fundamental to the culture they want to be part of are:

- **Openness**
- **Compassion**
- **Respect**

This has been further developed into a series of statements that underpin the values, elaborating on what colleagues told us the words mean to them, and the underpinning beliefs behind the language used.

Openness	
We believe in…	Being open and honest
What this means…	We all communicate clearly and honestly, asking for help when we need it and making it easier for the people around us to share ideas or concerns.

Compassion	
We believe in…	Ensuring people feel cared for
What this means…	We all take responsibility for actively supporting and nurturing a kind and compassionate environment for ourselves and others.

Respect	
We believe in…	Showing respect to everyone
What this means…	We all act with consideration and fairness, valuing each other as individuals and appreciating our different perspectives

Conclusion

The implementation of the proposed core values **Openness, Compassion and Respect** is an opportunity for Worcestershire Acute Hospitals NHS Trust to reaffirm our commitment to colleagues and patients, to improve the experience of people that encounter our services or work within them. These values align strongly with the NHS constitution[2] and were shaped by a cross section of colleagues who told us what mattered to them, in their own words.

Recommendations

The Board is requested to:

1. Approve the proposed new values.
2. Approve the development and co-creation of an implementation plan with colleagues, detailing the retirement of 4ward signature behaviours, noting that this plan will be monitored closely by the People and Culture Committee.

[2] NHS Constitution — Glossary (hee.nhs.uk)

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Worcestershire Acute Hospitals NHS Trust

Minutes for Quality Governance Committee

Thursday 29th August 2024 at 10.00 am
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director (Chair)	**Y**
Required Attendees	Sarah Shingler	Chief Nursing Officer	**Y**
	Rachel Dunne	Deputy Chief Nursing Officer - ICB	**Y**
	Justine Jeffery	Director of Midwifery	**Y**
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	**Apols**
	Helen Lancaster	Chief Operating Officer	
	Simon Murphy	Non-Executive Director	
	Vikki Lewis	Chief Digital officer	**Apols**
	Michelle Lynch	Associate Non-Executive Director	**Y**
	Edwin Mitchell	Associate Divisional Director - SCSD	
	Nicholas Purser	Surgery Governance Lead	**Apols**
	Stephen Collman	Managing Director	**Apols**
	Alison Robinson	Deputy Chief Nursing Officer	**Apols**
	Rosemary Smart	Public Patient Forum	**Y**
	Susan Smith	Deputy Chief Nursing Officer	
	Sue Sinclair	Associate Non-Executive Director	**Apols**
	Jules Walton	Acting Chief Medical Officer	**Y**
	Julian Berlet	Acting Chief Medical Officer	
	Chris Byrne	Healthwatch	**Y**
	Erica Hermon	Company Secretary	
Attending	Chris Douglas	Director of Performance	**Y**
	Rebecca Brown	Chief Information Officer	**Y**

Item	Title
QGC/24/1	**Welcome and Apologies for Absence**
	Dame Julie welcomed all present at the meeting.
QGC/24/2	**Declarations of Interest**
	There were no new declarations of interest raised.
QGC/24/3	**Minutes of the last meeting**
	The minutes of the meeting held on the 25th July 2024 were confirmed as a factual representation of the meeting and approved.

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QGC/24/4	**Action Schedule**
	Progress on the outstanding actions were reviewed and updates received.
QGC/24/5	**Escalations from Chief Medical Officer and Nursing Officer for items outside of standard report / not on the agenda**
	Ms Shingler informed that the CQC visited the Trust the previous day for an unannounced inspection of stroke services. It was a positive inspection and no concerns were raised. The draft report was awaited. The CQC would likely return to complete a medical core service review at some point. Dame Julie queried whether the inspectors had specialist knowledge of stroke. Ms Shingler replied that they did. A specialist advisor of stroke along with a specialist advisor from social care in regard to the Mental Capacity Act.
QGC/24/6	**Best Services for Local People**
QGC/24/6.1	**Perinatal Safety Report**
	Ms Jeffery presented the report and highlighted the following key points: • Workforce KPIs highlighted reduced sickness absence. • Trust mandatory training for junior doctors still requires improvement. All divisions are experiencing the same issue due to rotation. • PDRs are currently off track but was an area of focus. This will continue to be a challenge until there is an improvement in staffing. An improvement should be seen in Q4. • Role specific training KPIs were on track. • There were ongoing staffing issues with middle grades. Mitigations are being put in place. • QIS training is underway. • Complaints and triangulation with the CQC survey has highlighted an issue within the post natal ward. Delays in medication, bladder care and attitudes and behaviour had been raised. Focused work is underway. • Delays in induction was 30%. Increased staffing over the winter should have an impact. • CNST was 91% with implementation of saving babies lives. The figure will be validated next month but there was confidence that 10/10 would be achieved. • A regional heatmap was included within the report and the Trust was now green. Dame Julie queried the drug rounds issue. Ms Jeffery replied that midwives provided personalised care but unfortunately due to staffing issues, there had been delays. Self-administration had previously taken place but was ceased due to issues. Drug rounds would be implemented urgently and observation work was underway. Ms Shingler advised that no harm was being reported as a result, however there had been an increase in complaints.
	Resolved that: The report was noted for assurance.
QGC/24/6.2	**Perinatal Incident Report**
	Ms Jeffery advised that 1 neonatal death was reported in July. The patient attended with reduce foetal movements. A review was underway. A campaign was currently underway in relation to reduced foetal movement in order to raise awareness. 1 moderate harm incident was reported in relation to a uterine rupture. The issue was identified and the patient transferred to theatre promptly.

	A patient had died 1 year post delivery. The patient had a lot of support from the Trust community safeguarding midwives, however there was issues with engagement. Ms Smart referred to Badgernet and queried whether any consultant or GP could access it and whether there were any issues. Ms Jeffrey replied that there were various means of access for GPs and was not aware of any concerns. The Trusts works closely with GP colleagues through the LMNS lead. Ms Dunne added that concerns are monitored and nothing of significance had been reported in relation to Badgernet.
	Resolved that: The report was noted for assurance.
QGC/24/6.3	**Midwifery Safe Staffing Report**
	Ms Jeffery updated that there had been improvements around sickness absence management. Red flags had been met in month. 1:1 care and supernumerary status were met. The 6 monthly tabletop for Birthrate+ has been completed which indicates that the funded establishment is correct and no additional midwives were required currently. No harm incidents were reported across staffing and medication. Approx 16wte midwives were sue to start during September and October. Dame Julie asked if there were any issues with recruiting staff. Ms Jeffery replied that there were no issues and there were lots of students planned.
	Resolved that: The report was noted for assurance.
QGC/24/6.4	**Nurse Staffing Report**
	Ms Shingler informed that safe staffing on paediatrics, neonates and all adult inpatient areas was maintained. The Trust remains compliant with national safe staffing recommendations. In July, 19 insignificant or minor incidents were reported. The acuity and dependency reviews have now been completed and would be presented to the Trust Management Board for approval in September prior to Committee the following month. A reduction in agency spend continued to be seen. The average hourly rate remains a focus. The Strategic Workforce Plan is beginning to come into fruition as planned. By the end of month 12, the vacancy rate will be down to 31 RNs. The current vacancy rate for RNs is 6.9%. Dame Julie queried whether the attrition rate at colleges is known. Ms Shingler stated that it is quite high. Conversations were taking place with the University of Worcester in regard to this and sickness levels of students. Birmingham Newham University are providing nursing and AHP courses. In February, the Trust will start taking second year students at Redditch. Ms Shingler advised that the Trust is currently training around 250-300 international nursing students, which is creating pressure for assessors. A majority of the students later return home with their qualification, therefore the Trust is not benefitting from the process. Conversations were taking place with the university regarding financial support to ensure that students are adequately supported at the Trust.
	Resolved that: The report was noted for assurance.
QGC/24/6.5	**Fundamentals of Care**

