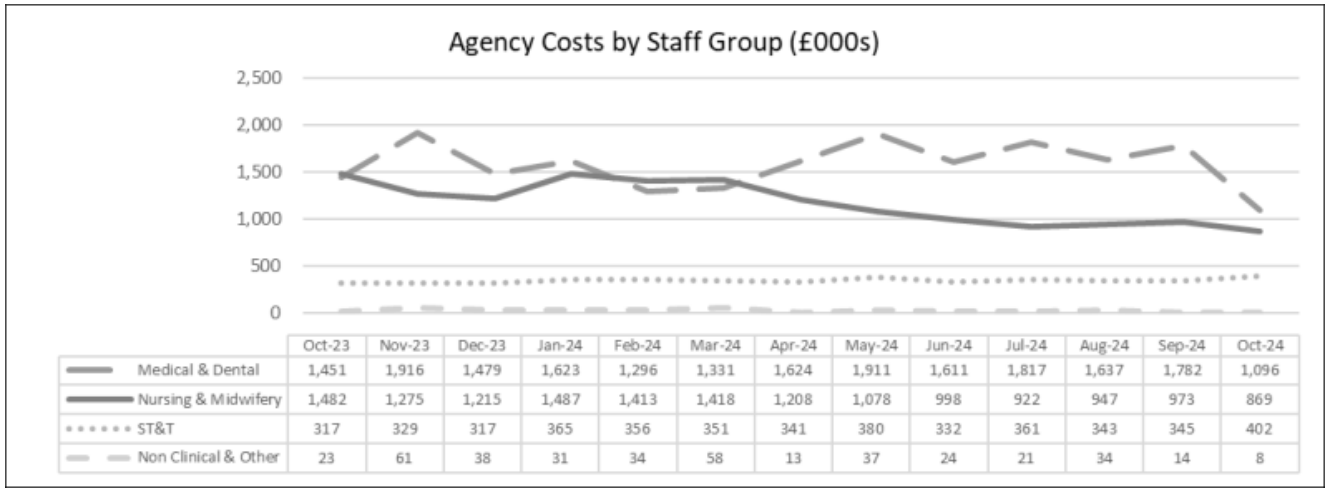
BEST USE OF RESOURCES – BANK AND AGENCY SPEND

We are driving this measure because

Expenditure on bank and agency is a significant driver of our financial performance and consequently our financial plan reflects a challenging target to reduce our agency spend to 3% of the pay bill by the end of 24/25. Delivery of this level of spend reduction is therefore key to achievement of our overall financial plan.



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Medical & Dental	1,451	1,916	1,479	1,623	1,296	1,331	1,624	1,911	1,611	1,817	1,637	1,782	1,096
Nursing & Midwifery	1,482	1,275	1,215	1,487	1,413	1,418	1,208	1,078	998	922	947	973	869
ST&T	317	329	317	365	356	351	341	380	332	361	343	345	402
Non Clinical & Other	23	61	38	31	34	58	13	37	24	21	34	14	8

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Medical & Dental	1,582	2,832	1,492	1,414	1,756	945	1,452	1,661	1,644	1,305	1,323	1,235	2,058
Nursing & Midwifery	1,611	1,623	1,668	1,904	1,979	1,964	1,856	1,935	1,838	1,890	2,007	1,952	1,949
ST&T	30	40	40	46	46	14	50	49	46	53	62	58	58
Non Clinical & Other	134	131	98	144	143	(44)	130	120	123	149	156	149	155

Performance and Actions

Total agency expenditure in October was £2.4m, a reduction £0.7m compared with September, of which £0.4m is a switch of the pay award accrual between Agency and Bank and the remainder is a reduction in Medical & Dental spend with reductions in Additional Capacity bookings in Urgent Care and Vacancy cover in Surgery.

- By staff group agency spend was £1.1m on Medical & Dental (£0.7m reduction compared to month 6), £0.9m on Nursing & Midwifery (£0.1m reduction compared to month 6), £0.4m on Scientific, Therapeutic & Technical staff (£57k increase compared to month 6) and £8k on Non-Clinical staff (a reduction of £5k compared to month 6).

Total bank expenditure was £4.2m in October, an increase of £0.8m compared with last month, of which £0.4m is a switch of the pay award accrual between Agency and Bank and the remainder is an increase relating to bank pay awards yet to be paid.

- By staff group bank spend was £2.1m on Medical & Dental (£0.8m increase compared to month 6), £1.9m on Nursing & Midwifery (£3k reduction compared to month 6), £58k on Scientific, Therapeutic & Technical staff (consistent with last month) and £155k on Non-Clinical staff (an increase of £7k compared to month 6).

Risks

A lag in delivery of the CPIP programme relating to recruitment will add to the pressure reflected in the Trust's overall financial performance. Emergency pressures continue causing additional capacity to remain open incurring higher agency costs. Sickness also remains significantly higher than the target impacting our ability to remove temporary staffing.

What the charts tell us

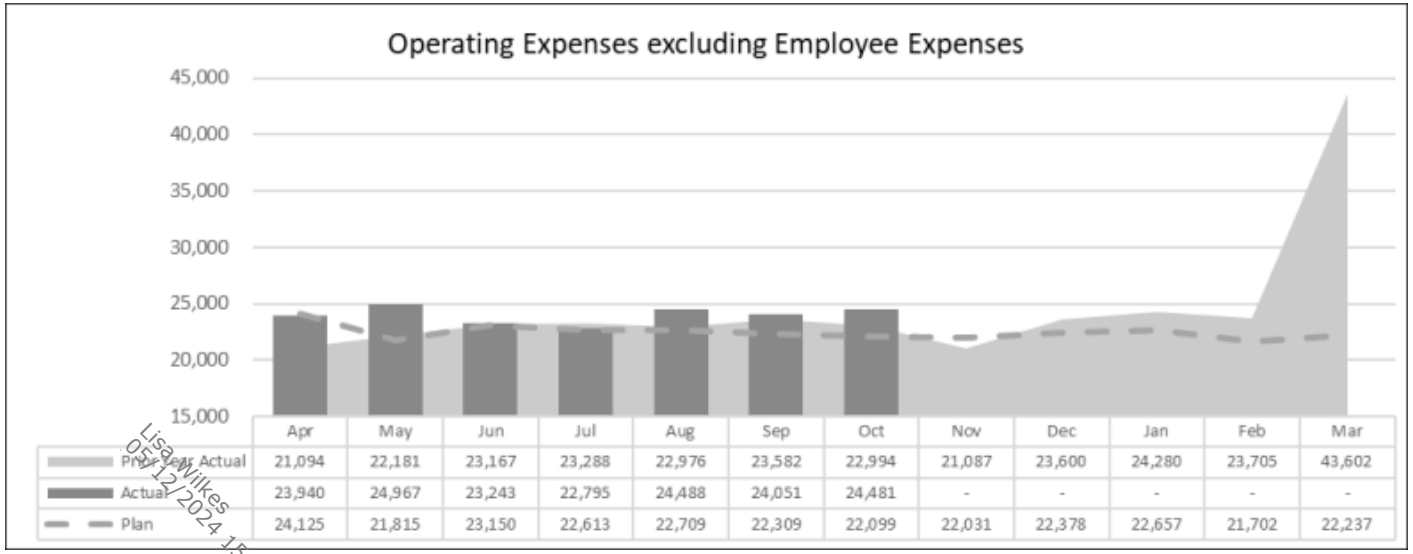
The Nursing and Midwifery trend continues to look positive with a largely falling trend on Agency and a relatively steady trend on Bank. Medical Agency has reduced by £0.7m compared to September of which £0.4m is switch of the pay award accrual between Agency and Bank and the remainder is a reduction in Medical & Dental spend with reductions in Additional Capacity bookings in Urgent Care and Vacancy cover in Surgery.

BEST USE OF RESOURCES – OPERATING EXPENSES

We are driving this measure because

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

Operating Expenditure excluding Employee Expenses	Year to Date		
	Plan £000s	Actual £000s	Variance £000s
Purchase of services from NHS bodies outside of the system	(3,297)	(3,146)	151
Purchase of services from non NHS bodies	(6,393)	(6,038)	355
Drugs Costs	(33,849)	(42,316)	(8,467)
Supplies and services	(50,972)	(55,891)	(4,918)
Other Operating Costs	(64,311)	(60,574)	3,737
Operating Expenditure Total	**(158,822)**	**(167,965)**	**(9,143)**



** In 2023/24, month 12 including one offs: Impairments £29.3m; Donated PPE £0.3m.*

Performance and Actions

Operating expenses excluding Employee Expenses £9.1m adverse YTD – this includes adverse variances of £8.8m on Non PbR Drugs and Devices (leaving a pressure on the H&W ICB fixed price contract for devices of £0.6m), activity related spend (£1.2m) in Specialty Medicine, tariff Drugs spend of £0.5m, Radiology reporting of £0.3m partially offset by vacancies and Dermatology insourcing offset by substantive vacancies above (£0.7m) the remainder being activity related spend on clinical supplies. This is partially offset by underspends relating to utility costs (£1.1m) excluding £0.6m declared as CPIP YTD, and insourcing reserves (£2m) as well as £1.1m over delivery on CPIP, of which £0.6m is the utility costs above.

Included in the above variance is £0.1m relating to Microsoft licenses where budget was reduced due to expected savings from centralised procurement by NHSE. No savings have been identified to date and the Digital Division are following this up with NHSE.

Risks

Non delivery of the CPIP schemes relating to non-pay will add to the pressure reflected in the Trust's overall financial performance.

A proportion of the devices budget is now fixed leading to a pressure of c.£0.5m versus pass through income, we are currently working with the Diabetes team to understand the run rate in H2 to assess the risk to the Forecast outturn.

What the charts tell us

Operating expenses of £24.5m in month, an increase of £0.4m compared with September. Favourable movements of £0.4m on Non PbR Devices relating to a stock adjustment in Cardiology, normalising for YTD corrections to invoices in M6 and £0.1m lower insourcing costs in Surgery, have been offset by an increase on Non PbR Drugs (£0.4m), tariff drugs linked to activity (£0.3m) and pay award on insourcing and outsourcing of £0.5m).

BEST USE OF RESOURCES – CAPITAL

We are driving this measure because

The Capital investment programme to replace existing and invest in new additional assets is key to driving improved clinical and financial sustainability. Given the size of capital programme there is a significant risk that the Trust has insufficient funding to support maintenance requirements and urgent replacement schemes.