	Ms Shingler presented the quarterly update from the Fundamentals of Care Committee. The Committee is chaired by Deputy CNOs and oversee basics of care and patient experience operational work. Improvements are being seen. There is good engagement by the divisions. Escalations were highlighted: • Gaps have been identified in pain assessment. • Increase in hospital acquired pressure ulcers. • Sensory boxes provided in ED to support patients with learning disabilities and autism. • Assurance required around risk assessments of boarding patients and comfort rounds. • Reintroducing back to the floor Fridays from 6th September. Ms Lynch referred to the sensory boxes, querying the take up and benefits being seen. Ms Shingler replied that it has only recently been introduced. Training and support has been provided to the ED team. Generally there is little feedback from these groups of patients but ward accreditation in ED was abut to get underway and would provide further assessment of the success. Dame Julie highlighted nutrition and queried where dieticians were included within the report. Ms Shingler replied that the Trust have dieticians who attend the Committee. Focus was on meeting the dietary needs of patients with advanced nutritional needs.
	Resolved that: The report was noted.
QGC/24/7	**Patient Safety**
QGC/24/7.1	**Risk to Patients Relating to Nutrition**
	Ms Shingler informed that there was a significant risk to patients not receiving the adequate nutritional specialist input, guidance and support. This is due to the insufficient resourcing of workforce of the nutrition team. The report was presented to highlight the concerns and steps being taken to mitigate the risk. Across the 3 sites, the Trust only have 1wte band 7 Clinical Nurse Specialist. There was also 1 consultant who has 2 PAs per week to support the agenda. There had been a number of serious incidents and patient deaths where the lack of enhanced nutritional support delayed in patients being fed has contributed significantly. The risk is included on the risk register and Ms Shingler is overseeing a business case which will address the nutrition gaps within the Trust. The risk is fully mitigating those risks currently.
	Resolved that: The report was noted.
QGC/24/7.2	**Patient Safety Incident Investigation (PSII) Report**
Wells Jo 04/10/2024 09:55:48	Ms Shingler provided an overview of the case which related to a non-verbal patient who had severe learning disabilities. Enhanced nutrition support played a significant part with this case, as did lack of consultant oversight, shared ownership of patents and a clear management plan. The case will be going to an inquest and a further neglect verdict is expected, including a regulation 28. The CQC are likely to attend the inquest.

	Work was underway to address the key issues highlighted, but the fundamental part is getting the resources of the team in place. Dame Julie noted that swallowing assessments are managed by speech and language, rather than dieticians. There needed to be a team-based approach and the more professionals that are involved create delays. Dame Julie encouraged looking at multi-skilling professionals. Mr Byrne queried the timescale of resolve. Ms Shingler replied that there are some areas outside the nutrition team that would lower the risk. Outlying patients outside of their specialist wards was an issue, boarding and moving patients. The business case was almost finalised but recruitment would need to commence. AHP recruitment from a dietician point of view may be more problematic. Ms Walton advised that there are some timelines included within the report, which the teams are working to. Ms Smart stated that the investigation has been exemplary and has highlighted some known issues. Ms Smart highlighted the lack of junior staff knowledge about fluids, which was quite surprising. Ms Walton informed that the issue was the oversight, which was concerning and was a reoccurring theme in a number of PSI's. Effective management discussions were taking place with clinical teams. Dame Julie observed the lack of team structure causes issues, particularly with junior doctor supervision and little oversight of the patient's care. Dame Julie queried whether alerts could be built in to an electronic system. Ms Walton replied that there is a working group reviewing IV fluids and the implementation of the EPMA. Ms Smart cautioned attitude and basic caring for patients, including viewing patient history. Ms Brown advised that there were support opportunities within EPMA and there was other digital learning from the case which had been taken in terms of record keeping issues. Dame Julie requested a progress update at a future meeting.
	Resolved that: The report was noted.
QGC/24/7.3	**Patient Safety/Clinical Governance Report Q1**
	Ms Walton updated that there was only 1 serious incident remaining on the previous framework which is being finalised. The others have been moved across to PServe. Tissue viability/pressure ulcers are highlighted as the highest incidents reported. Long waits in the ED are also linked to tissue viability as a consequence. Work was ongoing across the system in terms of pre-hospital and primary care elements. There was confidence of displaying a positive reporting culture. Dame Julie queried how the rollout of EPRR may affect medication errors. Ms Walton replied that prescribing should improve, however medication errors were often human error. Dame Julie queried the steps of mitigation for pressure ulcers and ED waits. Ms Shingler replied that repose mattresses were on trolleys in ED but some patients

	require specialist mattresses but there was limited space in ED for beds. One of the Deputy CNOs is managing the confirm and challenge meetings for a short period to ensure that rounds were being completed and every single incident is reviewed.
	Resolved that: The report was noted for assurance.
QGC/24/7.4	**Patient Safety Alerts Report**
	Ms Walton updated that 4 new national patient safety alerts and 20 other safety alerts had been issued over Q1. All had been acknowledged within the allocated 2 day framework. There were 2 outstanding PNSAs for Q4 but both had plans in place. 4 are currently open in total but should be closed within the appropriate timescale.
	Resolved that: The report was noted for assurance.
QGC/24/8	**Best Experience of care and best outcomes for patients**
	Experience
QGC/24/8.1	**Integrated Performance Report**
	Mr Douglas presented the report and updated that improvements continued to be seen in a number of areas. Ambulance handover delays continued to decrease, however there had been some recent challenging days, linked to IPC challenges and flow on the Worcester site. EAS remains challenged with discharges. Divisions were challenged regarding support at the Finance & Performance Executive meetings. The ED flooring scheme was commencing imminently. There may be an impact on performance while the work is underway. Cancer faster diagnosis standard in July was 79%. Only 2 specialties (lung and urology) were not achieving the standard. The Trust was not an outlier. 62 days is over 70% for the first time for a number of months. Lung performance delays were being monitored by the region. Additional funding from the Cancer Alliance was available to support additional posts into lung cancer. £150k was available to recruit an additional consultant. 31 day performance was decreasing and receiving national focus due to performance in the skin cancer pathway. In July, no patients waiting more than 78 weeks for treatment were reported. There were 365 patients waiting 65 weeks but the target for September was to deliver 0, which was currently looking unlikely to achieve. DNAs remain at 5%. Rollout of Octopus was under way, which was a room booking system for clinics and theatres. The Urology Intervention Unit and the Urology Same Day Emergency Care opened at the beginning of the month and will have a direct impact on A&E performance and cancer pathways. Kidderminster was accredited as a surgical hub and a further application was being considered for the Alex hub. Dame Julie queried whether the £150k of funding was recurrent. Mr Douglas that it was not. A business case will need to be drafted. Ms Lynch noted that lost hours remained high and asked what was being done to mitigate. Mr Douglas replied that there are fewer handover delays but there were protracted delays. There is a national move to a 45 minute handover which would form part of schemes of work of the weekly Emergency Access Standard meeting.

	Ms Walton informed that a refocus was required as ambulance handover delays and lost hours are one of the biggest patient safety risk and one of the biggest quality concerns because of the far reaching impact. Actions would be reviewed. Ms Shingler informed that the target to close complaints within 25 days is deteriorating. Out of the 139 open complaints, 60 have breached 25 days. Out of the 60, 53 sit within surgery. Interventions around governance have been made into surgery and positive changes are now being seen. A trajectory to clear the backlog was awaited. The total number of falls in July did significantly reduce from 128 to 93. The Trust remained below the national benchmark, however 4 falls resulted in moderate harm. All cases have been reviewed and there is oversight within the framework. Ms Walton stated that issues were ongoing with sepsis screening and neck of femur compliance. Teams were focused on trying to establish a solution. Dame Julie stated that assurance had been given that EPMA would improve sepsis screening but did not appear to be. Ms Walton advised that the issue was trying to reproduce the paper method within the EPR which is not working. A review of the whole process was being reviewed. Other Trusts had been approached but little feedback had been received. A further workshop was planned for next week. A fortnightly operational meeting is taking place which was overseeing the neck of femur pathway. It has been identified that more T&O bed capacity was required along with moving medically fit patients more timely into the community. An update on Ortho-geriatricians would be provided at the next meeting. Ms Shingler advised that the target for the Friends & Family Test was not being met. The inpatient survey had been implemented 6 months ago. 1700 patients complete the survey in July and do not often then complete the F&FT in addition. A proposal for approval would be presented to the Committee. The feedback received from the inpatient survey was more beneficial for the Trust to drive improvements. Dame Julie suggested expanding the inpatient survey to cover the F&FT element.
	Resolved that: The report was noted for assurance.
QGC/24/8.2	**TIPCC Q1**
	Ms Shingler presented the report and highlighted the following key points: The issue of capacity remains challenging, particularly with flow, length of stay, overcrowding in ED and boarding of up to 28 patients across medical and surgical wards at Worcester. All of these elements impact on IPC; the ability to clean areas and proximity of patients. The Trust is over trajectory in all reportable organisms for Q1, except for MRSA. The Trust remained at 0 MRSA. There had been several outbreaks of CPE, notably an Avon 4 outbreak which was declared on 14th May and had a total of 16 cases which were attributable to that ward. The ward was closed and deep cleaned. The number of cases have significantly reduced but there had been 4 cases since the ward reopened on 18th June. Drainage and environmental swabbing was underway as the source has not been identified. Progress was being made with water safety. The Trust now has a Water Safety Plan in place and compliance was being worked through. C-diff was significantly over trajectory. Most cases sit within medicine, as expected.