2024/25 original (May) plan, revised (July) plan and YTD capital expenditure:

Workstream	Scheme	24/25 Original Internal plan £'000	Adjustments for External Plan	Revised 24/25 External plan £'000	Total YTD Valuation £'000
P&W	Additional P&W Schemes	1,576		1,576	635
P&W	Generators (East and West, No 1& No 2)	71		71	50
P&W	Upgraded Fire Compartmentation	343	1,126	1,469	494
P&W	HV Works - DNO Substation and Site ISS)	359	389	748	603
P&W Total		**2,349**	**1,515**	**3,864**	**1,783**
Digital	Xerox Scanners	54		54	56
Digital	Xerox - Kainos Upgrades	26		26	(5)
Digital	Additional Digital schemes			-	34
Digital	Phase 2 - Digital System Production Environmer	152		152	4
Digital	Phase 2 - Telephony Systems Critical Upgrades	100		100	43
Digital	LIMS - Infrastructure	911		911	297
Digital Total		**1,243**	**0**	**1,243**	**429**
Equipment	Equipment Schemes	610		610	482
Equipment Total		**610**	**0**	**610**	**482**
Strategic	Urgent Emergency Care - Additional	570		570	321
Strategic	Cath Lab/IR Feasibility	1,974	(700)	1,274	10
Strategic	Acute Service Review - Maternity	2,677	(815)	1,862	349
Strategic	Linac Replacement	250		250	-
Strategic	Prior Year Strategic Schemes			-	33
Strategic Total		**5,471**	**-1,515**	**3,956**	**714**
IFRIC 12 PFI	IFRIC 12 PFI Lifecycle replacement	340	2,660	3,000	983
P&W	Donated P&W Schemes	-	4	4	4
Equipment	Donated Equipment Schemes		192	192	188
Contingency	VATrecovery across schemes reallocated				(1,238)
Leases	Lease Additions and Remeasurements	1,445	(220)	1,225	497
Other Total		**1,785**	**2,636**	**4,421**	**434**
Workstream total	**Internal Funded**	**11,458**	**2,636**	**14,094**	**3,841**

Workstream	Scheme	24/25 External plan £'000	Adjustments for External Plan	Revised 24/25 External plan £'000	Total YTD Valuation £'000
Digital	Front Line Digitisation	1,000		1,000	467
Digital Total		**1,000**	**0**	**1,000**	**467**
Strategic	Additional Capacity - TIF		144	144	36
Strategic	RAAC Works St KTC		2,270	2,270	403
Strategic Total		**0**	**2,414**	**2,414**	**439**
				0	0
Workstream total	**External Funded**	**1,000**	**2,414**	**3,414**	**906**
	Total Capital Plan	**12,458**	**5,050**	**17,508**	**4,747**

Performance and Actions

The capital YTD spend at month 7 is £4.75m shown in the below table and split by internally and externally funded schemes. This is an overall increase of £1.6m in Month 7.
This increase is largely attributed to capital expenditure on the following schemes: IFRIC PFI Lifecycle Replacement (£399k), ALX HV Substation (£540k) and Aconbury 0 (£221k).

The capital plan for 2024/25 was submitted at £12.458m and revised at month 6 to £17.432m. In month 7 the Trust has received an additional £76k for charitable funded donated assets, with the Month 7 plan now at £17.5m.

In Month 6, the Trust has received VAT benefits relating to expected VAT charges accrued in 2023/24 based on the advice of the Trust's VAT advisors. The benefit of £1.2m of VAT adjustments will be allocated as a contingency and schemes will be prioritised at CPDG and/or offset any scheme which are potentially forecast to overspend.

Risks

There remain several risks around the current capital programme in 2024/25 onwards:

- The Trust has allocated additional internal funding for Fire Compartmentation costs at the Alex site and work is being undertaken to provide a phased plan (capital and revenue) for the remedial works required in 2024/25 and onwards following a discussion at TMB in October 2024.
- No source of funding has been identified for this scheme at this time, however given the likely high values involved discussions have commenced with NHSE to identify additional funds. Failure to gain an external source of funds will necessitate a reprioritisation of existing schemes or lead to an overspend and failure of our statutory duty to remain within the Capital Resource Limit.
- IFRIC 12 (capital equipment lifecycle programme under PFI) additions for the remainder of the year exceed the current full year forecast as per the PFI model and this will therefore likely impact on the Trust cash position. This is currently estimated at c£3m
- There are some large equipment items beyond their useful life that are presently assumed to take place in future years. However, given their age / state may require earlier replacement. If replacement is required in this financial year, there is insufficient funds within the programme. The Trust will be undertaking an exercise to identify and profile equipment replacement requirements.
- Capital workstream leads are required to provide quarterly capital expenditure profiles to summarise risks to the FYF or any slippage, and to inform how any risks will be managed.

What the charts tell us

Ongoing capital expenditure on internal schemes continue to impact and delay a significant proportion of spend on backlog maintenance and equipment replacement. Discussions are continuing with ICB regarding a longer-term solution for 2024/25. The finance team will continue to work with the workstream leads to ensure all expected costs are identified at this stage.

BEST USE OF RESOURCES – CASH

We are driving this measure because

Daily monitoring of the Trust cash position to ensure there are sufficient funds to cover employee costs and the payment of Trust suppliers as per the BPPC guidance.

Performance and Actions

The Trust cash position at the end of month 7 was £24.208m. The Trust received deficit funding from the ICB of £15.217m, which is the balance of the original deficit phasing up to and including month 7 - £32.717m. The balance of £18.939m is to be paid as per the original phasing of the deficit in months 8-12. The Trust has also received £4.867m in October and £5.752m in November towards the 2024/25 Pay Awards for all staff categories. The ICB are currently in discussions with the Trust with regards to the amount requested and the availability of cash to the system (total amount requested for pay awards - £18.997, balance due £8.378m)

With the deficit funding from the ICB confirmed, the planned deficit is now £5.658m with the CPIP's of £45m assumed to be all cash releasing savings phased over the full 12 months.

The Trust is expected to manage the cashflow with the deficit of £5.6m. The Trust received PDC support from NHSE of £17.75m prior to the deficit funding being allocated, this funding will offset the £5.6m deficit, non-cash balance sheet CPIP schemes and capital costs from the PFI adjustment therefore assuming that the I&E and Capex plan are delivered, the Trust should not have a cash shortfall at year end.

To ensure that there is adequate cash to cover payroll costs including pay awards/back pay, Tax, NI and Pensions, the creditor payment runs were reduced up to month 7 and as a result were significantly impacting BPPC performance. This should now fall back into line given the deficit support funding has been confirmed.

Risks

If the CPIP is not achieved, the Trust will need to apply for additional cash support, to enable it to meet its payroll commitments and BPPC target to ensure there is no disruption to the supply of goods and services due to none/late payment of invoices to creditors.

The timing of drawdown of deficit financing is predetermined and could impact adversely on our BPPC performance should we not deliver the plan.

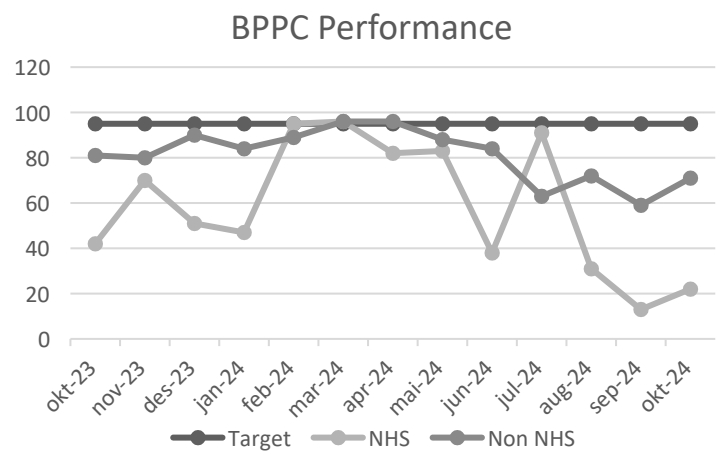
Assumptions made for the above cashflow

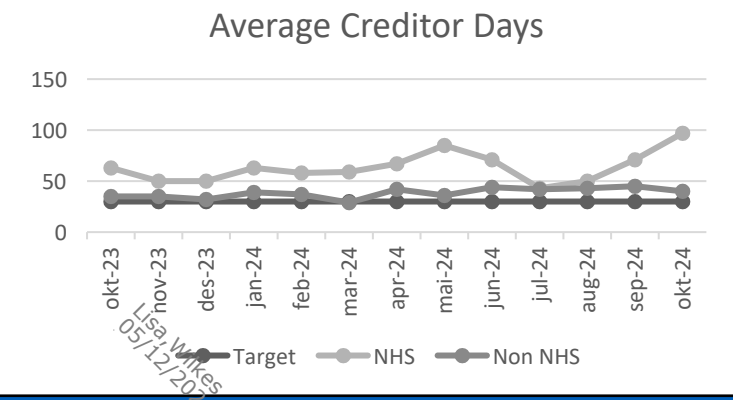
- IFRIC12 Lifecycle cashflow estimates of £3m yet to be factored in but can be managed from the PDC allocation.
- The pay award of 5.5% has been factored for pay expenditure.
- Non-Pay costs are as per plan, with amounts for payment of creditors set at £1.6m per run (2 per week), if the costs are not reduced as per plan, this will be insufficient, and the payment runs will be significantly reduced each week. Upon confirmation of the full funding (and timing) of the pay awards, the creditor payment runs will be increased.

BEST USE OF RESOURCES – CASH

We are driving this measure because

Daily monitoring of the Trust cash position to ensure there are sufficient funds to cover employee costs and the payment of Trust suppliers as per the BPPC guidance.





Performance and Actions

The BPPC performance for the month of October is 56% (34% in September) based on volume of invoices paid and 70% (55% in September) based on value;

- 6,016 invoices paid out of 10,688 due.
- £22.754m worth of invoices out of £32.612m were paid on time this month.

As a result of the agreed system deficit plan of £80m, the Trust has received £17.5m cash support via the ICB in Qtr. 2. The Trust received PDC Revenue Support of £17.75m from NHSE in Qtr. 1 and 2. The ICB have confirmed that the allocation of deficit funding for the Trust is £51.656m, which is phased as per plan. The Trust has received£15.217m in October. £2.64m has been received in November as part of the phased deficit funding.

Month	Applied £m's	Received £m's	Shortfall £m's	Date Received
April	0.00	0.00	0.00	
May	8.50	4.25	-4.25	20-May-24
June	7.50	6.00	-1.50	17-Jun-24
July	7.50	7.50	0.00	01-Jul-24
August	4.75	10.00	5.25	01-Aug-23
September	7.50	7.50	0.00	23-Sep-24
October	15.22	15.22	0.00	1 & 15-Oct-24
Total to date	50.97	50.47	-0.50	
November	2.64	2.64	0.00	01-Nov-24

Risks

The BPPC performance has improved from September due to the additional cash received for the deficit funding. Supplier payments are being monitored and payments made to avoid any supply issues and financial risk to our suppliers.

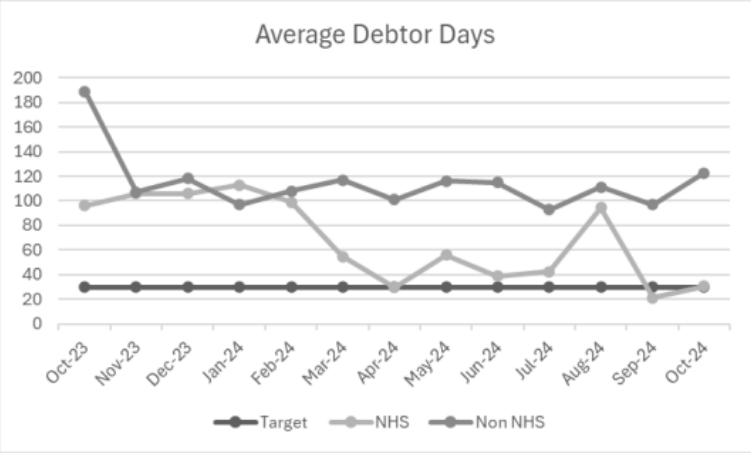
What the charts tell us

- Better Payment Practice Code (BPPC) overall performance for month 7 is 59% (59% in September) based on volume of invoices paid and 75% (76% in September) based on value against a target of 95%.
- The BPPC chart above details invoices paid based on value for NHS and Non-NHS, which for month 7 is 22% (13% in September) and 71% (59% in September) respectively.
- The Average Creditors Days chart above shows the average invoice date to payment date of invoices, which for month 7 is 97 days for NHS (71 days in September) and 40 days for Non-NHS (45 days in September) – the target is 30 days.

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 7, the average days for invoices outstanding are 31 days for NHS (21 days in September) and 123 days for Non-NHS (97 days in September).

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 – 188 invoices, which is 21% of the total.

Debt that is over 90 days totals £1.654m (527 invoices, which includes the 186 invoices as above).