	The review process has been scrutinised and micro-biologists are involved with reviewing every case. Notably, there had been no c-diff outbreaks and are individual cases. The micro-biologists are completing a deep dive into the cases. NHSE had been approached to review the action plan and the region lead had been invited to complete walk arounds over the coming weeks. Covid remains a challenge, with 56 inpatients. Concern was highlighted about the inability to recruit a Deputy DIPC. Currently there was no head of IPC either currently. The job description has been reviewed and made the role an Associate CNO as well as the DIPC in order to attract applicants. A recruitment agency was being used. The gap with IPC management was included on the risk register. The oversight of the cleaning process has been strengthened and audit scores are improving but needs to be sustained. Macerators are being trailed on the Worcester site currently.
	Resolved that: The report was noted for assurance.
QGC/24/9	**Governance**
QGC/24/9.1	**Professional Bodies Update**
	Ms Shingler presented the update regarding the number of cases referred to the NMC and the HCPC, for information.
	Resolved that: The report was noted for assurance.
QGC/24/9.2	**Risks**
	Ms Shingler advised that the key risks had been discussed and the report was taken as read, for information.
	Resolved that: The report was noted.
QGC/24/9.3	**Trust Transfusion Committee Report**
	Ms Walton advised that the Trust was still in an amber alert state due to decreased supplies nationally. Fortnightly touchpoint meetings were taking place with the EPR team, transfusion team and office of the CMO. There were no concerns. Blood track was moving to an electronic system and the rollout has commenced.
	Resolved that: The report was noted.
QGC/24/10	**Committee Escalations**
	Trust Board
	Escalations: C.diff action plan.
QGC/24/10.1	**Other Committees**
	No further items for discussion.
QGC/24/11	**Any Other business**
	There was no other business.
QGC/24/12	**Reflections on the meeting**
	There were a lot of areas of progress but understanding the issue was paramount.
QGC/24/13	**Close**
	The meeting closed at 11.30.

Worcestershire Acute Hospitals NHS Trust

Enc A

AUDIT AND ASSURANCE COMMITTEE

Minutes of the Meeting held on Thursday 11 July 2024 at 10.00am held via MS Teams

PRESENT:		
CHAIR:	Colin Horwath	Non-Executive Director
MEMBERS:	Simon Murphy	Non-Executive Director
	Tony Bramley	Non-Executive Director
	Karen Martin	Non-Executive Director
IN ATTENDANCE:	Simon Murphy	Non-Executive Director
	Neil Cook	Chief Finance Officer
	Lynne Walden	Associate Director of Finance (Financial Services & Coding)
	Emma Masters	Internal Audit
	Craig Bevan-Davies	Counter Fraud
	Kristina Woodward	Internal Audit
	Stephen Collman	Managing Director (for item 010/24)
	Jules Walton	Interim Chief Medical Officer
	Fiona Dwyer	Anti-Crime Specialist
	Vikki Lewis	Chief Digital Information Officer
	Tom Brown	Chief Technology Officer
APOLOGIES:	Erica Hermon	Company Secretary
	Paul Westwood	Counter Fraud
	Zoe Thomas	External Audit

001/24 **WELCOME AND APOLOGIES FOR ABSENCE** **ACTION**

Mr Horwath welcomed all to the meeting. There were no further items of business identified.

002/24 **DECLARATIONS OF INTEREST**

There were no new declarations of interest. Declarations are available on the Trust's website.

003/24 **MINUTES OF MEETINGS HELD ON 8 MAY AND 25 JUNE 2024**

The minutes of the meeting held on 8 May and 25 June 2024 were approved.

RESOLVED THAT: The minutes of the meeting held on 8 May and 25 June 2024 were approved.

004/24 **Matters Arising and Action Schedule**

The action schedule was reviewed and updates were noted.

Internal Audit

005/24 **Job Planning Update**

Ms Walton joined the meeting.

A theatre governance update had previously been provided. All actions have been completed and assurance levels of 6/7. Good progress had been made.

Ms Masters updated that she had attended some of the governance meetings and seen evidence to close down open actions. Thanks were extended to the team.

Ms Walton referred to high earners and advised there is still work to do in this area which will not be resolved quickly, neither will job planning.

There had been some progress with agency spend and medical agency spend is reducing. There is oversight by the CMOs who are reviewing all spend off framework. Divisions all have CPIP that is linked to it and were committed to swap out as and when they can.

Job planning will aid recruitment and will drive down agency.
There are inconsistencies in the foundation of processes. Historic issues are being worked through and trying seek a resolve in order to move forward.
A set of rules will be identified about what job plans should look like, which is fair and equitable and will be published.

Mr Horwath gave thanks for the work being done.

Ms Martin noted the timescales and assurance provided with picking up good practice from elsewhere and asked where the project is being monitored. Ms Walton replied that she was the lead and progress will be reported through the Medical Agency Workforce Group. Oversight reports were also presented to the People & Culture Committee.
Mr Horwath agreed that regular routine scrutiny should sit with the P&CC.

Mr Murphy cautioned that there has been limited progress on actions relating to bank and agency following the zero assurance report.
Mr Collman replied that teams were working together and reviewing resource with job planning. The team were also working closely with SWFT.

Mr Cook asked that financial risk is reported into the right place.

Mr Horwath welcomed short term reassurance of monitoring to the Committee. Ms Masters to review recommendations and dates with Ms Walton and will share with the Committee. **Action**.
Ms Walton was invited back to the Committee in 6 months with a further update.

Ms Walton left the meeting.

2024/25 Internal Audit Plan
Ms Masters introduced the Internal Audit Plan which had been presented at May Committee and internal Audit Charter was now included. Approval of the plan was sought and Committee members were asked if there were any amendments.

Mr Bramley observed that there were a large amount of items for reconsideration for 25/26 and encouraged prioritising the list. Mr Bramley referred to the PFI exit and recommended it for next year for the best chance of success.

Mr Horwath was concerned that it was a large list and not enough time. He noted a high degree of reviewing topics already done. Mr Horwath suggested an internal review of the topics as it was critical to get it right and have action plans in place. It

was suggested that some items were deferred to create more space for other issues not looked at.

Mr Cook informed that a discussion had taken place the previous day. Committee were given the opportunity to review prior to referencing any changes. PFI should be supported. Mr Cook queried whether any learning was being taken from Wye Valley.

Mr Collman noted that there is no particular theme to the list and asked for clarity about what was being audited for better outputs. Mr Horwath encouraged providing a further report with commentary.

Mr Murphy encouraged taking Chairs actions on items that need it. Ms Masters stated that she could share the plan before the next Committee. There is a PFI review, which includes the external review. A meeting was planned with Ms Lancaster to scope areas.

Ms Woodward advised that the list was first shared in November, prioritised and agreed with Executives. The Plan for 25/26 starts in November.

Progress Report
Ms Masters advised that page 2 outlines the current completed audits and on the agenda.
Bank and agency had been finalised and will come to September Committee.
Internal auctions and details were within the appendix.
Updates had been made on the plan.
2 ToR's were detailed in the report: DSPT and Head of Internal Audit Opinion.
KPI's and the action tracker were detailed.

DSPT Report
Ms Masters advised that it was a positive report and only 2 recommendations made. There was moderate assurance of the risk assessment and self-assessment.

Mr Horwath was assured that work is progressing well.

Head of Internal Audit Opinion
Ms Masters presented the report for information. A place governance and compliance framework has been put in place.

Mr Cook stated that a formal response would be bought to the next Committee.

Ms Masters advised that there was limited assurance. There were concerns around risk management strategy and the BAF. A new strategy was now in place.
The scope was yet to be agreed and a meeting was scheduled on Monday with Ms Lancaster. A new Accountability Framework was being developed and should be used across the organisation.