Non-NHS oldest invoices are £100k for Breast Unit which is under query, but progress is being made to resolve. £273k at month 7, (£252k mth 6) relates to invoices being chased under EDR, £38k (£33k at mth 6) for Private Patients where collection is in progress or in dispute and DMC Health Care pathology balance of £51k has been reduced by £25k as a payment on account until the issues are resolved. (information has been provided again to enable it to be checked and verified and the Trust is in communication with the to resolve).

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 – 31 days for NHS and 123 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 6, the amount of outstanding debt is £4.342m (month 6 - £3.320m).

Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Oct-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

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?
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?
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)?
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?

Overall KPI Rating Key
No Assurance
Limited Assurance
Reasonable Assurance
Substantial Assurance

Quality of care, access and outcomes		Responsible Director	Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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%**	76.7%	69.7%	71.5%	63.1%	69.5%	76.9%	73.4%	80.0%	78.3%	80.8%	80.4%	80.0%	-	2,020	2,524	78.7%		75.5%	Sep-24			
	2 Week Wait all cancers	Chief Operating Officer	**93%**	95.0%	95.6%	85.7%	87.9%	88.9%	86.0%	86.0%	89.0%	85.4%	93.0%	96.2%	96.5%	-	2,298	2,382	90.9%		79.5%				
	Urgent referrals for breast symptoms	Chief Operating Officer	**93%**	99.0%	93.7%	80.0%	77.8%	32.0%	16.8%	35.0%	27.4%	30.0%	67.0%	89.8%	94.0%	-	94	100	55.5%		74.6%				
	Cancer 31 day diagnosis to treatment	Chief Operating Officer	**96%**	84.7%	90.0%	90.9%	87.2%	88.5%	87.2%	85.3%	87.1%	85.6%	82.4%	78.5%	79.9%	-	270	338	83.2%		92.2%				
	Cancer 31 Days Combined (new standard from Oct 23)	Chief Operating Officer	**96%**	86.9%	89.4%	89.7%	87.3%	90.5%	87.5%	84.5%	86.8%	87.4%	83.6%	84.0%	84.3%	-	451	535	85.0%		91.7%				
	Cancer 62 days urgent referral to treatment	Chief Operating Officer	**85%**	52.6%	49.0%	42.3%	42.3%	44.1%	50.6%	57.9%	54.4%	60.4%	67.5%	65.7%	68.4%	-	149	217	62.4%		64.1%				
	Cancer 62-Day National Screening Programme	Chief Operating Officer	**90%**	45.7%	58.8%	83.3%	44.4%	67.8%	61.9%	65.8%	59.4%	66.2%	70.6%	59.0%	79.3%	-	23	29	66.6%		66.5%				
	Cancer consultant upgrade (62 days decision to upgrade)	Chief Operating Officer	**85%**	71.4%	78.2%	77.8%	78.1%	81.9%	79.5%	82.7%	77.2%	82.6%	84.6%	77.2%	77.8%	-	62	79	80.4%		79.0%				
	Cancer 62 days Combined (new standard from Oct 23)	Chief Operating Officer	**85%**	55.1%	57.5%	54.1%	51.4%	56.7%	58.4%	63.6%	60.9%	66.9%	71.3%	68.3%	72.0%	-	237	329	67.2%		69.2%				
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	**Plan**	391	389	379	409	366	141	159	176	145	151	177	172	177									
Urgent and emergency care	% emergency admissions discharged to usual place of residence	Chief Operating Officer	**90%**	84.0%	84.3%	82.9%	82.6%	82.3%	84.7%	85.6%	85.5%	85.4%	87.2%	87.4%	87.5%	85.5%	2,720	3,182	86.3%		92.2%	Feb to Jan			
	A&E Activity (any type)	Chief Operating Officer	**Plan**	18,564	17,403	16,960	17,647	17,190	18,537	18,677	19,875	19,293	19,351	18,672	18,444	19,292			133,604						
	Ambulance handover within 30 minutes	Chief Operating Officer	**98%**	48%	56%	53%	53%	55%	64%	64%	60%	64%	71%	65%	54%	46%	1,665	3,585	60%		73%	July			
	Ambulance handover over 60 minutes	Chief Operating Officer	**0**	1,272	1,064	1,166	1,072	1,029	869	836	922	784	639	784	1085	1268			6,318		12%				
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	**Plan**	99%	100%	100%	116%	111%	112%	130%	119%	104%	123%	114%	123%	134%	4,331	3,223	120.4%						
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	**>40%**	39%	39%	37%	43.8%	41.3%	41.9%	42.2%	41.7%	38.2%	35.2%	28.8%	29.9%	31.8%	1,351	4,246	35.8%		36%	Feb to Jan			
	A&E - % of patients seen within 4 hours (any type)	Chief Operating Officer	**76%**	63.1%	62.5%	59.6%	60.5%	61.0%	68.0%	64.4%	66.3%	67.9%	66.2%	67.8%	68.5%	65.1%	6,733	19,282	66.6%		73%	Oct-24			
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer	**-**	19.0%	16.0%	17.0%	19.3%	18.5%	15.8%	16.6%	16.3%	15.4%	14.5%	14.8%	17.0%	17.8%	2,408	13,498	16.1%		16%	Feb to Jan			
	A&E - Time to treatment	Chief Operating Officer	**-**	155	152	167	161	166	143	158	150	146	145	136	135	157			1417		01:41				
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	**<15 minutes**	19	16	16	16	16	14	14	15	15	15	15	16	16			15		00:22	Feb to Jan			
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	**0**	211	203	260	316	304	301	248	271	307	270	335	369	487			2,287						
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	**3%**	6.7%	6.8%	7.1%	6.7%	7.2%	7.5%	6.8%	7.4%	7.5%	7.5%	7.7%	7.7%	7.2%	975	13,497	7.2%		8%	Feb to Jan			

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Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks)	Chief Operating Officer	**92%**	53.2%	56.3%	55.6%	56.6%	56.0%	54.3%	54.8%	55.9%	56.1%	55.9%	55.6%	56.9%	56.9%	34,066	59,873			58.5%	Sep-24			
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		58,046	58,058	59,242	59,900	61,458	61,753	61,740	62,118	62,152	61,348	61,862	60,779	59,873					7,570,000				
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	3,593	3,194	2,968	2,746	2,672	2,536	2,204	2,089	1,980	1,891	1,804	1,604	1,576					249,343				
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	1,211	1,064	1,048	891	766	587	472	464	402	357	300	105	57					22,903				
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	100	119	125	109	68	27	13	14	4	0	0	2	1					2,703				
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	3	1	0	0	0	0	0	0	0	0	0	0	0					113				
	GP Referrals (electronic referrals ONLY. Includes RAS even if rejected)	Chief Operating Officer	**2019/20**	8,873	8,970	7,206	9,156	9,374	8,711	9,438	9,533	8,546	9,787	8,699	8,978	10,138			65,119						
	Outpatient Activity - New attendances (% v 2019/20)	Chief Operating Officer	**2019/20**	126%	124%	107%	110%	120%	136%	118%	112%	119%	123%	129%	127%	148%	23,542	15,960	125%						
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	113%	111%	98%	105%	104%	103%	106%	88%	84%	101%	93%	95%	100%	23,542	23,601	95%						
	Total Outpatient Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	117%	113%	102%	104%	116%	123%	113%	108%	110%	113%	118%	117%	132%	66,435	50,259	116%						
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	111%	113%	103%	111%	111%	107%	119%	99%	92%	111%	99%	106%	106%	66,435	62,590	104%						
	Total Elective Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	95%	100%	101%	105%	107%	129%	110%	105%	109%	115%	114%	115%	115%	8,576	7,488	112%						
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	94%	101%	99%	101%	102%	104%	97%	102%	98%	117%	99%	110%	111%	8,576	7,714	105%						
	BADS: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end)	Chief Operating Officer	**Actual**	85%	84%	84%	84%	84%	84.2%	84.0%	83.8%	84.0%	84.2%	-	-	-	5818	6921	-		81%	Dec			
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	81%	84%	81%	82%	81%	82%	82%	83%	82%	83%	82%	84%	84%			83%		78%	February			
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	**85%**	84%	88%	84%	84%	83%	85%	84%	86%	85%	86%	84%	87%	87%			86%		82%				
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer	-	55	63	45	59	40	57	37	49	40	38	42	40	59			305		21,053	Q4 23-24			
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	**Plan**	109%	109%	112%	117%	115%	118%	115%	119%	115%	111%	112%	113%	113%	7,573	6,721	114%						
	Diagnostic Activity - Endoscopy	Chief Operating Officer	**Plan**	89%	104%	91%	92%	96%	85%	115%	112%	97%	110%	103%	99%	112%	1,598	1,433	107%						
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	**Plan**	89%	92%	103%	97%	86%	89%	100%	105%	96%	101%	116%	120%	113%	2,769	2,453	107%						
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<15%**	14.2%	15.8%	18.4%	25.2%	19.5%	25.8%	27.4%	29.7%	34.3%	31.1%	34.7%	29.2%	22.9%	2,930	12,816			22.7%	Sep-24			
Maternity	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	84%	85%	86%	87%	88%	87%	83%	85%	86%	88%	88%	84%	90%	445	471	86%						
	Caesarean section rate for Robson Group 1 women (rolling 6 month)	Chief Medical Officer	**TBC**	5.6%	5.1%	4.4%	4.4%	4.4%	4.7%	5.5%	6.5%	7.2%	7.6%	8.1%	8.4%	-					8.6%	Sep-24			
	Caesarean section rate for Robson Group 2 women (rolling 6 month)	Chief Medical Officer	**TBC**	59.2%	59.6%	60.0%	59.5%	59.6%	59.2%	59.3%	60.1%	60.7%	62.1%	63.1%	63.9%	-					61.5%				
	Caesarean section rate for Robson Group 5 women (rolling 6 month)	Chief Medical Officer	**TBC**	81.9%	82.4%	81.7%	81.4%	81.3%	81.8%	82.9%	82.3%	83.3%	84.6%	88.6%	87.0%	-					86.0%				
	Maternity Activity (Deliveries)	Chief Nursing Officer		393	357	358	396	372	413	380	418	371	387	416	409	410			2,791						
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	**<4%**	5.6%	5.8%	5.8%	5.5%	4.8%	5.0%	4.8%	5.2%	5.3%	5.0%	5.2%	5.3%	5.1%	3,515	68,361	5%		5.1%	Sep-24			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	88%	89%	89%	90%	91%	91%	89%	90%	89%	88%	89%	89%	89%	40751	45711	89%						
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Chief Operating Officer	**v 2019/20**	112%	109%	100%	101%	114%	118%	110%	106%	106%	109%	113%	113%	125%	42,893	34,299	112%						
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	110%	114%	106%	114%	114%	110%	126%	105%	97%	118%	102%	112%	110%	42,893	38,989	110%						
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	18%	18%	18%	18%	18%	17%	16%	17%	15%	16%	15%	16%	16%	10,370	66,715	16%		18%	Feb to Jan			
Prevention long term conditions	Maternity - Women who were current smokers at 36 weeks (or last smoking status)	Chief Nursing Officer	-	3.5%	2.6%	2.9%	3.4%	2.0%	3.4%	1.9%	2.1%	3.1%	2.6%	3.5%	4.3%	5.6%	15	410	2.7%						