Mr Bramley queried whether concerns were flagged with Mr Horwath.
Ms Masters replied that a monthly update is provided regarding audit but any emerging concerns can be included. Mr Collman encouraged raising with Executives also.

RESOLVED THAT: The reports were noted.

Counter Fraud

006/24 **Counter Fraud Progress Report**

Mr Bevan-Davies highlighted the 23/24 standard return was submitted and was green throughout. A review of all work was being done against the requirements and mapping against the requirements against the workplan would be presented at the next meeting.

Fraud new and emerging risks were highlighted within the report and alerts within the appendix. One alert issued and causing slight concern was around CEO unsolicited emails requesting faster payments and scam frauds. A rise of AI had been seen and was being used to make emails look professional. Fraudsters are using social engineering to get names of senior individuals then targeting staff members. Raising awareness for staff was being drafted.

2 cases were ongoing. In regard to the first case, the CPS have approved the charges and is progressing to Crown Court with the trial scheduled for later this month. The police have requested more information which has been provided.

The second case has been adjourned until September 2025 due to likely assigning a new barrister.

Ms Martin asked if and how the actions being taken were being used as deterrents across the organisation in our communications. Mr Bevan-Davies replied that it would be a matter for the Trust but reporting outcomes is useful. Mr Collman updated that updated are included in the Worcestershire Weekly bulletin.

RESOLVED THAT: The report was noted for assurance.

External Audit

007/24 **External Audit Progress Report**

No External Audit members were present.

RESOLVED THAT: The report was noted.

008/24 **Security Annual Report**

Ms Dwyer joined the meeting to present the Annual Report and highlighted the following key points:

Body cameras are worn at both Worcester and the Alex and have been used in HR investigations. 6 cameras had been purchased for Kidderminster.
Violence and aggression incidents have increased but it is being seen as a positive that people are reporting them.
Yellow and red alerts are being issued.
Racism and sexual related incidents are being tracked. 15 incidents had been reported related to race and 9 incidents related to sexual harassment.

Physical assaults and intent were monitored. 264 unintentional assaults were reported and only were 60 intentional. Most have been on frailty wards and there is training in place. 1 incident resulted in adding an extra security guard to a ward for patient safety.
There have been issues in learning and development.
The team had concentrated on the ability to lockdown areas and improvements made at the Alex.
The Trust worked with the police and clinical staff regarding welfare checks.
A process has been put in place for absconders.

Mr Murphy noted some of the trends and the increase of the reporting and queried the outcome when presented to Committee. Ms Dwyer replied that the report is reviewed by the Health & Safety Committee and Security Group. It clearly required a reporting route. Ms Martin did not recall receiving a formal report through the People & Culture Committee.

Mr Bramley informed that he is the NED lead for security. The Security Group was newly formed and queried the membership. Ms Dwyer replied that the membership includes matrons, divisional reps, security and health & safety. It is an open forum, meeting monthly to raise concerns for learning and welcomed Mr Bramley to join.

Mr Collman stated that violence and aggression is a health and wellbeing issue for staff. Incidents relating to frailty patients is a clinical issue. Mr Collman encouraged linking in with H&C Trust partners. Putting in extra security on a frailty ward isn't the resolve.

Ms Dwyer left the meeting.

RESOLVED THAT: The report was noted.

009/24 **Cyber Security**

Mr Brown joined the meeting and Ms Lewis circulated a presentation, providing the following update:

The Pathology attack in London recently is still ongoing and was a supply chain issue breach. The team had been speaking with colleagues around their security.
17 high severity alerts had been reported.
NHSE are putting more into the universal offer. The Trust email system is run nationally by NHSE and their cyber security benefit.
A threat was reported in Scotland with email phishing.
The Trust had invested in a security operations centre (Wavenet) and were in the process of setting up a SOC with a more visual view of our cyber security.
The Chair is keen that Committee is sighted on KPIs and the risks. It is a fluid landscape that changes all the time.

Mr Bramley was interested in how we can successfully manage the risk in the supply chain as it's a vulnerability and queried how it is resourced and managed. Mr Brown replied that there are a number of suppliers who have access to our systems but assurance was required that they have appropriate checks in place and whether they are a manged or hosted service. The Trust have 2 data centres which we control.

Mr Murphy asked whether the team have everything they need to deliver on what we need to do to keep ourselves safe. Ms Lewis replied that they did not. The SOC was beneficial but internal resource needed to be considered. Mr Brown replied that the team have procured tools to make the Trust secure but were struggling with resource to manage it as there was no dedicated resource. A request was being created for 3 cyber security managers. A consultant was assisting who is paid through capital but there was a need for dedicated resource. Ms Lewis reiterated it is financially challenged.

Mr Bramley suggested collaboration with the Foundation Group and the ICB as all faced the same types of threats and queried whether activity, intelligence and resource could be shared. Ms Lewis informed that intelligence is shared but all were in a different place due to complex delivery landscapes. There will be opportunities over the next 5 years into a more consolidated view. Cyber security specialists are a scarce and skilled resource. Mr Brown recommended using a single SOC provider with the ICS for collaboration.

Mr Horwath thanked the team for the work being done, noting the limited resources. Mr Horwath was assured that steps were being take for improvements and the Trust was as secure as it could be, but those who wish to do harm are innovative and determined. There was limited assurance but the team were doing the best they can. The Committee should have oversight and will review in the annual cycle of the Committee. Mr Bramley suggested regular updated as threats are getting more extreme.

RESOLVED THAT: The report was noted.

016/24 **Waiver Update**

Mr Cook suggested that the report was presented quarterly and it was last presented in May.

For Information

017/24 **Any Other Business**

There was no other business.

018/24 **Committee Escalations**

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	#WeAreVolunteering 2024-2025
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Other
If Other, provide details:	Fundamentals of Care Committee
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Anna Sterckx Head of Patient, Carer and Public Engagement Janet Neate, Volunteer Manager
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The purpose of this report is to provide an update for assurance and a position statement on developments and focus on volunteering 2024-2025.

2. Recommendation(s)

The Trust Board is invited to:

- **Note** the contents of this report, which highlights ongoing development of the Volunteering Service at the trust.
- **Note** the additional resource required to provide equity with other Foundation Group trusts and to support Worcestershire Acute Hospitals to develop approaches to support current and future NHS pressures.

3. Chief Officer/Executive Director Opinion[1]

We have a small but committed volunteer team in the trust who are well connected with our Foundation Group partners and the wider ICS/VCSE system. The team have been working closely with Helpforce to develop a proposal to discharge patients home sooner and to provide follow up support to help combat loneliness. It is evident when looking at the volunteering resource across the Foundation Group that the team will be able to deliver so much more and support the patient flow and fundamentals of care agendas with a small investment.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☒ ***Focus on Flow***	☒ ***Think/Act as a Lead Provider***
☐ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

Meeting	Public Board
Date of meeting	08.10.2024
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#WeAreVolunteering 2024-2025: an update

Introduction/Background

387 volunteers are currently registered as supporting Worcestershire Acute Hospitals Trust. 161 volunteers are registered as direct Trust volunteers supporting across the three main hospital sites. These volunteers are encouraged to record their hours and in Q1 3348 hours were recorded which equates to £54,907.20 of added value. There has been an increase of 14% of hours recorded. Volunteers can record their hours on the Trust's bespoke App which is available to access on personal mobile phones and computers.

Streamlining and Efficiency Approaches – to support capacity and delivery:
A review in 2023-2024 focused on volunteer recruitment and onboarding processes to understand opportunities for improvement and the ability to mobilise volunteers to support with Trust pressures and priorities.

The review has facilitated continued best practice and the ability to understand approaches needed to enhance timely recruitment of volunteers into valued and effective roles.

Outcomes and best practice developments have included:

- The development of a system to monitor recruitment (there are approximately 25 new and potential volunteers being processed at any one time). The staff team continues to work closely with dedicated IT support to develop the bespoke volunteer App which was developed "in house". This App holds demographic data for reporting purposes and supports DBS and mandatory training compliance. Foundation Group members pay annually for their volunteering management systems at a cost of between £560 and £1,100 pa + set up fee.

- A successful pilot supported volunteer staff time by holding group inductions for 12 new Breast-Feeding Friends volunteers in two cohort groups, to onboard these volunteers together over a 6 week period which included all training and recruitment processes. This afforded significant time savings by removing the necessity to repeat the process for each individual volunteer. Staff time efficiencies were observed due to the reduction of individual enquiries and the need to track multiple volunteer recruitment stages. It was noted that additional administration time would be required to replicate this process on a larger scale to effectively co-ordinate recruitment days for volunteers joining a variety of roles (and not limited to all starting in one role at the same time). The approach supported volunteer inductions onto the wards and staff capacity as the Infant Feeding team joined at the induction day. The process additionally facilitated peer support with teams of new volunteers beginning their role at the same time, which in turn supported retention.

- The Trust's 'Adopt a volunteer' initiative has been further publicised to wards, departments and clinics wishing to support volunteers. This enables staff to understand their commitment when working with a volunteer and the role of the volunteer which in turn has supported retention and volunteer satisfaction.

- The Wellbeing and Safeguarding teams have supported the development of a wellbeing offer for volunteers including a leaflet to support the onboarding process. An article in the newly developed Trust volunteer quarterly newsletter includes a focus on wellbeing and support offered if any volunteer encounters a safeguarding concern. The newsletter includes key messaging to minimise queries coming into the volunteer service staff team – this is in

addition to regular bulletins to volunteers and the Integrated *Getting Involved* newsletter with the Herefordshire and Worcestershire Health and Care Trust.

- Volunteers are now offered the Blue Light Card discount system which is available to NHS staff to further demonstrate value and recognition. This is available to access after a set number of shifts and volunteers are empowered to self-sign up.

- Patient feeding support volunteers and associated training led by the Trust has been resumed and Outpatient Transportation was launched in Volunteer Week 2024 to train volunteers to support patients in wheelchairs – these measures enable volunteers to further support patients' physical and mental wellbeing and supports staff capacity to focus on the delivery of clinical care.

- The number of volunteer roles have been increased in response to PALS and complaints feedback and with a focus on staffing capacity support – these include the Accident and Emergency Telephone support role and Dementia Buddy role. The focus is ongoing to develop innovative, impactful and valued roles including new Cancer Quality Assurance steering group volunteers.

Networking and Leadership:

- The Trust is represented at the NHSE Volunteer Lead monthly network meetings to discuss best practice and challenges and to share NHSE updates regarding national initiatives, including the Volunteer recruitment portal and mandatory demographic information collection.

- Worcestershire Acute Hospitals Trust (WAHT) initiated and chaired an inaugural Foundation Group Volunteer Leads quarterly face to face meeting and initiated and chairs a bi-monthly network session. A robust peer support network has been established enabling sharing of local initiatives and positive leadership - for example learning regarding the impact from role development including the Volunteer Led Contact Centre at George Elliott Hospital which was supported by Helpforce. WAHT has demonstrated leadership within the Foundation group by demonstrating the Adopt a Volunteer approach and the volunteer App.

- The Volunteer Manager attends and Chairs on rotation, the Worcestershire Volunteer Leads Forum which is convened by Worcestershire County Council. This includes representation from Community Development and the WeCan group (Worcestershire Volunteer Centres). Joint initiatives agreed and developed include the development of a Worcestershire Volunteer Portal – which is being designed as a one stop shop for all county-wide recruitment opportunities. This is expected to operate alongside a national NHSE portal which can link volunteers to WAHT's website.

- The Head of Patient, Carer and Public Engagement Co-Chairs the bi-monthly Worcestershire Engagement Network for those who undertake engagement as part of their role within Herefordshire and Worcestershire ICS organisations. The purpose of the group is to enable ICS partners to collaborate around the community engagement agenda, network, build on best practice, adopt a shared system approach around methods and principles (co-production, lived experience), Asset Based Community Development and share expertise). The group includes leads from VCSE and statutory organisations.

- Links have been developed with the Royal Voluntary Service, the League of Friends at the Alexandra Hospital and at Redditch, the Friends of Worcester and the Charles Hastings

Education Centre's Charity museum volunteers to support the promotion of their volunteering opportunities which further support patient's and loved one's wellbeing. The number of volunteers engaging with these groups is now included where possible in the Trust's volunteering numbers to provide parity when comparing volunteer numbers with other members of the Foundation Group.

Opportunities and Learning to enhance capacity:
To bring WAHT in line with Foundation Group Trusts, there is opportunity to develop the volunteering substantive team, to offer targeted support to the Discharge process and teams, the Virtual Ward project and Outpatients to support with patient flow.

The current staffing team which is comprised of 1.8WTE (1WTE Band 6 Manager and 0.8 Band 4 Administrator) is at capacity and there is a requirement to develop the administration support within this staffing team, to support a greater number of volunteers to be recruited. 1WTE Band 3 would enable a greater number of volunteers to be successfully onboarded and would support recruitment to drive the additional projects, developments and impact that is being realised at other Trusts.

The recommended approach is to work with Helpforce (in line with learning from George Elliott Hospital and Trusts nationally) to develop the Volunteer Offer and demonstrate impact through the recruitment of a team of Responder Volunteers who would support a timely discharge (collecting TTOs and delivering key discharge tasks), a Contact Centre volunteer led service which would facilitate comfort calls following discharge to identify issues/signpost for community support.

This approach would be further supported through referrals to NHS Responders to utilise their telephone befriending service, shopping service and/or in-home befriending service which helps to combat social isolation and help prevent readmission. The NHS Responder Driving Support Plus service could also be utilised to support Virtual Wards by delivering and collecting small pieces of equipment. Requests for NHS Responder support would be made directly by ward staff who then monitor task take-up via a dashboard. The volunteering team would be required to have oversight to enable initial set up, staff communications and impact reporting. NHS Responders comes at no cost as a service, however this would need to be managed by the Volunteering Staff team and would require support from an additional staff member to provide dedicated staffing support. This post holder would also support development of an emerging additional discharge support service for Carers as outlined below and would support current capacity with recruitment to ensure the Trust is prepared for the new NHSE and Worcestershire Volunteer Portals – and the associated increase in volunteering enquiries and successful onboarding.

Carers at Discharge Support:
Additional support for Carers can be accessed through the Worcestershire Association of Carers / Worcestershire County Council's Accelerating Reform Fund (ARF) partnership. The aim of the ARF is to address barriers to adopting innovative practices and build capacity in adult social care. The priorities for innovation and scaling cover a broad range of areas under the 3 objectives of the Government's 10 year vision for adult social care reform. WAHT has joined the partnership initially through the Head of Patient, Carer and Public Engagement and a priority area is services that reach out to, and involve, unpaid carers through the discharge process. Additional staffing resource as detailed above, in the volunteering team is required to support delivery, ensure that this project is linked with NHS Responders and the potential partnership with Helpforce and that impact is measured and understood.

Meeting	Public Board
Date of meeting	08.10.2024
Paper number	

NHS Responders overview – all services delivered at no cost to the Trust by volunteers who are managed by NHS Responders:

- Prescriptions and small equipment can be taken to a patient after discharge (to support Virtual Wards). This excludes controlled drugs or biological samples
- Referrals can be made for social support for up to 6 weeks
- The volunteer can enter the patient's property to help store equipment and medicines (supporting Virtual Wards)
- Training can be provided for Trust staff
- The work requests are sent to volunteers via the GoodSam app. The Trust would have a dashboard giving updates regarding requests
- A Trust in Barnsley who use the pick up and deliver service has seen a reduction in hospital stays of 3hrs/patient on average

The NHS Responders programme has NHS England assurance and governance (DBS checks and Safeguarding) is in line with their guidance. The service is ready to be accessed by the Trust if additional staffing capacity is in place. The trust will be linked with a Regional Relationship Manager for the West Midlands to guide the process.
It is to be noted that WAHT's Virtual wards team has requested volunteering support with the launch of a COPD Virtual ward in September, which will be followed by a GAU Virtual ward. Additional capacity in the volunteering team can also focus on gaining patient, carer and loved ones feedback about service delivery.

Issues and options

The Volunteering for Health NHSE funding application, submitted in Q4 2023-2024 by the Herefordshire and Worcestershire ICS Strategic Alliance for Volunteering was unsuccessful. This bid was intended to draw on VCSE support with one element focused on capacity and discharge through Age UK. Successful bids were more closely aligned to the outcomes of the scheme and demonstrated how the proposed work had potential to bring about ambitious strategic and system change as aligned to system priorities and strategy.