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Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	96%	96%	96%	97%	96%	96%	96%	96%	95%	96%	95%	95%	94%	765	811	96%		90%	Sep-24			
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	70	65	63	75	102	82	69	67	59	56	48	60	65			424		3,655	Sep-24			
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	7.4	7.9	7.5	8.1	8.2	8.1	7.8	7.9	7.7	7.5	7.2	7.7	8.1	22063	2708	7.7		4.4	Feb to Jan			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	3.4	3.4	3.5	3.0	3.7	3.2	3.3	3.1	3.3	2.8	3.1	3.0	3.6	1711	747	3.2		3.1				
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	16%	15%	15%	14%	14%	12%	12%	13%	14%	12%	12%	15%	15%	121	773	13.0%		23.1%	Dec			
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	6.5%	6.6%	7.2%	7.1%	7.9%	8.5%	7.5%	8.2%	7.2%	6.9%	6.9%	5.1%	4.8%	12814	616	5.3%		7.5%	Jan to Dec			
	Mortality SHMI - Rolling 12 months (new methodology introduced Dec-23 onwards)	Chief Medical Officer	**100**	103.9	104.5	105.8	104.0	103.0	103.5	102.8	103.43	103.17	-	-	-	-				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**	0	0	0	0	1	1	0	0	0	0	0	0	0			0						
	MSSA Bacteraemia	Chief Nursing Officer	**17**	0	4	5	2	4	2	3	3	3	5	5	6	7			32						
	Number of external reportable >AD+1 clostridium difficule cases	Chief Nursing Officer	**78**	7	14	8	8	15	9	11	10	14	17	16	11	13			92						
	Number of falls with moderate harm and above	Chief Nursing Officer		6	3	1	4	2	5	3	6	5	13	10	2	6			45						
	Serious Incidents	Chief Nursing Officer	**Actual**	1	0	0	2	1	0	1	1	0	0	0	0	0			2						
	VTE Risk Assessments	Chief Medical Officer	**95%**	92.4%	93.6%	91.0%	93.3%	93.0%	92.2%	96.3%	96.0%	97.0%	96.9%	97.0%	96.4	97.11	12248	12612	97%						
	WHO Checklist	Chief Medical Officer	**100%**	97%	97%	98%	98%	97%	98%	98%	98%	99%	98%	98%	99%	98%	1650	1680	98%						
	Stroke: % of high risk TIA patients seen within 24 hours	Chief Medical Officer	**60%**	86%	85%	86%	83%	61%	66%	45%	62%	69%	83%	84%	75%	85%	107	126	73%						
	Stroke: % of patients meeting thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	67%	50%	50%	50%	75%	75%	33%	57%	57%	43%	55%	67%	-	6	9	52%						
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	**80%**	79%	70%	81%	77%	75%	82%	78%	68%	74%	75%	59%	64%	-	48	75	70%						
	Number of complaints	Chief Nursing Officer	**2022/23 (747)**	63	71	51	88	77	75	80	66	73	72	70	58	70			489						
	Number of complaints referred to, and investigated by, Ombudsman	Chief Nursing Officer	**0**	1	0	0	0	0	0	0	0	0	0	0	0	0			0						
	Complaints resolved within policy timeframe	Chief Nursing Officer	**85%**	44%	42%	62%	63%	82%	69%	48%	62%	73%	61%	62%	70%	59%	41	70	64%						
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	**95%**	86%	87%	84%	74%	71%	77%	76%	75%	75%	78%	82%	79%	75%	1902	2526	77%		79%				
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	**95%**	97%	98%	96%	94%	93%	94%	94%	94%	94%	95%	96%	95%	94%	4281	4574	95%		94%	Sep-24			
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	**95%**	94%	70%	94%	33%	94%	100%	100%	88%	92%	86%	78%	85%	85%	75	92	86%		92%				
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**20%**	17%	21%	14%	23%	23%	23%	22%	23%	21%	22%	24%	22%	21%	2526	11764	22%						
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	30%	36%	25%	35%	37%	37%	35%	37%	38%	39%	44%	40%	36%	4574	11464	39%						
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	3%	6%	12%	1%	9%	1%	4%	9%	8%	20%	10%	26%	19%	92	492	13.0%						

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People		Responsible Director	Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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%**	9.4%	9.7%	8.5%	9.6%	8.4%	8.8%	8.6%	9.0%	7.9%	8.6%	7.9%	8.3%	5.3%			7.9%						
	Appraisals - Non-medical	Chief People Officer	**90%**	79.0%	79.0%	80.0%	79.0%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	82.0%	82.0%	4,798	5,825	80.6%						
	Appraisals - Medical	Chief People Officer	**90%**	92.0%	94.0%	96.0%	93.0%	93.0%	93.0%	94.0%	96.0%	94.0%	93.0%	94.0%	93.0%	94.0%	527	560	94.0%						
	Mandatory Training	Chief People Officer	**90%**	88%	88%	88%	90%	90%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	90.0%	90.0%	77,218	85,972	90.7%						
	Overall Sickness	Chief People Officer	**4$%**	6.2%	6.0%	6.3%	6.3%	5.9%	5.8%	5.9%	5.6%	5.3%	5.5%	5.0%	5.1%	5.5%	11,651	212,171	5.4%						
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**11.5%**	11%	11%	11%	11%	11%	11%	11%	11%	10%	10%	10%	10%	10%	604	6,008	10.5%						
	Vacancy Rate	Chief People Officer	**7.5%**	9%	8%	8%	8%	7%	7%	10%	9%	9%	9%	8%	7%	6%	462	6,858	8.4%						

Finance and Use of Resources		Responsible Director	Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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**	-£2,331	£2,279	-£4,897	-£5,562	-£4,361	-£3,361	-£7,799	-£4,672	-£5,283	-£5,507	-£5,253	£24,901	£6			-£3,607						
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-4.1%	3.7%	-8.7%	-9.8%	-7.5%	-4.7%	-14.0%	-7.8%	-9.1%	-9.8%	-9.0%	28.2%	18.7%			-0.8%						
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£3,822	£528	-£5,177	-£7,277	-£6,677	-£4,954	£971	-£836	-£635	£7	-£75	£190	£355			-£24						
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	-64.0%	77.0%	-6.0%	-31.0%	-53.0%	-47.0%	-11.0%	22.0%	14.0%	0.0%	1.0%	1.0%	-102.0%			1.0%						
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£2,603	-£1,772	-£2,195	-£2,510	-£2,741	-£1,323	-£669	-£223	-£240	£251	£194	£368	£456			£136						
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	-£3,272	-£3,581	-£3,049	-£3,505	-£3,098	-£3,158	£3,186	£3,406	£2,965	£3,121	£2,961	£3,113	£2,375			£21,127						
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	9.4%	9.7%	8.5%	9.6%	8.4%	8.0%	8.6%	9.0%	8%	9%	8%	8%	5%			7.8%						
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	-£2,607	-£2,467	£757	£401	-£925	£25,631	£0	£0	-£2,314	-£832	-£118	-£1,592	£934			-£3,922						
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£7.736m	£1.019m	£1.303m	£7.862m	£20.333m	£11.384m	£1.125m	£1.712m	£1.182m	£1.617m	£6.732m	£13.291m	£24.208m			-						
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	80.0%	79.4%	88.2%	83.1%	88.5%	95.6%	95.1%	87.9%	83%	64%	70%	55%	70%			-						
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	82.6%	78.6%	88.2%	85.9%	89.8%	93.3%	87.4%	89.3%	71.5%	41.1%	54.2%	55.0%	56.3%			-						

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Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**10/12/2024**
Title of Report:	Perinatal Safety Report October 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)

Trust Board 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					

	Nov	Dec	Jan	Feb	March	April	May	June	July	August	Sept	October
1.Findings of review of all perinatal deaths using the real time data monitoring tool	√	√	√	√	√	√	√	√	√	√	√	√
2. Findings of review of all cases eligible for referral to HSIB	√	√	√	√	√	√	√	√	√	√	√	√
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	√	√	√	√	√	√	√	√	√	√	√	√
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	√	√	√	√	√	√	√	√	√	√	√	√
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	√	√	√	√	√	√	√	√	√	√	√	√
3.Service User Voice Feedback	√	√	√	√	√	√	√	√	√	√	√	√
4.Staff feedback from frontline champion and walk-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%	90.2%	84.2%
Term admissions	6%	3.64%	2.2%
PMR (MBRRACE 2022)	<5.04 per 1000 births (rolling)	3.83	3.14
Stillbirth rate (MBRRACE 2022)	<3.35 per 1000 births (rolling)	1.89	1.88
NND rate (MBRRACE 2022)	<1.69 per 1000 births (rolling)	1.47	1.26
Maternity and Neonatal Moderate or above incidents	-	2	5
Maternity PALS	-	8	9
Neonatal PALS	-	0	0
Maternity Complaints	-	3	2
Neonatal Complaints	-	0	0

Summary of Key Workforce Performance Indicators

Metrics	Target	Current position	Previous month
Sickness rate (MWs)	4%	5.16%	4.02%
Turnover rate (rolling) (MWs)	11.5%	8.85%	9.22%
Vacancy rate (MW)	7%	8%	10%
Sickness rate (MSWs)	5.5%	19.61%	14.91%
Turnover rate (rolling) (MSWs)	11.5%	14.22%	12.52%
Vacancy rate (MSW)	7%	13%	14%
Sickness rate (RNs)	4%	8.3%	6%
Sickness rate (NNs)	4%	13.8%	11.6%
Turnover rate (rolling) (RNs)	11.5%	7.5%	9.63%
Turnover rate (rolling) (NNs)	11.5%	5.26%	12.89%
Vacancy rate (RN)	7%	0	0
Vacancy rate (NN)	7%	0.02%	0.16%
Shifts staffed to BAPM	100%	70.97%	93.3%
Supernumerary shift leader (NNU)	100%	100%	100%
QIS trained	70%	67.1%	67.1%

Summary of Key Training Performance Indicators

Metrics	Target	Current position	Previous month
PROMPT – Human Factors & Maternity Emergencies	90%	85.5% ↑	84.5% ↑
PROMPT – Neonatal Basic Life Support	90% (including Doctors and Neonatal Nurses)	tbc	tbc
Fetal monitoring	90%	97% ↑	96.5% ↑
Maternity Trust Mandatory training (non-medical)	90%	88%	88%

Maternity Trust Mandatory training (Obstetricians)	90%	74%	74.%
Maternity PDR rate	90%	69%	70%
Neonatal PDR rate	90%	88.06%	81.82%
Neonatal Trust Mandatory Training (non-medical)	90%	91.96%	92.93%
Neonatal Trust Mandatory Training (medical)	90%	80.82%	80.49%

2. KPI Booking by 12+6 weeks' gestation

The KPI for booking by 12+6 weeks' gestation has been met this month. Maternity self-referral is due to launch in November.

3. Perinatal Mortality Rate (PMR)

The national average rates for stillbirth and neonatal rates have recently been updated by MBRRACE to reflect the data from 2022. Nationally, the stillbirth rate has decreased but the neonatal rate has increased slightly as below. The link to the online report is https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/.

The national extended perinatal mortality rate is 5.04 per 1000 births based on 2022 data. 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 updated national and group rates (all per 1000 live births):

	National rate	Group rate (other Trusts with 4000+ births)	Trust 2022 MBRRACE rate	Crude Trust rolling rate (from 01.11.23 – 31.10.24)
Stillbirths	3.35	3.18	3.21	1.89
Neonatal deaths	1.69	1.08	1.12	1.47
Extended perinatal mortality	5.04	4.25	4.32	3.83

As can be seen from the table above the Trust is below the national rates for stillbirths across a similar group/Trusts; our current crude rolling rate is below the Trust 2022 rate though this may change once it is stabilised and adjusted by MBRRACE.

With regard to neonatal deaths, the rates from 2022 are below the national rate, but above the group rate. The 2022 MBRRACE report acknowledges the impact that congenital anomalies have on perinatal mortality rate.

The graph below shows a decreasing trajectory in our perinatal mortality rates. As always, it is 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*.

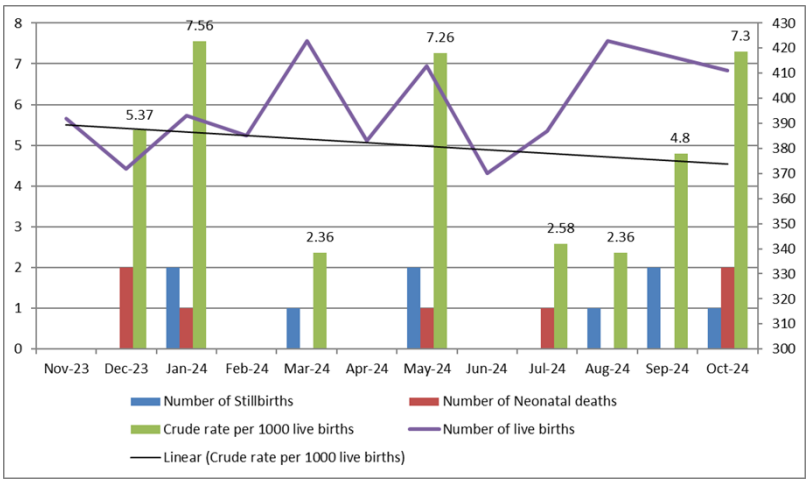


Figure 1. WAHT Perinatal Mortality Rates

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; 2023 and 2024 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	4005	9	2.25**	5	1.25**	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 October 2024.

In October, there was one stillbirth and two 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.

4.2 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	With family for factual accuracy – update requested from MNSI as has been some time.
MI037490	May 2024	Yes	Draft report received by Trust for factual accuracy – now with family for factual accuracy.

**DOC completed – The provides confirmation that the family have received the relevant information regarding the nature of the incident (Duty of Candour disclosure), the role of MNSI and the EN scheme from NHS Resolutions. An example letter template can be found in the CNST compliance table in item 14 – safety action 10.*

4.3 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 October 2024.
There were two incidents reported in October 2024; one case was related to a woman who was readmitted with a severe wound infection and the other is related to a baby who required transferred for neurosurgery at Birmingham Children's Hospital.

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	88% ↑	86% ↑	
Maternity Mandatory Training – (3 yearly)	MSW/MCA	78% ↑	76% ↑	
Annual Saving Babies Lives training	Midwives	94% ↑	92% ↓	
Annual Saving Babies Lives training	MCA/MSW	85% ↑	70% ↑	
Annual Saving Babies Lives training	Obstetricians	86% ↑	80% ↑	
Annual fetal monitoring training	Midwives	99% ↔	99% ↑	
Annual fetal monitoring training	Obstetricians (all on rota)	94% ↔	94% ↓	
PROMPT training (Human Factors/MDT Obstetric Emergency	Midwives	95% ↔	95% ↔	
PROMPT training (Human Factors/MDT Obstetric Emergency	MSW's	89% ↑	86% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	Obstetricians (all on rota)	90% ↑	86% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	Anaesthetists (all on rota)	68% ↓	71% ↓	See notes below
Neonatal Life Support	Midwives	95% ↔	95% ↔	
Neonatal Life Support (NLS 4yearly)	Neonatal Nurses	100% ↔	100%	
Neonatal Life Support (NLS 4yearly)	Neonatal Drs	90.6%	90.6%	
Neonatal Resuscitation Update (annual)	Neonatal Nurses	98.55% ↑	92.8%	
Neonatal Resuscitation Update (annual)	Neonatal Drs	97.9% ↔	97.9%	
Trust Mandatory Training	Obstetricians	74%	74% ↓	
Trust Mandatory Training	Midwifery Staff	88%	89%	
Trust Mandatory Training	Neonatal Nurses	91.96%	92.93%	
Trust Mandatory Training	Neonatal Drs	80.82%	80.49%	

Figure 2. Training Compliance

Maternity specific training:

Positive news:

- Continue to maintain targets with PROMPT and SBL for midwives. Improving compliance with the new support staff in post and aim to be >90% into November
- 'Bespoke' training demand continues to grow – small group neonatal Resus sessions, Community PROMPT, theatre staff training and some ad hoc shoulder dystocia sessions are booked in.

Points for escalation/information:

- Anaesthetist compliance is not improving on PROMPT - many cancellations in recent sessions has had a great impact. A meeting has been held with the Lead Obstetric Anaesthetist and the roster clerk.

- Many bookings made in November and extra PROMPT session has been arranged for 21st November to capture remaining anaesthetists.

Neonatal training:

Mandatory training compliance for medical staff remains similar to the previous month.

The majority of substantive medical workforce includes consultants and specialty doctors. However, the medical workforce, includes FY doctors and Specialty Trainees (from the deanery) who rotate in and out on a 4-monthly and 6-monthly basis. Maintaining compliance is problematic as all new staff are entered onto ESR on appointment which flags as non-compliance as training in other services is not currently transferred on commencement with the Trust. This is an ongoing problem which all services experience.

The directorate team continues to work with line managers to improve their position. All staff are encouraged to check their training records and monitor their personal compliance with Mandatory Training through their ESR account. Staff are supported and released from clinical duties to attend training.

Neonatal nurses have remained above the Trust target for mandatory training with 91.96% compliance.

PDRs for non-medical staff have shown an increase on the previous month. Staff are reminded prior to their expiry date. A new process of recording the PDR completion electronically is being trialled to provide assurance around the data accuracy.

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. In addition, this training is also accessible through PROMPT. NLS compliance for medical staff and non-medical staff remains above the 90% recommended.

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 410 births in October. The escalation policy was enacted on 22 occasions to reallocate internal staff which is an increase on the previous month. The community and continuity teams were asked to support on two days.

The vacancy rate has reduced for midwifes and MSW/MCAs – there are additional midwifery staff commencing in November with a further 15WTE in the pipeline and planned to start in February. The

rolling turnover rate for midwives remains below Trust target further however for non-registered staff remains high. Sickness absence rates for midwives and non-registered staff have increased in month.

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

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	77%	n/a	n/a	n/a
Antenatal Ward/Triage	93%	87%	71%	69%
Delivery Suite	94%	93%	41%	95%
Postnatal Ward	92%	93%	74%	81%
Meadow Birth Centre	72%	70%	81%	64%

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 have an ATR approved for a Maternal Medicine post to fill the PAs we have lost secondary to the increase in SPA and external roles and are hoping this will get uploaded to NHS jobs within the next month.

There are 2 Consultants who underwent elective surgery during September. One, who covers only Gynaecology, remains off sick (total period likely to be 3 months) and one has returned to clinics but is not yet covering Obstetric on calls.
A further 2 Consultants are planned to have surgery in November (One covers Gynae on calls and the other Obstetric on calls).

A new locum consultant started in Mid-October and our post CCT Registrar is acting up for some Obstetric on calls and Caesarean section lists.

Registrars

The registrars work a 1:9 on call rota. We currently have 18.6 WTE in post (funded for 19.6 WTE), with 16 WTE on the on-call rota. One Registrar is currently on a phased return to work following a prolonged episode of sickness and one has gone 'Out of Programme' working with us one day a week.

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 a Urogynaecology Clinical Fellow also working in clinics and shadowing on calls but not yet on the on-call rota.

We are interviewing 5 applicants for our Post CCT Clinical Fellow post in November and are also interviewing 2 people for a second Clinical Fellow post. We have had 2 further ATRs approved to backfill

our future maternity leaves so may be able to appoint more candidates in November if they are appointable at interview.

We have recently had joint application for a Urogynaecology Subspeciality Training post with Leicester approved and we are hopeful they will commence in post at WAHNHST in February 2026.

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 CSRH trainee working with us 2 days per week and our Physicians Associate left us in October.

Consultant Attendance

In October Consultant presence was achieved in 12 of the 12 cases (100%) mandated by the RCOG and Action 4 of CNST.

Compensatory Rest

There were no episodes in October where a consultant did not meet the required 11 hrs compensatory rest.

7.3 Neonatal Staffing

7.3.1 Neonatal Nursing

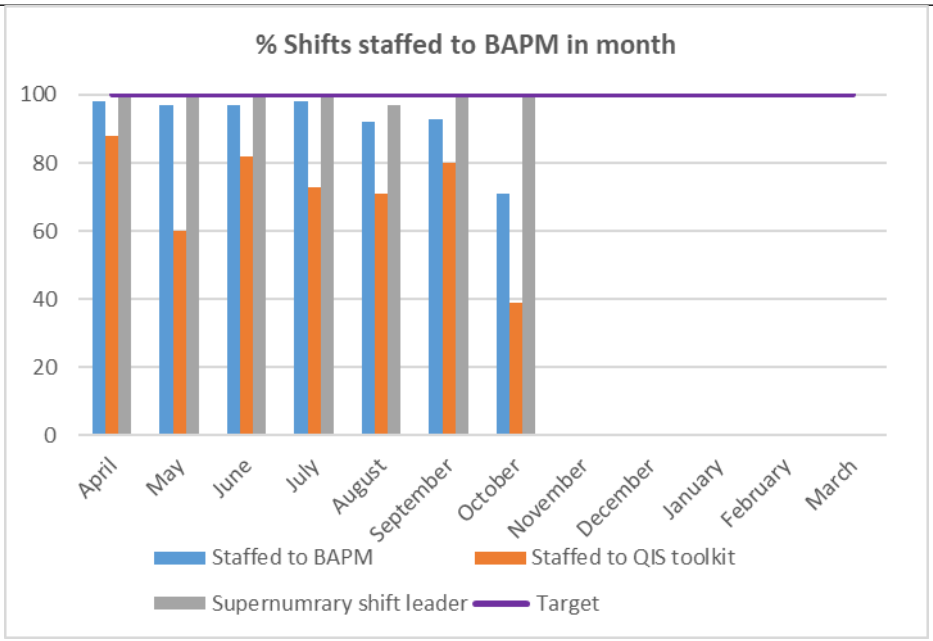
Safe neonatal nurse staffing is monitored by taking the following actions:

- 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 October 70.97% of shifts were staffed to BAPM. There were 17 shifts short on achieving BAPM due to sustained high acuity on the Neonatal Unit. Average variance from BAPM compliance was 0.5. The average number of nurses required on shift was 7.4. 38.71% of shifts in October were staffed to QIS, which is a considerable decrease on the previous month. There were a total of 38/62 shifts short on QIS. There was a total of 46 ITU bed days, which is 3 times more than previous months and 118 HDU bed days. The supernumerary status of the shift leader was achieved 100% in October. All shifts remained safe despite the acuity, 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 and training 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 67.1% against the 70% recommended. This equates to 0.89wte short. 1.73wte commenced the QIS course in September and another 0.8wte commences in December. 70% compliance should be achieved by the end of March 2025 when the September cohort have completed their course.

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

Sickness absence rates increased to 8.3% in October for registered nurses. Sickness amongst the non-registered also increased from the previous month to 13.8%. This gives a total percentage of 9% which is 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 to support the implementation of a separate paediatric and neonatal medical rota.

Currently there is a shortfall of 0.5wte consultant. Following appointment into consultant posts there are plans to implement the split rota commencing January 2025.

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 MNVP highlights reports from May, July and September have been included in CNST compliance table below (safety action 7) to provide assurance to Trust Board of the current work streams and focus of the group and to demonstrate that the voices of women and birthing peoples' are heard and inform the delivery of our local maternity service.

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; our action plan was submitted in September.

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 October 2024, 3 formal complaints were received:

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
92010	21/10/2024	Maternity (formerly Obstetrics)	Clinical Treatment	Scanning errors
91044	25/10/2024	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure to follow up
91940	15/10/2024	Maternity (formerly Obstetrics)	Clinical Treatment	Mismanagement of labour

In addition, there were 8 Maternity PALS query received as below.

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
92557	30/10/2024	Maternity (formerly Obstetrics)	Communications	PALS – Insufficient information given
91543	08/10/2024	Maternity (formerly Obstetrics)	Communications	PALS - request for debrief
91921	16/10/2024	Maternity (formerly Obstetrics)	Communications	General concerns over maternity service
92144	22/10/2024	Maternity (formerly Obstetrics)	Clinical Treatment	PALS – Delay or Failure in ordering tests
92152	22/10/2024	Maternity (formerly Obstetrics)	Clinical Treatment	PALS – Post-treatment complications
91684	10/10/2024	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	PALS – Attitude of Nursing Staff/Midwives
92580	31/10/2024	Maternity (formerly Obstetrics)	Communications	PALS – Insufficient information given
91920	16/10/2024	Maternity (formerly Obstetrics)	Communications	PALS - request for debrief

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

9. Safety Champion escalations

The Safety Champions meetings took place on 3rd October and 22nd October. See full meeting notes in CNST table safety action 9. In summary, Delivery Suite, PNW, NNU and Kidderminster Maternity Hub were visited by all safety champions. In the main communications were positive and environments pleasant, some sign posting and encouragement to use datix system were given surrounding subjects

such as staffing shortage. Matrons were informed and presentation of fully staffed rotas were given as reassurance and that this was due to short notice sickness. Guest speakers included the Patient Experience Midwife and Guidelines and Audit Midwife to present the CQC Action plan, progress with MNVP work streams and the National data bank (providing digital solutions to pregnant women and birthing people who do not have access).

No immediate safety concerns were raised. Discussions surrounding the windows temperature on delivery suite continue with plan in place. New actions added to the log, include the utilisation of the OCTOPUS room booking system for KTC as rooms were noted as not being utilised at that time and also a mixed use of areas with rooms allocated to resident RMO (which also exists at the Alex site).

Items completed on the action log included door number signs on the corridor in delivery suite, Fire door on MBC auto close now installed and Postnatal drug keys resolution to provide a central location.

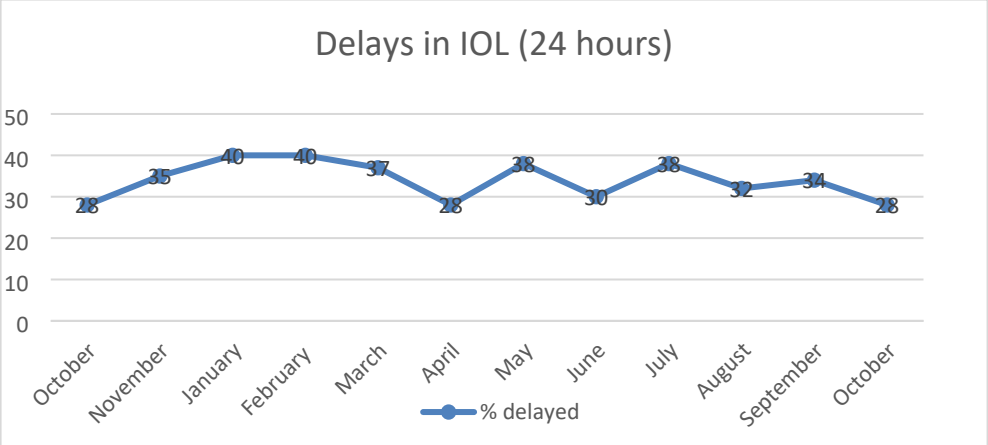
Quad are due to attend in November to update the Perinatal Culture Improvement plans.

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. A new electronic booking system was launched in October and there has been a noticeable 6% decrease in delays in month despite an additional 5% increase in the IOL rate in October.

9.2 Claims scorecard review in conjunction with incidents and complaints

The Q2 maternity and neonatal claims and learning review for 2024/2025 is presented in the appendices.

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	WAHT_RAIT Maternity 14.11.24.x
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 October 2024.

12. In-utero and ex–utero activity

The table below summaries the transfers as per network pathway:

Type of Transfer	October		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	1	1	1 in from Good Hope as gestation necessitated a level 2 cot. 1 out to Stoke as per <27/40 gestation pathway
IUT Transfers for non-clinical reasons	2	1	2 in from BWH to assist with their capacity 1 out to BWH to assist with acuity on WRH NNU.
IUT Transfers outside of the network	0	2	1 out to Bristol & 1 out to Bath due to acuity on WRH NNU
Ex-utero Transfers for clinical reasons as per network pathway	0	4	2 out to BWH for clinical reasons and 2 out to BCH for Surgical issues
Ex-utero Transfers for non-clinical reasons	3	2	3 in – 2 Repatriations from BWH to be closer to Hereford. 1 repatriation back to WRH from Manchester. 2 out to Hereford - Repatriations
Ex-Utero Transfers out of network for clinical reasons	0	1	1 out to Bristol Children's Hospital for cardiac surgery – no bed at BCH
Delays in transfer in/out	0	0	
IUT or Ex-utero Exceptions	3		2 IUT exceptions – Out of Network 1 Ex-UT out of Network

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.

Focus continues on the following actions:

- PDR compliance rates
- Increasing Consultant led theatre lists
- Enact findings of administrative review
- Review GTT service efficiencies

- Exploration of service improvements at AGH.

A furthermore detailed update will be provided in next months 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, a further summary of the total reporting period for CNST year 6 has been presented in the appendix 1. Highlighted in orange are for focus to ensure full compliance.

Evidence of documents requiring approval and confirmation of receipt for CNST MIS year 6 presentation to QGC (28.11.24) in the linked document - QGC 28th November Evidence for CNST - End of year compliance required.docx

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 *Previous evidence Q1 presented in September Perinatal Safety Report (PSR)* *NHSR – update 26.6.24 date range moved. Validation commences 1.4.24 for SA1a) & c)* • Evidence collation to be discussed with NHSR	Q2 24-25 PMRT case report.docx	Q3,4 Outside reporting timeframe
2	MSDS	• Submission and criteria met July 24 *Previous evidence embedded Septembers PSR– Submission complete and compliant*		None Complete
3	ATAIN/ TCU	• Quarterly reporting in place *(Previous evidence Q1 presented Septembers PSR)* *QI project commenced with baseline audit presented in Perinatal Governance June 24, for LMNS update presented 23rd Oct, full project 11th Dec.*	ATAIN Report Q2 24-25.docx	None Q3,4 Outside reporting timeframe
4	Clinical Workforce	• Medical and Midwife Safe Staffing reports in place • NCCR implementation plan *(Previous evidence presented in Septembers PSR dated 8.8.24)* • Audits for Obstetric Medical staff now complete *(Previous evidence presented in Septembers PSR)* • Consultant attendance item 7.2 within report • Clinical Supervision of Locum and Temporary Medical staff in Obstetrics and Gynaecology shared in Septembers PSR • Compensatory rest monitoring/ Action log within Octobers Medical staffing report - embedded	Medical Staffing Report - Oct24.docx	None
5	Midwifery Workforce	• Monthly Safe staffing report in place. • Item 7 within report *SN status of the SL requirement changed in Yr 6 of scheme*	BR+ tabletop (Jan & July 24) BR+ Audit May 22	None
6	Saving Babies Lives	• Quarterly reports in place • NHS Futures Implementation Toolkit – Q1 toolkit embedded in Septembers PSR. • Validation with LMNS quarterly (27.3/24/ 26.6.24/ 25.9.24/ 11.12.24). • Current level of Compliance 93%	SBL - 6 Element Summary audit Q2 cc	None Q3, 4 outside reporting timeframe
7	MNVP	Some changes to this year's requirements – additional funding from LMNS and strategic lead planned • Additional funding from LMNS agreed • Currently recruiting to Strategic lead for MNVP	Worcs MNVP Highlights Report for	None

<table>
<tr><td></td><td></td><td>CQC action plan (Picker survey) agreed at Safety champions and trust board received plan in Septembers PSR.
MNVP highlights reports embedded
MNVP included in Terms of reference as members for, Guidelines, Perinatal Governance, Labour Ward Forum and Patient experience meetings</td><td>Worcs MNVP Highlights Report for
Worcs MNVP Highlights Report for</td><td></td></tr>
<tr><td>8</td><td>MDT Training</td><td>On target
For Rotational medical staff that commenced work on or after 1.7.24 a lower training compliance will be accepted. Training planned for November 2024 project full compliance. However, trust board are asked to review and approve the action plan below should any unforeseen circumstances occur with attendance.</td><td>Item 6 within this report</td><td>Final Compliance Figures</td></tr>
<tr><td></td><td>Action plan to be agreed by Trust Board</td><td colspan="3"><table>
<tr><th>Rotational Staff group</th><th>Action to complete training within 6 months of commencement</th></tr>
<tr><td>Anaesthetists/ Obstetric Doctors – PROMPT Training</td><td>*Highlighted as priority booking by PDM
*To attend training on the 6/12/24, 7/1/25, 28/1/25, 14/2/25
*Assurance to Trust Board via Perinatal Safety Report</td></tr>
<tr><td>Obstetric Doctors – EFM Training</td><td>*Highlighted as priority booking by Fetal Surveillance Midwife
*To attend training on the 20/12/24, 17/1/25, 21/1/25, 28/2/25
*Assurance to Trust Board via Perinatal Safety Report</td></tr>
<tr><td>Neonatal Doctors – Basic Neonatal Life support (annual training)</td><td>*Highlighted as priority booking by Fetal Surveillance Midwife
*To attend training on the
*Assurance to Trust Board via Perinatal Safety Report</td></tr>
<tr><td>Neonatal Doctors – NLS course (4 yearly Resus Council)</td><td>*Highlighted as priority booking by Neonatal Consultant (PK)
*To attend training on the 3/12/24, 11/2/25
*Assurance to Trust Board via Perinatal Safety Report</td></tr>
</table></td></tr>
<tr><td>9</td><td>Safety Champions/ Perinatal Safety</td><td>Reporting process in place.
Roles embedded and SC meetings working well.
Perinatal Surveillance guideline updated in line with yr 6
Claims scorecard Quarterly reporting embedded Q1 & Q2 (Q2 due to be presented at Safety champions meeting 15.11.24)
DMT present at every Safety Champions meeting embedded 3.10.24/ 22.10.24 (Previous evidence – Meeting Notes embedded in Septembers PSR 23.4.24/7.6.24/ 25.6.24/ 5.9.24)
Regular Safety champions meeting with Quad quarterly 7.6.24/ 5.9.24 / 15.11.24 (Previous evidence – Meeting Notes embedded in Septembers PSR for 7.6.24/ 5.9.24)
Summary of Perinatal Culture SCORE survey results D/W Safety champions on 5th September (Previous evidence embedded in Septembers PSR with meeting notes)</td><td>06.06 Claims and incidents Q1 2024-20
Claims and incidents Q2 2024-2(
MSC meeting notes 03.10.2024 (2).docx
MSC meeting notes 22 10 2024 (1).docx</td><td>Q3,4 24-25 Claims scorecard Outside reporting timeframe

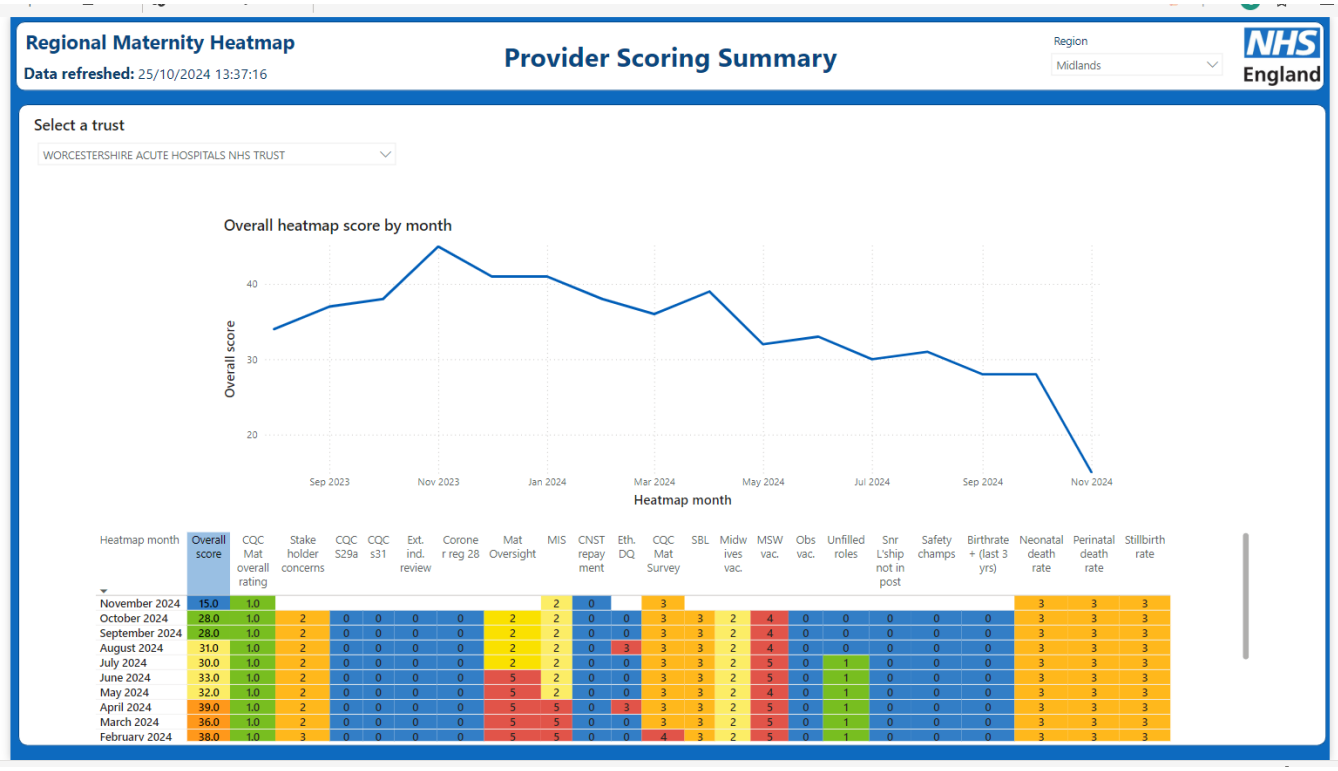
15th Nov Safety champions meeting notes – Quad Perinatal Improvement plan</td></tr>
<tr><td>10</td><td>NHSR EN Scheme</td><td>Reporting process in place – externally validated.
DOC template letter embedded for assurance that information surrounding Duty of Candour is the role of MNSI and EN scheme (NHSR) is given when investigation commences. See monthly table in item 4.2</td><td>DoC letter - example for MIS (1).docx</td><td>Validation data</td></tr>
</table>

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 October is as follows:



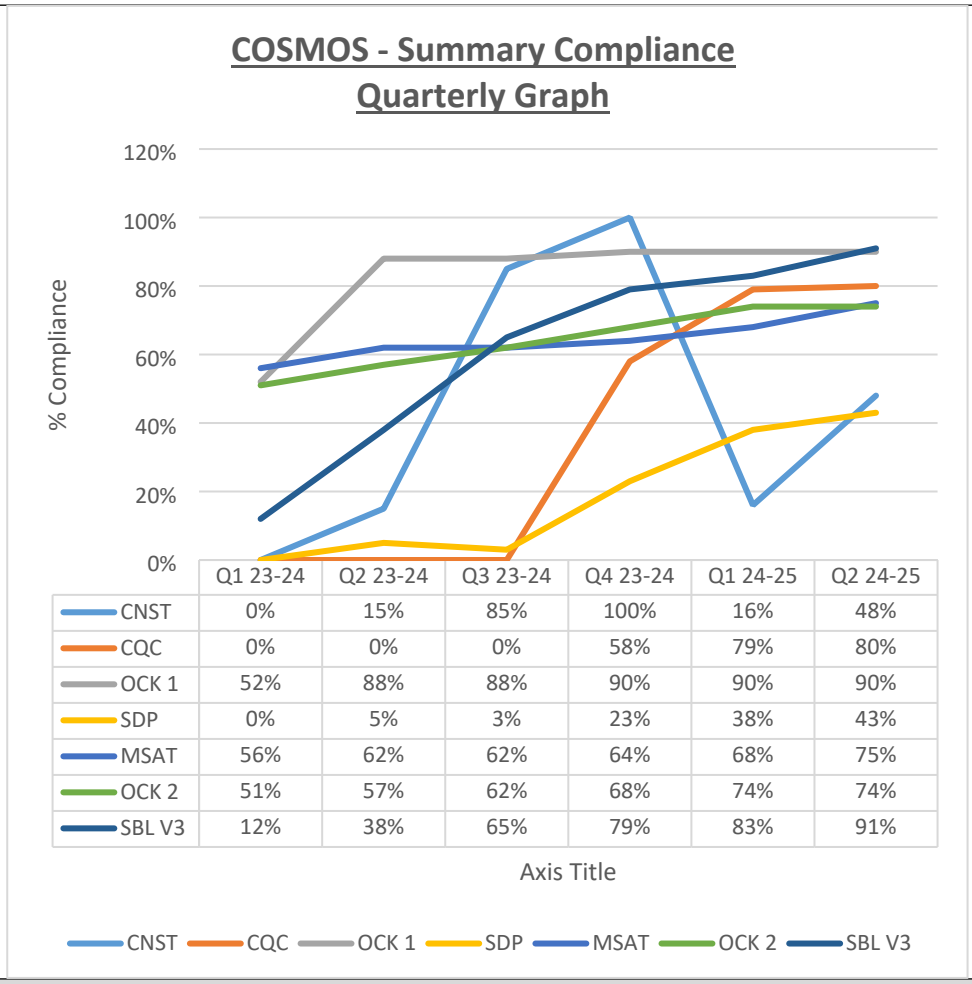
Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coronor reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
November 2024	15.0	1.0							2	0		3									3	3	3
October 2024	28.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	4	0	0	0	0	0	3	3	3
September 2024	28.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	4	0	0	0	0	0	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

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 24-25	Q2 24-25
CNST	0%	15%	85%	100%	16%	48%
CQC	0%	0%	0%	58%	79%	80%
OCK 1	52%	88%	88%	90%	90%	90%
SDP	0%	5%	3%	23%	38%	43%
MSAT	56%	62%	62%	64%	68%	75%
OCK 2	51%	57%	62%	68%	74%	74%
SBL V3	12%	38%	65%	79%	83%	91%

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. Q2 Claims scorecard

Claims and incidents Q2 2024-2025.pptx

Quarter 2 – 2024-2025

Maternity Incentive Scheme – Safety Action 9: Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Worcestershire Acute Hospitals NHS Trust

Claims scorecard – updated by NHSR in June 2023, received by Trusts in November 2023. aim summary on following page)

- The claims scorecard contains all CNST claims with an incident date 01/04/2013 and 31/03/2023
- Q2 discusses the updates from the previous quarter – a meeting with NHSR took place on 24.09.2024 to explore in more detail.

- The NHSR presentation is embedded on the next slide but they identified that :
- In the last 10 years 94 obstetric claims have been submitted to the Trust.
- If all claims were paid out in full, this would cost almost £150 million.
- There are currently 32 open claims
- Out of the 62 closed claims, 18 were settled without damages; 44 were settled and damages paid totalling just under £5million
- The most common 'cause code' for volume of claims is fail/delay treatment with a total of 39
- These are further broken down into:
- Additional/unnecessary operations – 8
- Unnecessary pain – 4
- Stillbirth – 3
- Bladder damage – 3
- Sepsis – 2

When the value of settled claims is examined, the reasons are different however:
- Brain damage ~ £29 million
- Cerebral palsy ~ £14.8 million
- Other visual problems ~ £2 million
- Additional/unnecessary operations ~ £1.05 million
- Sepsis ~ £700,000

- It will be interesting to note over the next few years how our brain damage and CP claims change as we transition to physiological CTG interpretation – anecdotally we feel we have already seen a reduction in MNSI cases/therapeutic cooling as result of the work already undertaken
- Further work is required to understand more about the additional/unnecessary operations and what these relate to eg. return to theatre for RPOC, secondary PPH etc.
- Increasing use of the SEIPS model is suggested by NHSR to further enhance and understand the interactions between systems instead of focusing on simple linear cause and effect relationships.
- Training on SEIPS is available and being explored by the directorate.

Incidents Q2 24-25

299 incidents reported under maternity and neonates in Q2 24-25

Top 9 sub-categories:
- Unexpected term admissions (54)
- PPH >1500ml (24)
- Malfunction [of CTGs] (17)
- Omission/missed drug (14)
- Maternity staffing issues (8)
- Shoulder dystocia (8)
- IUD, Stillbirth or Neonatal Death (7)
- Cord gases pH <7.1 at birth (5)
- Breach of confidentiality (4)

Complaints Q2 24-25 - 12 received (1 under neonatal but actually relates to maternity care)

- Delay in induction of labour (4)
- Attitude of Nursing Staff/midwives (2)
- Inadequate frequency of observations(1)
- Birth injury (including fetal laceration at LSCS) (1)
- Delay or failure to follow up (1)
- Delay or failure undertake scan/x-ray etc (1)
- Blood transfusion inappropriate/unnecessary (1)
- Communication with patient (1)

Themes Q2 24-25

- The total number of term admissions in Q2 was actually 47 – again, it is excellent that there are more incidents submitted as this means there is duplicate reporting between both areas
- PPH's continue to be reported as expected as part of the ObsUK trial – ongoing work is underway to ensure these are appropriately reviewed without duplicating work to ensure a more streamlined process.
- The emerging theme of omitted/missed drugs is a new one and has been seen equally across maternity and neonates. There is no definitive cause or reason – the medications vary from missed vitamins, delayed antibiotics and feeding supplements, late completion of the KP sepsis tool and others – this will be monitored over the next few months to see if there is an ongoing trend or just a one off. No harm has occurred.

Learning Q2 24-25

- From a complaint - a baby had their newborn blood spot test taken on day 6 at home, when ideally it should have been taken on day 5. Though compliance is generally >96%, reminders have been shared with staff
- A woman was admitted to the ANW for 48hrs before it was recognised her baby was too small to be born at WRH if needed and she was transferred to a level 3. This should have happened on admission. Learning has been shared with staff and is included on the SBL study day.

RCOG clinical escalation toolkit launched in September 2024 – the maternity team have launched the RCOG toolkit – including Teach or Treat, Team of the Shift and AID – this has been well-received and is included on PROMPT training. This is long term project to improve our clinical education, and we have also produced a guideline to support this too, particularly addressing when there is a difference of clinical opinion.

Action Plan Q2 24-25 - Actions that have been completed and require monitoring to ensure embedded are on the following page

Not started | In progress | Complete

Review of handover processes unit wide is required – need standardised approach to handover – QI project identified and planned for early 2025	SS to coordinate	03.03.25	
Ensure all staff aware of translation technology via iPad Discuss with Comms team, LMNS and MNVP around Trust wide message informing patients that staffing can be male and/or female.	LK SS/LK	15.11.24 30.11.24	

Update and information from Q2 2023-2024

Claims scorecard April 13 – March 23 – summary *(NB. It would appear as if some cases have been recategorized from the previous scorecard)*

Top 5 injuries by volume:	Top injuries by value (14):
• Fail/delay in treatment (33) • Fail/delay in diagnosis (8) • Fail to respond to abnormal FHR (5) • Failure to recognise complication of (4) • Inadequate nursing care (3)	• Fail / Delay Treatment (5) • Fail to make response to Abnormal FHR (4) • Fail To Recognise Complication (1) • Failure to interpret USS (1) • Other (bladder damage) (1) • Birth defects (1) • Inappropriate case selection (requested CS – did not happen) (1)
Top causes by volume: • No cases listed	**Top causes by value:** • No cases listed

Learning and Themes Q2 24-25 – update for Q2 in bold - some have and will be monitored through the action plan

- Medical discharge reviews to be completed by senior clinician – **no recent reported issues in Q2 – IT inform us if any have not been received and this is monitored by our Digital midwives**
- **VTE risk assessments is now being monitored via the ISAG report and included on ward to board reports**

NST/CTG update – as mentioned in Q1, there was an issue identified with the NST accuracy – ongoing regular meetings have been held with Philips and Siemens; an MHRA submission has been sent and it is likely we will request a return of 14 machines and replace with an alternative, while we work with Philips to improve their algorithm. No harm has been identified with any of these issues due to the mitigations in place and vigilance of staff.

Action Plan 24-25

Not started	In progress	Complete	Paused

	Action	Date	Initials	Update	
Q1	VTE audit to review accuracy of completion on admission	31.12.24	DB	This audit is paused at present due to other competing priorities	
Q1	Share learning regarding uterine anomalies (as above)	20.08.24	SS	A poster has been developed and shared with staff – info re anomalies is also on the SBL study day	
Q1	Review guideline to ensure is clear with easy to follow referral pathways	31.12.24	DA/CHC	New Preterm Midwife will be in post shortly – guideline is under review	
Q1	Produce SOP for contraindicated medication to ensure all staff aware of need for urgent referral if taken by women and birthing people	31.12.24	SS/DA/ CHC	A SOP is in draft and will be circulated and approved in December 2024 – the issue is much of the medication has American names and therefore needs to be cross-checked with English brands/versions	
Q1	From SB deep dive – ongoing work required regarding BSOTS, training, audit and compliance – this has also been evidenced in a recent MNSI draft report				
	Refresh and update guideline and recirculate	31.10.24	DA	Guideline updated and shared	
	Repeat audit from Jan 2024 with a particular focus on identifying barriers to 15 minute initial assessment	31.12.24	DA/MT	Already in progress	
	Holistic risk assessment for antenatal and intrapartum care – ongoing work required and ensure guidance is clear and detailed and algorithm correct in BN	02.02.25	KG/CR/ DM/CB	Already in progress as part of fetal surveillance work – needs further detailed investigation to ensure accurate for all women	

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**10/12/2024**
Title of Report:	**Midwifery Safe Staffing Report October 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)

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'***

Lisa Wilkes
05/12/2024 15:27:32

[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%	5.16%↑	19.16%↑
Turnover rate (rolling)	11.5%	8.85%↓	14.22%↓
Vacancy rate (MW)	7%	8% ↓	13.%↓ *
Maternity Leave	-	4.73%↓	2.89%↓
Midwife to birth ratio (in post)	1:24	1:21	
1:1 care in labour	100%	Achieved	
Shift leader SN	-	Achieved	

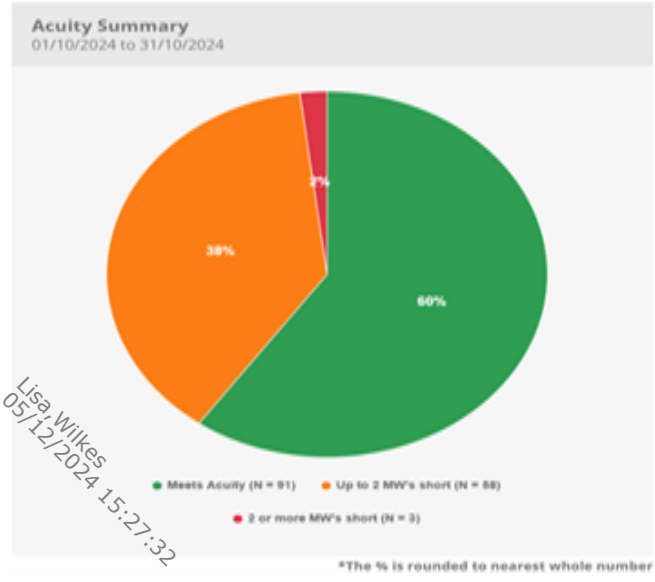
*Following change in establishment

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 82% of the expected intervals therefore the data presented is now reliable.



The diagram above presents when staffing met or did not meet the acuity. From the information available the acuity was met in 60% of the time and recorded at 40% when the acuity was not met prior to any actions taken. This is a decrease to the previous month. This indicator is recorded prior to any action taken. Safe staffing levels were maintained on all shifts in October following the mitigations taken that are detailed below.

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=18 occasions) of when staff are reallocated from other areas of the inpatient service. In addition, there were four reported occasions when the community/continuity teams were deployed to supported the inpatient area. There was one report of staff not being able to take breaks,

Number of Management Actions
01/10/2024 to 31/10/2024

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	18	78%
MA2	Redeploy staff from community	4	17%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	4%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	0	0%
MA11	Maternity Unit on Divert	0	0%
TOTAL		23	

*The % is rounded to nearest whole number

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 five red flag reported in September – the SL reported that they were not supernumerary during the shift, however they were rostered to be supernumerary at the onset of the shift. There were also 3 reported delays/cancelled time critical activity.

Number of Red Flags recorded
01/10/2024 to 31/10/2024

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	50%
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	1	50%
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	0	0%
TOTAL		2	

*The % is rounded to nearest whole number

Birth Centre

In October the completion rate for the acuity app for the birth centre was at 80%. The acuity was reported as being met 100% of the time.

Intrapartum & Non-Birthing Categories
01/10/2024 to 31/10/2024

Categories	Number in Categories	Percentage
Cat I	33	57%
Cat II	6	10%
Cat PN	19	33%
Cat X	0	0%
TOTAL	58	

*The % is rounded to nearest whole number

The number of women accessing the birth centre has fallen in month mainly due to deployment of staff to delivery suite and the ward areas to maintain safety, Antenatal & Postnatal Wards

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 were three no harm staffing incidents:

1. Antenatal ward staffing at minimum safe staffing levels
2. Delay in ANC start due to late arrival of medical staff
3. Cancelled NHSP shift – midwife sonographer

Medication Incidents

There were three no harm medication incidents:

1. Drugs omitted /administered late
2. Adverse reaction to Ferrinjet
3. CD book not completed accurately

Monitoring the midwife to birth ratio

The ratio in October was 1:21 (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 September 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	77%	n/a	n/a	n/a
Antenatal Ward/Triage	93%	87%	71%	69%
Delivery Suite	94%	93%	41%	95%
Postnatal Ward	92%	93%	74%	81%
Meadow Birth Centre	72%	70%	81%	64%

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 2023. 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 21WTE unfilled clinical midwifery posts and no unfilled specialist roles – vacancy rate now at 8%. There are 6WTE MWs expected in November. The remaining posts have been offered and the are expected to start in February 2025. There are 7 WTE MCA posts vacant with plans to recruit.

Sickness

Sickness absence rates for midwives were reported at 5.16% and 19.16% for non-registered staff – this has increased in month. 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 8.85% for midwives and at 14.22% for non-registered staff – this is a reduction in both groups. 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.

Two 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 six datix reports for staffing and medication incidents submitted, no harm was identified.

Sickness absence rates for midwives and non-registered staff has increased in month. Ongoing actions are in place to support ward managers and matrons to manage sickness effectively and maintain improvements.

The rolling turnover rate is at 8.85% (MWs) and 14.22% (MSWs & MCA's). The vacancy rate is at 8% for MWs and 13% for MCA's. There are 21WTE 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 COMMITTEE REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**10/12/2024**
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 October 2024 with numerical data presented for September 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 October 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 has been presented to TMB. The winter acuity and dependency study commenced on September 2nd 2024, and ran for the advised 30 days. Data has now been analysed and meetings with CNO have been booked for the beginning of December.

Reduction of agency spend & average hourly rate, remains a focus. We continue to demonstrate sustainability in the reduced usage of Tiers 2, 3 & 4 and in the removal of off framework agencies in general areas. As all tier 1 agencies are now capped rate the focus moving forwards is to look at the continued offset of agency with bank, specifically for registered nursing.

4. Executive Summary

Lisa Wilkes
05/12/2024 15:27:32

[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 stable agency spend.
- The reduction in overall absence rates for both registered and unregistered nursing in September 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

N/A

Lisa Wilkes 05/12/2024 15:27:32

NHS
Worcestershire
Acute Hospitals
NHS Trust

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 October 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 October 2024 there were 18 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.

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 September 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>97%</td><td>100%</td></tr><tr><td>HCSW</td><td>97%</td><td>116%</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 116% is raised but stable for the 6th month and is impacted by areas acknowledged to have both high acuity and high numbers of boarders. This has been described in the acuity and dependency review paper and agreed at TMB, substantive recruitment is underway.	6

Lisa Wilkes
05/12/2024 15:27:32

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 September 2024 was **8.7 (decreased slightly from 9.1 in August)**. The average national range for CHPPD is **9.1** with a variation of **6.33 to 15.48**, which the Trust falls within.

In September two areas fell below the minimum of 6.33, which were Aconbury 3 & Aconbury 4 with both areas scoring 6.0. This was a focus at the acuity and dependency meetings.

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%)

September 2024 data

Current Trust Position **WTE** **September 2024 data**	**Previous month** **August 2024**	**Model Hospital data Dec 2023 Benchmarking**	**Current level of Assurance**
RN 3.96% (86.33 WTE) HCSW 9.33% (99.82 WTE)	RN 6.14% (133.92 WTE) HCSW 10.04%	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.

To note, there are 24 confirmed HCA starters in October, with a further 45 in the pipeline due to start November / December.

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. Data regarding the international pipeline has been circulated to all divisions to allow for the development of CPIP's.

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.

The Trust held a face-to-face recruitment event on the 21st of September at CHEC, with exceptionally good attendance, predominantly from the Feb 2025 cohort at University of Worcester, with 37 offers of employment being made on the day. A further event aimed at the September 25 qualifying co-hort is booked for the 5th and 6th of April 2025.

A recruitment event for HCA's was held on the 8th November at KTC with 30 offers being made across the Trust, (these are included in the pipeline previously mentioned). Further face-to-face recruitment events are planned through to April 2025.

Bank and Agency Usage
September 2024 data

Bank and agency usage, total combined RN & HCSW of 604.28 WTE deceased in September (from 634.83 WTE in August).

Triangulated data for sickness / vacancy and maternity leave gives an overall absence of 307.19 WTE for registered (not including midwifery) and 214.12 WTE for un-registered nursing.

Model Health System (MHS) data shows wards fully established hence the difference from 4.6% (MHS) to 16-24% at WAHT.

Overall nursing pay costs in month 6 are £14.8m.
Substantive nursing pay spend of £11.8m in September is an increase of £0.1m compared with spend in August. The adverse movement is a normalisation following an old year accrual release in the previous month which was partially offset by an increase in spend relating to the bank holiday worked in August.
Bank spend of £2.0m in September is a decrease of £0.1m compared with spend last month. The favourable movement is due to less shifts being used to cover vacancy and specialing.
Agency spend of £1.0m in September is consistent with last month.