Dissimilarity has been identified between staffing numbers to support volunteering, capacity and flow at George Elliot Hospital and South Warwickshire University NHS Trust when compared with WAHT. This determines that there is no capacity to further develop volunteering at WAHT or to harness existing and potential support from national initiatives which are supporting other Trusts including Helpforce and NHS Responders as well as support from the local VCSE and the local community.

The current WAHT Volunteering Staff team recruits between 5-10 volunteers every month. This is variable and can depend on the time taken by the volunteer themselves to respond to required tasks – for example training requests and DBS checks. The team are processing an average of 25 volunteers at any one time on a rolling basis. 1WTE dedicated Band 3 could increase the recruitment processing capacity to 15 new volunteers a month. Whilst this will increase the number of new volunteers, the net number may remain relatively static throughout the year due to natural volunteer attrition and the type of roles undertaken. The Trust asks for a 6-month minimum commitment and many volunteers undertake their role on this basis as it supports their requirement for university applications and Duke of Edinburgh volunteering for example. The 1WTE Band 3 role would need to be funded as there is no current budget available. It is recommended that this post be developed as soon as possible.

1WTE Band 4 post is required to realise the free support available through NHS Responders (to support development and delivery and ensure the support maximises on opportunity and delivers on impact – as well as ensuring a link with additional partnerships to support with discharge), opportunity through the Worcestershire County Council's Accelerating Reform Fund (ARF) partnership, facilitate the development of volunteering to support Virtual wards and to support with team capacity to manage the recruitment of volunteers as detailed in this paper. This would increase the Volunteer staffing team to 3.8WTE.

A review of approaches taken and in place at other Trusts within the Foundation group has informed this recommendation. Approaches include dedicated roles to focus on specific volunteer project delivery – Hospital Volunteer and Discharge support including Responder Volunteers and Contact Centre support for example. Appendix 1 contains a slide deck overview with Foundation Group Volunteer staffing numbers and volunteer total numbers.

A separate paper will be submitted to Trust Board to provide details about a Helpforce partnership proposal, the outcomes that can be delivered for the Trust in improving patient flow this winter and the required resource which is to be considered as separate to this paper.
It is to be noted that this paper is to be considered as separate to developments with the Patient Voice and Involvement Strategy (expected launch in Q1 2025-2026).

Conclusion

It is evident that the team are committed to increasing the numbers of volunteers that we have in the trust and that they are working closely with other foundation group to share learning and best practice.

Meeting	Public Board
Date of meeting	08.10.2024
Paper number	

The current staffing team is at capacity and to gain greater equity with other Trusts in the Foundation group to harness opportunity to support patient flow and support clinical staff, additional staffing resource is required amounting to 2.0WTE (1WTE Band 4 and 1WTE Band3).

Appendices

1. Foundation Group Volunteer team staffing structure:

Foundation Group staffing structure Aug

2. NHS Responder slide deck: Help to Improve Patient Flow and Quicker Discharge

Discharge Webinar 180724.pdf

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**08/10/2024**
Title of Report:	Risk Register
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Risks (15+) as at 2 October 2024.

1. Purpose of the report

To present to the Board the Trust's risk register, which identifies the operational risks faced by WAHT.

2. Recommendation(s)

The WAHT Trust Board is invited to note:

- The operational risks faced by WHAT.

3. Chief Officer/Executive Director Opinion[1]

The Trust's extreme risks (scored currently at 15 or above) are provided and are reviewed monthly by the Executive Risk Committee, with a deep dive of each divisions' risk registers taking place on a rotational basis.

Whilst significant improvements have been made to the Trust's risk registers since March 2024, work continues to ensure a consistent and proportionate application of the policy. Included is the need to focus on providing assurance to the Board that effective mitigations and controls are in place and are proving effective in reducing or controlling the risk alongside actions being in place to reduce the risk to achieve the target risk rating.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☐ *Focus on Flow*	☐ *Think/Act as a Lead Provider*
☒ *Governance*	☐ *Improve Staff Experience*
☐ *Home First Mindset*	☐ *Tertiary Partnerships*
☐ *4ward Improvement System*	☐ *Leadership and Structures*
☐ *Elective Care: No Delays*	☐ *Strategic 'Big Moves'*

ID	Opened	Title	Description	Hospital Director or Executive Lead	Rating (initial)	Risk level (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)
4205	20.08.2019	A risk of not being able to manufacture SACT within the trust and therefore inability to meet patient need.	There is a risk of not being able to provide a SACT compounding service within the trust, therefore being unable to meet patient need and cause patient harm. This is as a result of both aseptic units working at or close to capacity limit despite maximising outsourcing of SACT. Both units are out dated and do not meet current guidance. This could lead to SACT supply disruption and delay as this service is required alongside outsourcing for the supply of SACT especially where SACT is short expiry, urgently required, not available from outsource manufacturer or supply is delayed. This could also reduce income to the trust if patient numbers treated need to be reduced.	Chief Medical Officer	12	High	Major	Likely	16	Extreme	4	Moderate
5511	21.03.2024	Aging Mandolite (fire retardant material) used at Alexandra Hospital	Due to the use of Mandolite (used for fire protection) being past its suggested life span, there is a risk that in the event of a fire the compartmentation of the building may be compromised. This could lead to the site`s evacuation times being reduced and escape routes compromised. Resulting in: Enforcement action / fines, potential for injury or harm to patients, staff or public, litigation, reputational harm and prosecution.	Director of Estates and Facilities	20	Extreme	Catastrophic	Likely	20	Extreme	10	High
4167	02.07.2019	Cash Flow - risk that the Trust does not have sufficent cash	There is a risk that the Trust does not generate sufficient cash from contracted activity to cover the cash required for the Trusts outgoings. Risk- There is a risk of an unplanned deficit causing insufficient cash to cover outgoings for the Trust. Any future revenue support will be in the form of PDC which will increase the dividend payable for this funding. Cause - The Trust income has been sufficient to cover the Trusts costs . In 2021/22 the deficit was £1.7m and in 2020/21 a surplus of £1.3m, with an accumulated deficit of £343.6m. 22/23 planned deficit of £19.9. 23/24 planned to breakeven. 2024/25 the Trust has a reported deficit c£57m. Effect- the effect is that the Trust has had to borrow money from the DHSC to support day to day operations. The trust applies for PDC funding from the DHSC on a monthly basis to manage cash shortfalls to enable the Trust to pay its creditors within the credit terms. Impact - Until the Trust returns to a surplus there will be a continued reliance on cash to support the Trust.	Chief Financial Officer	9	High	Catastrophic	Likely	20	Extreme	10	High
4773	06.09.2021	CLINICAL APPLICATIONS - Timely implementation of EPR to realise quality and safety benefits	There is a risk that if there are delays to the implementation of the Digital Care Records Programme, this may lead to the financial model being compromised resulting in failure to make improvements on identified patient safety issues. Furthermore, if implementation does not cover all identified areas, then benefits will not be realised. Quality and safety benefits will not be realised in line with the benefits realisation structure, delaying improvements to patient care as outlined in the EPR business case. Examples include delivering ePMA in spring 2025 rather than autumn 24. Impact on patient safety and continued prescribing errors This will have a negative impact on patient care.	Chief Digital Officer	25	Extreme	Major	Likely	16	Extreme	12	High
3603	13.10.2017	CYBERSECURITY - by not securing our Digital estate, a significant Cyber attack will occur, leading to loss of patient info	IF we do not take adequate precautions to secure our IT systems, and the patient data within them, THEN there is a risk that the Trust will be subject to a cyber-attack RESULTING in loss of personal data, disruption to core services and reputational damage. The Cyber Security Action Plan (restricted access document) has detailed actions on outstanding cyber risk and is used to support the outstanding actions in this risk. High level risks are: Operating systems Access Control Supported Hardware Digital Procurement Constantly changing / developing landscape in cyber security Human factors	Chief Digital Officer	16	Extreme	Major	Almost certain	20	Extreme	8	High

4084	09.04.2019	DATACENTRES - by not replacing power or maintaining environment a severe failure will occur, leading to loss of Digital Services	ISSUE - As a result of not replacing our 2 x Data Centers power, a severe failure will occur, leading to loss of all Digital Services Datacentres are being supported by Computacenter and PFI / Estates on a best endeavours basis. ISSUE - Datacentres true power and cooling capability are not known, additional hardware required for critical projects increases load. CAUSE - The datacentres have a number of outstanding issues that are deemed not fit for purpose. CAUSE - The datacentres were not built to the specification requested. IMPACT - PFI & Computacenter will not accept liability should failures occur, they will look at data centre problems at a best endeavours basis. IMPACT - Additional hardware has been added with risk accepted and mitigation plan to shut down additional hardware if required. If hardware does not remain stable this will impact project delivery.	Chief Digital Officer	16	Extreme	Major	Likely	16	Extreme	2	Low
5568	03.05.2024	DIGITAL CLINICAL SAFETY - by not complying to standards, future developments in AI may not be used safely, patient issues likely	IF the Trust does not comply with national standards around digital clinical safety, THEN systems, applications and future developments in artificial intelligence may not be procured, deployed and used safely, RESULTING IN an impact on patient safety and quality of care.	Chief Digital Officer	16	Extreme	Major	Likely	16	Extreme	4	Moderate
5498	05.03.2024	DIGITAL STORAGE - by not procuring new data Storage, significant failures will occur, leading to loss of clinical systems	DIGITAL STORAGE - by not procuring new data Storage, significant failures will occur, leading to loss of clinical systems. The affects staff productivity, and impacts upon timely patient care. We have implemented new Hardware for a production environment, to address legacy infrastructure debt, however due to the increasing about of clinics and use of imaging services, our forecast storage will reach capacity as soon as we migrate systems to the new production environment. The current Production environment consist of over 500 servers running all our Digital Systems (expect EPR and PAS). The biggest area of storage consumption is PACs images. We require funding to procure a Vendor Neutral Archive storage solution, which is attached storage to our new production environment. This storage will be used primarily to storage our medical images and the M drive data. We are already experienced various issues including but not limited to 1-M Drive saving issues 2-Backup failures 3-Performance issues across numerous systems Estimate costs for this VNA solution will be £900K	Chief Digital Officer	16	Extreme	Major	Likely	16	Extreme	1	Low
5138	10.02.2023	Due to equipment failure, there is potential risk and delay to treatment of patients presenting with AMI	There is a risk that increasing issues with x-ray machines within the Cath Lab require input from external engineers; this will lead to unwarranted downtime, resulting in elective patients being cancelled and increasing delays in treatment and in-patient waiting procedures which will effect patient safety, patient experience and patient outcome	Chief Medical Officer	20	Extreme	Major	Almost certain	20	Extreme	4	Moderate
4115	14.05.2019	E&F10002 Fire Door Damage can lead to enforcement action / lack of protection.	Risk of fire compartments being compromised due to damaged fire doors, causing a local fire to spread compromising patient safety possibly resulting in multiple deaths and catastrophic damage to the hospital buildings. Risk of enforcement action / legal action if doors are none compliant	Chief Operating Officer	10	High	Major	Likely	16	Extreme	5	Moderate
4940	25.05.2022	Inadequate medical cover in Obstetrics and Gynaecology services at all levels	There is a risk that due to significantly reduced medical cover across all levels in Obstetrics and Gynaecology services due to sickness, vacancies and poor allocation from the Deanery may result in adverse outcomes for patients, affecting the quality and safety of care provision and may also lead to significant adverse publicity for the Trust		25	Extreme	Catastrophic	Possible	15	Extreme	5	Moderate
5692	04.09.2024	Job Planning Compliance	There is a risk that we fail to have compliant and accurate job plans in place for all relevant medical staff resulting in pay inaccuracies and lack of oversight of clinical activity.	Chief Medical Officer	16	Extreme	Major	Likely	16	Extreme	8	High
5614	03.07.2024	Lack of theatre capacity affects RTT for 62 days for treatment of breast cancer	There is a risk that due to lack of capacity within theatre that women's surgical treatment for breast cancer will be delayed therefore potentially worsening prognosis and outcome. This affects the NHS target of RTT of 62 days. The lack of capacity is secondary to availability of theatre sessions and surgeons which is a fixed/limited resource	Chief Medical Officer	16	Extreme	Major	Almost certain	20	Extreme	4	Moderate
4481	25.08.2020	Long delays (risk of 52 week breech) for new pt OPA's in Gastro may cause harm and poorer outcomes for disease progression.	Clinical and endoscopies may have to be cancelled which could result in long waiting times for patients leading to complaints ,poor outcomes for patients which could lead to patient harm caused by COVID pandemic The Trust is currently unable to meet or maintain the NHSE expectation of no 65 weeks breeches and patients are at risk of poorer outcomes and disease progression as assessment and treatment is delayed	Chief Medical Officer	16	Extreme	Major	Likely	16	Extreme	8	High
4964	06.06.2022	Patients and staff will come to harm due to ED Crowding and Exit Block	Emergency Department crowding causes delays in timely review, access to tests and access to timely treatment. Patients will not receive effective clinical care resulting in significant patient harm, poor patient experience, increased staff sickness, burnout and morale.	Chief Medical Officer	25	Extreme	Catastrophic	Likely	20	Extreme	9	High
3908	13.11.2018	Patients arriving by ambulance may come to harm if they can't be safely brought into the ED due to crowding	There is a risk that patients may come to harm on the back of ambulances when they can't be brought into the ED due to crowding. They will experience delays in the time to investigations and treatment which may be life-saving or life-changing.	Chief Operating Officer	15	Extreme	Catastrophic	Possible	15	Extreme	4	Moderate

5329	20.09.2023	Patients may come to harm due to delays in specialty reviews following referral by the Emergency Department team	There is a risk that patients will come to harm due to delays in specialty response times. This harm is caused by: delays in senior specialty review; delays in prescribing regular medications; delays in receiving additional treatments and investigations needed for their onward care.	Chief Medical Officer	20	Extreme	Major	Likely	16	Extreme	12	High
5260	28.06.2023	Patients will not receive adequate nutrition nurse input trust-wide due to lack of capacity - this will cause significant harm	There is a significant risk to patients not receiving adequate nutritional specialist input, guidance and support due to the insufficient resourcing of work force of the nutrition team for the trust. This will lead to delay to care, delay to feeding, delay to discharge and result in increased length of stay, malnutrition and harm to patients.	Chief Nursing Officer	16	Extreme	Major	Likely	16	Extreme	8	High
5575	10.05.2024	Potential delay to patient pathways due to Typing Backlog	Due to a backlog in typing across multiple divisions in the trust, there is a risk that patients will not receive timely information to support their care, pathway and treatment resulting in risks to: patient safety, such as GPs are delayed in receiving any changes in medication and onward referrals; the impact on RTT; and, patient experience.	Chief Digital Officer	16	Extreme	Major	Likely	16	Extreme	8	High
5675	21.08.2024	Risk of Echocardiography data not being accessible to clinicians due to current software system not functioning correctly	There is a risk of reduced access to Echocardiography and Cath Lab reports and images due to the current Phillips CARDIO PACS software systems poor reliability and it being prone to errors. This has led to delays in clinicians accessing Echo reports and results in both acute and outpatient settings and could result in delays to treatment and discharge. During cath lab procedures when the system is out of action manual transfer of files is required adding further risk. The ongoing contract for this system is under review and expires 31/12/24 however there has been a lack of engagement and support from current suppliers to remedy faults and provide fixes to software failures resulting in ongoing problems.		12	High	Major	Almost certain	20	Extreme	12	High
5189	28.03.2023	Risk of loss of acute MRI service at WRH as a result of MRI scanner being end of life	EQUIPMENT: There is a risk the MRI scanner will breakdown as a result of it being end of life. This could lead to loss of the acute MRI service at WRH.	Chief Operating Officer	16	Extreme	Major	Likely	16	Extreme	4	Moderate
5269	17.07.2023	Risk of negative impact on patient experience, operational performance and staff satisfaction in dietetics weight management	There is a risk of increased patient dissatisfaction, poor operational performance, compliance with national obesity audit data collection, loss of staff morale and reputational damage as a result of decreased dietetic capacity in the Tier 3 Weight Management Service, leading to likely increased waiting lists, complaints, poor clinical outcome, staff stress and sickness and turnover of staff.	Chief People Officer	12	High	Moderate	Almost certain	15	Extreme	6	Moderate
5458	30.01.2024	Risk of negative impact on patient experience, operational performance and staff satisfaction in SaLT	There is a risk in decreasing operational performance, reduced capacity to review open episodes of care in inpatients and increasing waiting times in voice outpatients due to Staffing capacity being reduced in SaLT due to vacancies, maternity leave and sick leave resulting in a drop of over 30% of available staffing resource. This is most pronounced in acute general medical cover and ENT voice outpatient work. which will lead to a marked impact on staff experience and morale at present, slow response time to inpatient referrals resulting in potential patient harm and delay to correct advice	Chief People Officer	12	High	Moderate	Almost certain	15	Extreme	6	Moderate
5592	04.06.2024	Risk of patient harm and increased length of stay, due to decreased levels of medical staffing and clinical input	There are urgent patient safety concerns on the General medical wards at both WRH, Avon 2 and Avon 4 and Ward 15 at the Alex due to issues with continuous insufficient clinical staffing. Avon 4 and ward 15 opened in December 2023 to mitigate winter pressure; this was only agreed to cover a 6 week period. The wards have remained open and now appear to be substantive wards caring for acutely unwell patients requiring clinical assessments on a 24/7 days per week basis. The medical staffing model is not equitable with other wards with similar patient groups and there is no staffing to provide effective and efficient cover; for example, Avon 2 is reliant on locum medical workforce and regularly has insufficient cover for the weekends. The outcome of these issues has resulted in the increase of complaints, submitted Datix incidents causing increasing concerns of capacity and flow, patient safety, patient experience and patient outcome.	Chief Medical Officer	20	Extreme	Catastrophic	Likely	20	Extreme	5	Moderate
4873	28.01.2022	Risk of Patient harm due to exceeding 36 hours to theatre for repair of fractured neck of femur	There is a risk of Patients coming to harm due to breaching the 36 hour best practice tariff target for fracture neck of femur pathways which will increase their mortality, increase length of stay and increase the chance of hospital acquired functional decline. This has an impact on the patients not being able to move from ED in a timely fashion to be in the 'right place at the right time' GIRFT	Chief Medical Officer	12	High	Moderate	Almost certain	15	Extreme	6	Moderate
5606	19.06.2024	Risk to patients not receiving diagnosis and treatment due to Lung Function equipment failure	There is a risk of patient cancelation and delayed diagnosis and treatment due to the Service contract for ALX lung function equipment having expired. Should ALX lung function equipment fail all patients would be sent to WRH increasing waiting times, affecting patients on a 2 week wait lung cancer pathway and this will have financial implications to the trust	Chief Operating Officer	8	High	Major	Almost certain	20	Extreme	4	Moderate

3761	31.05.2018	TELEPHONY - if we do not upgrade the telephone systems, critical services will stop working, leading to patient safety issues	RISK Risk to patient care and safety due to Trust wide telephony system due to becoming End of Life with no vendor support The telephone systems at Kidderminster Hospital & Treatment Centre, and Alexandra Hospital are currently on `best endeavours` support, the manufacture ATOS (formerly Siemens Enterprise Communications Ltd)will no longer issue any system licences to expand the system, this includes no additional extensions, circuits, or cards that will allow external SIP services. All parts that are available to repair faults in the system are refurbished, as manufacturing stopped many years ago. Availability of service engineers is getting more difficult for the limited number of maintainer now available to provide support, as training stopped many years ago, what engineers that were available are reducing significantly. CAUSE The Siemens telephony platform is 35+ years old and the supplier no longer supports the system to an SLA. The supplier requires all organisations that use this solution to upgrade to a new platform. Siemens no longer manufacture parts or write software upgrades or fix new software bugs. EFFECT IF there is a issue with the telephony solution, Maintel will only respond on a best endeavours basis to calls that are logged with them. There are no credible 3rd parties that can provide support. IMPACT	Chief Digital Officer	16	Extreme	Major	Likely	16	Extreme	4	Moderate
5133	31.01.2023	TELEPHONY - not upgrading from analogue to digital lines, critical services will stop working, leading to patient safety issue	TELEPHONY - Risk to external telephone lines and services - BT Exchange Decommissioning BT Openreach are in the process of decommissioning their legacy telephones exchanges that operate using ISDN and analogue technology. These services are what currently provide external telephone connectivity to the Trust at all of its sites. The deadline for completion of the UK wide switch-off is 2025, however dates for individual switch-off will be phased over the period leading up to 2025 which in reality could be much sooner for the Trust. The current information available to the Trust is that with effect from as early as August 2023 no new orders or requests for changes will be allowed for services connected to the Worcester exchange. Therefore the Trust will need to ensure funding is made available to upgrade its telephony infrastructure and switch to PSTN SIP services ASAP. The following risk is a precursor and needs to be addressed before some of this work can be done - Risk 3761 - TELEPHONY - by not upgrading the telephone systems, critical services will stop working, leading to patient safety issues. Capital funding has been requested to complete this activity.	Chief Digital Officer	20	Extreme	Major	Almost certain	20	Extreme	15	Extreme
5625	08.07.2024	Temporary Workforce	There is a risk of an over reliance on temporary workers leading to increased costs and potential impact on provision of patient care.	Chief People Officer	16	Extreme	Major	Likely	16	Extreme	8	High
4875	28.01.2022	The Ambulance Service Rapid Release Protocol may compromise safety for patients and staff in the ED	When the West Midlands Ambulance Service Rapid Release Protocol is enacted, there is a risk of increased patient harm for patients being offloaded into areas with neither the staffing nor infrastructure to provide safe care.	Chief Operating Officer	16	Extreme	Major	Likely	16	Extreme	8	High
5374	19.10.2023	There is a risk of harm to patients who are overdue their follow up appointment	On a review of the follow up waiting list as part of the Trust requirement to reduce OP follow up activity, there are a total of 28000 patients within the Specialty Medicine division who are overdue their follow up appointment according to OASIS	Chief Operating Officer	16	Extreme	Major	Likely	16	Extreme	12	High
5402	15.11.2023	There is a risk that patients may come to harm if their planned follow up and treatment plan is not enacted	Patients may come to harm if their planned follow up and treatment plan is not enacted. New processes are required to prevent lost to follow up occurring. A short term process for the directorate to support tracking of these patients is required. A long term review between cancer services and the directorate is required to assign roles and responsibilities	Chief Operating Officer	20	Extreme	Catastrophic	Possible	15	Extreme	5	Moderate
4998	27.07.2022	There is a risk to patient safety due to delays and backlogs in contemporaneous and timely typing and actioning clinic letters	There is an issue with timely and contemporaneous typing of clinic letters across the division. The risk to the patient can not be underestimated: when seen in clinic for their next appointment there is no record of what the previous plan / action was; delays to appointments / interventions based on the clinic letter are being delayed. WREN reports on Bluespier do not provide an accurate picture of the typing situation as it only measures what is in the system waiting to be sent or be approved, it does not record or reflect the numbers 'waiting' to get on the system. Secretaries are unable to make any impact on the workload, secretary	Chief Medical Officer	15	Extreme	Moderate	Almost certain	15	Extreme	6	Moderate
5177	14.03.2023	There is a risk to the cellular pathology service due to vulnerability of pathologist staffing.	There is a risk that the service provided by cellular pathology will be suboptimal as a result of lack of consultant pathologists. This could lead to delays in reporting with associated pathway breaches, increased outsourcing and reliance on locum support, as well as increased pressure on substantive staff which may affect safety causing risk to the service and patients	Chief People Officer	12	High	Major	Likely	16	Extreme	4	Moderate

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
ATAIN	Avoidable Term Admissions into Neonatal Units
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CCOSMOS	CNST, CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CNST	Clinical Negligence Scheme for Trusts
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council

HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HIE	Hypoxic-Ischaemic Encephalopathy
HSE	Health & Safety Executive
HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LocSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Maternal Early Warning Scores
MCA	Mental Capacity Act
MCA	Maternity Care Assistant
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIS	Maternity Incentive Scheme
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MNSI	Maternity & Newborn Safety Investigations
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MSW	Maternity Support Worker
NEWS	National Early Warning Scores
NEWTT	Newborn Early Warning Trigger and Track
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NHSR	NHS Resolution
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document

PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PMR	Perinatal Mortality Rate
PROMs	Patient Reported Outcome Measures
PROMPT	PRactical Obstetric Multi-Professional Training
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review
RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SDP	Single Delivery Plan (maternity)
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur