Worcestershire Acute Hospitals NHS Trust

A G E N D A

TRUST BOARD

Thursday 19th October 2023

13:30 – 16:00

Microsoft Teams
Live streamed on YouTube.

Russell Hardy
Chair

Item		Assurance	Action	Enc	Time
088/23	**Welcome and apologies for absence:**				**13:30**
089/23	**Items of Any Other Business** To declare any business to be taken under this agenda item				
090/23	**Declarations of Interest** To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.				
091/23	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on 18th September 2023*		*For approval*	**Enc A** **Page 4**	
092/23	**Action Log**		*For noting*	**Enc B** **Page 14**	
093/23	**Chair's Report**		*For noting*	**Verbal**	
094/23	**Chief Executive's Report**		*For noting*	**Enc C** **Page 15**	**13:35**
	Best Services for Local People *BAF 2, 11, 13, 14, 16, 17, 18, 21*				
095/23	**10 Point Plan** Chief Executive		*For discussion*	**Enc D** **Page 19**	**13:40**
	Patient Story				
096/23	**Patient Story**				**14:00**
	Best Experience of Care and Outcomes for our Patients *BAF 3, 4, 11, 19, 20*				

097/23	**Integrated Performance Report** Executive Directors		*For assurance*	**Enc E** **Page 23**	**14:20**
098/23	**Committee Assurance Reports** Committee Chairs		*For assurance*	**Page 54**	
099/23	**Maternity Safety Report** Director of Midwifery	Level 5	*For assurance*	**Enc F** **Page 66**	**14:40**
100/23	**Bed Cleaning Report** Chief Nursing Officer	Level 4	*For assurance*	**Enc G** **Page 82**	**14:50**
101/23	**IPC Update** Chief Nursing Officer		*For assurance*	**Verbal**	**15:00**
	Best Use of Resources *BAF 7, 8, 11*				
102/23	**Accountability Framework** Chief Operating Officer		*For approval*	**Enc H** **Page 91**	**15:10**
	Best People *BAF 9, 10, 11, 15, 17*				
103/23	**Safest Staffing Report** Chief Nursing Officer **a) Adult/Nursing** **b) Midwifery**	 Level 5 Level 6	*For assurance*	**Enc I** **Page 125** **Page 134**	**15:20**
104/23	**Guardian of Safe Working** Chief Medical Officer	Level 6	*For assurance*	**Enc J** **Page 142**	**15:30**
105/23	**Responsible Officer Report** Chief Medical Officer	Level 5	*For assurance*	**Enc K** **Page 146**	**15:40**
	Governance				
106/22	**Audit & Assurance Report** Committee Chair	Level 5	*For assurance*	**Enc L** **Page 163**	**15:50**
107/22	**Board Assurance Framework** Company Secretary	Level 6	*For approval*	**Enc M** **Page 165**	**15:55**
108/23	**Any Other Business** *as previously notified*				**16:00**
	Close				

Appendices are enclosed within the Reading Room

Seven Levels of Assurance

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time ie 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

Board Assurance Framework

Strategic Objective	*Assigned BAF Risks*
Best Services for Local People	BAF 2 – Public engagement BAF 11 – Reputation BAF 13 – Cyber BAF 14 – Health & wellbeing BAF 16 – Digital BAF 17 – Staff engagement BAF 18 – Activity BAF 21 – ICS
Best Experience of Care and Outcomes for our Patients	BAF 3 – Clinical Services BAF 4 – Quality BAF 11 – Reputation BAF 19 – System (UEC) BAF 20 – Urgent Care
Best Use of Resources	BAF 7 – Finance BAF 8 – Infrastructure BAF 11 – Reputation
Best People	BAF 9 – Workforce BAF 10 – Culture BAF 11 – Reputation BAF 15 – Leadership BAF 17 – Staff engagement

** Note - assurance against BAF risks is as stated on each report and risks/objectives may overlap*

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON MONDAY 18 SEPTEMBER 2023 AT 12:30 PM AT WORCESTER ROYAL HOSPITAL AND STREAMED ON YOUTUBE

Present:		
Chair:	Russell Hardy	Chair
Board members: (voting)	Glen Burley	Chief Executive
	Simon Murphy	Non-Executive Director
	Neil Cook	Chief Finance Officer/Deputy Chief Executive
	Colin Horwath	Non-Executive Director
	Dame Julie Moore	Non-Executive Director
	Karen Martin	Non-Executive Director
	Helen Lancaster	Chief Operating Officer
	Sarah Shingler	Chief Nursing Officer
Board members: (non-voting)	Richard Oosterom	Associate Non-Executive Director
	Richard Haynes	Director of Communications and Engagement
	Rebecca O'Connor	Director of Corporate Governance
	Jo Newton	Director of Strategy & Planning
	Vikki Lewis	Chief Digital Information Officer
	Michelle Lynch	NExT Director
In attendance	Justine Jeffery	Director of Midwifery
	Jo Wells	Deputy Company Secretary
	Jules Walton	Deputy Chief Medical Officer
	Liz Faulkner	Deputy Director People & Culture
	Scott Dickinson	Director of Estates & Facilities
	David Raven	Divisional Director – Urgent Care
	Wendy Joberns-Harris	Director of Operations – Urgent Care
	Rebecca Lloyd	Dementia Clinical Nurse Specialist
	Simon Adams	Healthwatch
Public		Via YouTube
Apologies	Tina Ricketts	Director of People and Culture
	Tony Bramley	Non-Executive Director
	Christine Blanshard	Chief Medical Officer/Deputy Chief Executive
	Sue Sinclair	Associate Non-Executive Director

070/23 **WELCOME**

Mr Hardy welcomed all to the meeting which was the first meeting since Worcestershire joined the Foundation Group. There had been incredible support amongst staff.

Thanks were extended to the following members of staff:
Sue Backburn, T&O nurse has left the Trust after a number of years.
Clare Bush, Divisional Director of Nursing for her work regarding the new Urgent & Emergency Care Centre.
Team members who joined the 10k Worcester City Run on behalf of the Trust Charity.

Mr Hardy was conscious there were significant delays being experienced within the hospital and extended apologies to patients affected. The need to improve performance was recognised along with hospital acquired decline when patients remain in hospital.

071/23 **ANY OTHER BUSINESS**
No further business was declared.

072/23 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

073/23 **PATIENT STORY**
Ms Ria Wilkins joined the meeting to share the experience of her family following her mother's diagnosis of early onset dementia in 2011, through to her death in 2023 aged 65.

Sue was aged 54 when she sought help from her GP after she had had symptoms for some time. Her final diagnosis of early onset dementia was given in October 2011. A dementia diagnosis was not well known at the time and the family had to do much of their own research and were not informed of different agencies to liaise with.

Sue visited a dementia café which was helpful, but they were often held in the day which were difficult to attend and the evening meetings were cancelled. At one meeting at the café, the family were informed that that they could apply for a disabled parking badge, which the family were not aware Sue was entitled to.

Sue saw a Psychiatrist in the community on 5 occasions but once her medication levels were right, they disengaged. Ria's father became ill and was in and out of hospital over a period of 4 months. During this time, the family arranged for some daycare options but these had to be sought themselves.

Sue had worked as a dinner lady and had to see a specialist in order to retire the grounds of ill health. A Social Worker assisted with funding for care and was assigned NHS carers but there were occasions where they did not arrive so the family sought private carers as there were gaps in care.

During the summer of 2022, Sue had a TIA. An ambulance was called and Sue was taken to Worcester. Due to delays, she remained in the ambulance for 8-10 hours. She was not able to leave to visit the toilet and had nothing to eat or drink. Eventually Sue was given aspirin and sent home with a follow up with her GP. A RESPECT form and SALT were mentioned but the family were not aware of what they were and neither were followed up.

In time, Sue declined, could not weight bear and had low blood pressure. The family called 111 who arranged for an ambulance. Worcester was on divert to Redditch at the time and though Hereford actually a closer hospital, the request to transfer there was refused. On arrival at Redditch, there were no delays and Sue was taken to a side ward. It was found that she had a chest infection and was treated with antibiotics. She was then transferred to a ward and the family left for the evening. The family received a phone call from a consultant seeking permission to have a GN tube fitted. The complications were explained but recommended that it was fitted. The following day, Sue had been moved again and it became apparent to the family that she was being discharged. The nurse in charge did not know that there was no care package in place and at this point, Ms Lloyd intervened and moved Sue to another ward. The family were given a card which allowed them to stay with Sue at all times. No one had explained to the family that Sue was likely weeks from passing away. A SALT assessment was undertaken where Sue was deemed to be 'feed at risk' and recommended pureed food.

The family found Ms Lloyd and the team very helpful, but between Sunday to Friday Sue had been moved 5 times, which was confusing for a patient with dementia. There was a lack of communication between wards and Sue was non-verbal.

When Sue returned home, she required a hospital bed which the family moved themselves to a bedroom from the ground floor. Carers were put in place who visited 4 times a day. There were issues with 'just in case' medication as this took time to acquire. No hospice support was offered.

The key learning from the story was communication and the lack of resources or signposting to get information.

Mr Hardy thanked Ria for sharing her difficult story and thanks were extended to Ms Lloyd for her assistance and support. Ms Lloyd advised that communication could have been better. Patients with dementia are now subject to limited moves and it was important that relatives can stay with the patient, particularly when they are non-verbal.

Ms Shingler apologised on behalf of the Trust. Work was underway with the fundamentals of care, communications and feeding. Working closely with families to co-produce work was encouraged and Ms Shingler advised that she welcomed Ria's feedback and opportunity to work with her to make further improvements.

Mr Hardy thanked Ria for sharing the challenges the family experienced and their willingness to help others.

074/23 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 13 JULY 2023**
The minutes were approved.

RESOLVED THAT: The Minutes of the public meeting held on 13 July 2023 were confirmed as a correct record.

075/23 **ACTION SCHEDULE**
The actions were updated as per the log. Only one action remained open and Ms O'Connor noted the Board Development plan would be reviewed.

076/23 **CHAIR'S REPORT**
There was nothing further to escalate outside of the Chair's introduction.

RESOLVED THAT: The Chair's report was noted.

077/23 **CHIEF EXECUTIVE'S REPORT**
Mr Burley thanked the teams at Worcestershire for making him feel welcome at the Trust and highlighted the following areas within his report:

- There are a number of issues the organisation faced which would be focused upon, one being ambulance handover delays.
- Ian Sturgess had carried out a number of reviews of urgent and emergency care. The issues had been discussed with clinicians at both Worcester and the Alex. Flow needed to improve and getting patients home as quickly as possible.
- A 10 point plan had been shared with the Board during a development workshop earlier in the day and was endorsed.
- Priorities over the next 12 months had been identified and would be shared at the next Board meeting.

- Mr Steve Colman had been appointed as the Managing Director and would be joining the Trust on 1st November 2023.
- The Lucy Letby case was something that could happen in any part of the NHS. Staff should be supported to speak up and challenge data.
- A winter planning letter was published at the end of July and allowed preparations to be put in place. This included job cards across the system for accountability.
- The capital incentive linked to UEC performance was referenced along with the NHS workforce plan.
- Changes to fit and proper persons were being introduced.

Mr Murphy referred to the flow problems and reflected that the causes of the issues are not in isolation of the Acute Trust. Mr Hardy agreed and added that all partners needed to work together to ensure that patients flow quickly and are discharged as quickly and safely as possible.

RESOLVED THAT: The report was noted.

078/23 **COMMUNICATIONS & ENGAGEMENT REPORT**

Mr Haynes presented the report and highlighted the following:

- Thanks were extended to everyone who had supported the fund-raising appeal for the new ED development.
- The paediatric VR headsets were successful.
- Rumour Mill was proving to be a popular service for staff.
- The Worcester City Run had taken place over the weekend and it was anticipated over £7k would be raised for the Charity.
- Culture month starts in October.
- The Trust was moving ahead with the new internet and Intranet service.

RESOLVED THAT: The report was noted.

Best Services for Local People

079/23 **TRUST RESPONSE TO NHSE LETER – VERDICT IN THE TRIAL OF LUCY LETBY**

Mr Hardy introduced the report and confirmed that all members of staff who work at the Trust can reach out to him personally with any concerns that they may have.

Ms Shingler presented the letter received from NHSE which asked the Board to rapidly review 5 points. The report presented outlined the Trust our assurance which had been discussed in detail at the Quality Governance Committee.

Strong governance processes are in place, but people who wish to cause harm will try to work around processes in place regardless. Focus was on being alert and early identification of concerns and near misses. This is applicable to the whole Trust, not just maternity and neonates.

All 5 key aspects had been reviewed. Processes are in place along with avenues that staff can raise concerns. Ms Shingler had been approached by staff reporting issues to her since her commencement in post and there were staff networks, Freedom to Speak Up (FTSU) Guardians and Champions available within the Trust. Safeguarding training included gaslighting awareness and a Managing Allegations Policy was in place.

In 2016, an increase in deaths was identified and a review was undertaken. No trends or causes for concern were found. The concern was acted upon appropriately with the Chief Nursing Officer at the time requesting the review and prompt action was taken. There was robust governance with regards to safeguarding and Board oversight.

Dame Julie noted that until relatively recently, the Trust did not have a Medical Examiner but the team were now in place and every death is reviewed. Listening to people raising concerns was paramount and taking lessons learnt was encouraged. Mr Hardy added that FTSU was not introduced until after the events reported in this case had taken place.

Ms Martin noted that although there was awareness and support in place, she had been informed by staff that that it took a long time for them to receive feedback, particularly following Datix reporting. Ms Shingler replied that quality boards in ward areas were being reviewed and a new process for daily huddles in all clinical areas were being adopted from another Trust with affect from October.

Mr Hardy commended the paediatric and midwifery teams who go to phenomenal effort to ensure safety.

RESOLVED THAT: The report was noted for assurance.

080/23 **UEC OPERATIONAL READINESS**

Ms Lancaster noted that a Board Workshop had been held earlier in the day to discuss readiness and preparedness regarding the opening of the new ED.

The Board were informed that though the new ED would be opening, the rest of the organisation needed to support improved flow.

The original proposed go live date was 2nd October 2023, however the date now coincided with industrial action by Junior Doctors and Consultants and was deemed to be a clinical risk. Approval was sought for a rescheduled go live date of 16th October 2023. The Quality Impact Assessment and go/no go criteria is detailed in the report.

Mr Hardy thanked the teams involved and advised that the recommendation to reschedule the opening was sensible. Mr Hardy cautioned that ED delays will likely remain until the root causes of flow issues were resolved.

Mr Burley supported the rescheduled date and encouraged taking learning from other Trusts. Mr Raven confirmed that the Trust was working with partners regarding the priority pathway. The team had also worked with Walsall, visiting their site to discuss the opening of their new ED. Mr Raven extended his thanks to local residents for their generous donations. A successful launch was at the heart of those involved, a number of whom were also local residents.

RESOLVED THAT: The recommendation of 16th October UEC go live was approved.

Best Experience of Care and Outcomes for Patients

081/23 **INTEGRATED PERFORMANCE REPORT**

Mr Cook introduced the newly formatted report which continued to focus on flow as a key improvement initiative. The Trust continued to struggle with elective long waits.

Cancer standard challenges remained within dermatology and urology and teams were working with partners for longer term sustainability. Pressures were also being experienced in relation to the capital programme.

Operational Performance

- Ambulance handover delays over 60 minutes during July were significantly challenged. A slight improvement was seen in July but the position has not been sustained.
- Flow is important to reduce ambulance handover delays and is an area of focus.
- Standard Operating Procedures were being reviewed to maximise opportunities.
- A number of 'No delays today' events have been held. A further event was planned in October prior to the opening of the ED.
- The frailty service was under review across the Group.
- Length of stay was also under review.
- Reporting on activity through SDEC and the number of patients that are waiting in ED was underway.
- Virtual ward programmes are limited. Work was underway to drive supporting earlier discharge out of wards.
- The cancer 28 day faster diagnosis standard as of July was reported as 70.4% against a target of 75%.
- Some access to diagnostics challenges were reported. Actions are in place and supported by mutual aid from the Foundation Group.
- A business case to increase the clinical workforce in urology diagnostics was being drafted.
- There were challenges around dermatology and plans were in place to mitigate. The team were working with partners at Wye Valley.
- Challenges were reported around histology reporting and 62 day cancer targets due to capacity in the teams.
- Issues with urology were detailed in the report.
- 3 104 week waiters were reported.

Mr Murphy referenced the insufficient alternatives to ED and queried if there were any plans of any initiatives that may be introduced in due course. Ms Shingler advised that she was leading this piece of work. It had been agreed that there would be one point of access to stream patients to alternatives. Services would be reviewed who can provide support better for patients and families in their own home. There will be certain access points through SDECs so patients are not waiting in ED. The timeline was being agreed with a view to implementing shortly. Mr Oosterom advised that more information on length of stay, discharges and patient moves would be useful.

Mr Oosterom referred to dermatology and asked for an update on the plans. Ms Lancaster replied that the Trust no longer have a significant number of substantive Consultants. Working was underway with Wye Valley to be a lead provider of dermatology using outsourcing and mutual aid. Primary care had been approached to ensure that referrals are appropriate. Mr Burley added that services will be delivered locally. Mr Hardy encouraged taking the learning from how it became a fragile service and apologised to patients who are waiting a long time.

Quality

- A new patient safety reporting framework was going live at the end of the month.
- Sepsis work would relaunch to improve screening.

- Fractured neck of femur remains an area of focus. An action plan was being created with the division.
- Additional theatre capacity was being worked through to deal with surge more effectively.
- The Trust was not compliant with any YTD targets for IPC.
- An increase in Covid-19 outbreaks was reported.
- In 23/24, new metrics were being introduced to monitor hospital acquired pressure ulcers. There is no national target to benchmark, but teams were working across the Foundation Group to agree local targets.
- No hospital acquired pressure ulcers were reported in July that caused harm.
- Complaints performance achieved 70% in July but 130 complaints remain open and 62 have breached the 25 day target. The surgery division continue to struggle and hold 53 of those breaches. A trajectory has been agreed with the division and additional support had been introduced to clear the backlog by November. A specialist lead was being considered to review the process over the next 12 weeks to make improvements.

Mr Murphy advised that a regional comparator on crude rates with peers would be useful. Mr Hardy replied that the full Foundation Group meet every 3 months where cross Group comparisons could be made.

<u>People & Culture</u>

- Plans were in place to reduce agency spend down to 6%. There is a challenging PEP scheme to contribute towards reduction.
- Sickness absence had reduced to 4% from 5.5%, in line with partners.
- A deep dive of sickness absence had been undertaken. Plans were in place to support managers with the policy.
- Job planning compliance challenges were reported. Divisions were being supported and teams were working with Group partners regarding software.

Ms Martin referred to recruitment, specifically HCAs and sought clarification that the 241 leavers were overall and not related to new starters. Ms Faulkner informed that there was a 15% turnover of HCAs and clarified that the 241 leavers were overall.

Mr Horwath noted that the time to hire had reduced and asked whether it was sustainable. Ms Faulkner replied that it should be sustainable following the recruitment team business case. Mr Oosterom encouraged focus on meeting job planning targets given their importance to productivity.

<u>Finance</u>

- A £1.7m adverse variance was reported. A summary table of key drivers is included within the report.
- Assumed elective recovery income is £1m off track.
- PEP reported an adverse variance of £1.4m at month 4.
- Capital is severely challenged as a consequence of UEC overspend. £5.5m was the expected overspend.
- VAT reclaim is being appealed.
- Cash balance was reported as £11m which is £4.4m below plan.
- Run rate will be a challenge as the year progresses.
- Agency spend is a key focus. Significant resource had been invested into the recruitment team but the benefits were not yet being seen.

Mr Oosterom noted a significant amount of insourcing was in place and asked why. Mr Cook replied that it was largely at tariff and above due to pressures. A deep dive would be undertaken next week.

RESOLVED THAT: The report was noted for assurance.

082/23 **COMMITTEE ASSURANCE REPORTS**

- Finance & Performance – Main issues highlighted in report have been discussed.
- Quality Governance Committee – The Letby report and issues with bed cleaning were the key items of discussion. A review of bed cleaning would be presented at the next Trust Board. C.Diff and IPC issues in kitchens were also discussed.
- People & Culture Committee – New icons were being introduced for staff to better understand the tools in place.

RESOLVED THAT: The Committee reports were noted for assurance.

083/23 **PROTECTING ELECTIVE CAPACITY SELF ASSESSMENT**

Ms Lancaster advised that a letter had been received from NHSE requesting submission of a self-certification by the end of September, against four key areas of focus: Validation, first appointments, outpatient follow ups and support required.

For each of the four areas the following levels of assurance are proposed for board approval:

- Validation (four elements) – two assured, two partially assured
- First Appointments (two elements) – two assured
- Outpatient follow-ups (four elements) – three assured, one partially assured
- Support required (one element) – one assured

For those areas above that are partially assured, further plans in are place or in development which will be overseen by the Elective and Cancer Delivery Group and the Trust Management Executive.

Approval was sought for the delegation of sign off of the self-certification by the Chair and Chief Executive.

Mr Horwath queried if there were any implications of only reporting partial assurance. Mr Burley replied that it was likely that there would be further assurance required.

RESOLVED THAT:

- **Approved the proposed assurance ratings for submission to NHSE by 30 September 2023.**
- **Delegation of sign off by the Chair and Chief Executive was approved.**

084/23 **COMPLAINTS & PALS ANNUAL REPORT**

Ms Shingler presented the Annual Report which highlighted the performance and activity of 2022/23.

The highlighted key priority in 2023/24 is for focus on complaint themes and to drive the quality improvement agendas. Work was underway to standardise how the complaints process is managed across divisions and focus was the on improvement of first responses to reduce the number of complaints.

Ms Martin observed that response times within the surgery and women's and children's divisions were poor. Ms Shingler replied that experienced support had been assisting the surgery division. Women's and children's have some complex complaints and the team preferred to meet with families which adds time. There was the option of extending the timescale of complex complaints. Ms Jeffrey added there had been a recent fluctuation in complaints within the division. Investigations are completed prior to complaint responses, therefore the 28 day timeline is challenging. Mr Hardy encouraged completing responses with empathy and sympathy at a pace that is agreed with the family.

Ms Martin noted that the common theme is clinical treatment and asked for reflection on how the issue could be tackled with divisions.

RESOLVED THAT: The Complaints & PALS Annual Report 2022/23 was approved.

Best Use of Resources

085/23 **STANDING ORDERS**

Ms O'Connor advised there were technical changes required to the Standing Orders to enact the Board decision to join the Foundation Group as detailed in the report. The Audit & Assurance Committee had reviewed the Standing Orders and were subject to legal review.

Mr Hardy advised that as Chair he would present any Vice Chair and/or Board nominations to Board for approval via his Chair's report. Ms O'Connor confirmed this was in accordance with the current practice.

RESOLVED THAT: The Standing Orders were approved.

Best People

086/23 **SAFEST STAFFING REPORT**

a) Adult/Nursing

Ms Shingler highlighted the following key points of the report:

- Paediatric and Neonatal were safely staffed.
- Staffing on all adults areas were also safe.
- No incidents or safety concerns had been raised as a result of industrial action.
- Surge capacity around UEC and A&E corridors continue and replied on temporary staffing solutions.
- 61 minor incidents had been reported regarding nurse staffing absence but resulted in no significant harm.

b) Midwifery

Ms Jeffrey highlighted the following:

- There had been a reduction with sickness performance.
- Turnover has increased due to long term sickness resignations.
- 1:1 care in labour was achieved.
- Supernumerary status of team leader was not met. This has impacted the CNST status for this year.
- There was no additional funding in relation to Birthrate+.
- Acuity was met 81% of time without any redeployment.
- 4 medication incidents had been reported, 1 led to harm.

- There was a high level of vacancies but 21wte were joining across September to November.
- Focus was on retaining support workers.

RESOLVED THAT: The reports were noted for assurance.

Governance

087/23 **ANY OTHER BUSINESS**

Healthwatch were invited to comment. Mr Adams looked forward to continuing the good relationship that was being built with the Foundation Group.

Mr Hardy thanked Ms O'Connor for her support and assistance during her time at the Trust and wished her well for the future in her new role.

DATE OF NEXT MEETING

The next Public Trust Board was scheduled for 18th October 2023.

Signed _____ **Date** _____
Vice Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

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

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

NHS
Worcestershire Acute Hospitals
NHS Trust

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

Chief Executive Officer's Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
N/A		

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

Risk														
Which key red risks does this report address?	N/A		**What BAF risk does this report address?**	N/A										
Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	X				
Financial Risk	None directly arising as a result of this report.													

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

Worcestershire Acute Hospitals NHS Trust

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

Introduction/Background

Outpatient Transformation

The challenge of the Elective Recovery Plan nationally has accelerated thinking on the transformation of outpatient activity. Around 80% of activity on the NHS waiting list actually takes place in a non-admitted pathway i.e. In Outpatients rather than in operating theatres. Our outpatient activity falls into two main groups, first outpatient attendances (new patients) and follow up outpatient attendances. The ratios of new to follow up activity vary greatly between specialties and between clinicians. Some of the higher follow up ratios can be explained clinically, such as those associated with complex long term conditions or where prescribing cannot be managed by primary care. But in many cases the variation appears unwarranted.

The national Getting it Right First Time (GIRFT) programme has been very successful in developing best practice data by specialty and then comparing this to local, clinician level data. Last year the Trusts in the Foundation Group were invited to join the GIRFT-enabled 'Further Faster' programme. This programme works with 28 pilot trusts to improve outpatient productivity in collaboration with clinicians across all sites.

The Further Faster programme will hopefully soon be rolled out to include a further cohort of trusts including ourselves but the learning from elsewhere in the Group can be shared now. I have been impressed with the programme, particularly by way that it is grounded on clinical evidence. One of the bigger areas of focus has been the drive to reduce unwarranted follow up appointments, in many cases replacing these with arrangements which are more flexible for patients. Patient Initiated Follow-Up (PIFU) is one solution. Here the patient is not given a fixed date for a follow up but instead given the opportunity to book one if needed over a time limited period. This therefore leads to a greater level of patient awareness of their condition and allows them to take control. What we have found through the programme is that the level of reactivation (i.e. request for a further appointment) is really quite low. Those who do wish to be seen again are able to be seen more rapidly than the previously fixed re-appointment slot. My only concern relating to this approach is that it could lead to more patients being 'held' on a PIFU pathway where in some cases it may be better and potentially more motivational for them to be discharged. In such cases they can return to their normal life content that our excellent Primary Care teams are there to support them. As a consequence, I have introduced the alternative mantra of TOFU (Take Off Follow Up!) as a challenge to ensure that both options are fully considered.

We are also using technology to make services more accessible and responsive. Telephone and video clinics provide a very convenient way of following up patients where a hands-on clinical examination is not required. Wearable devices and other assistive technologies can also support such an approach. Such clinics can then also triage patients so that they can go 'straight to test' into outer diagnostic services where required. App based technologies can also support triage to test.

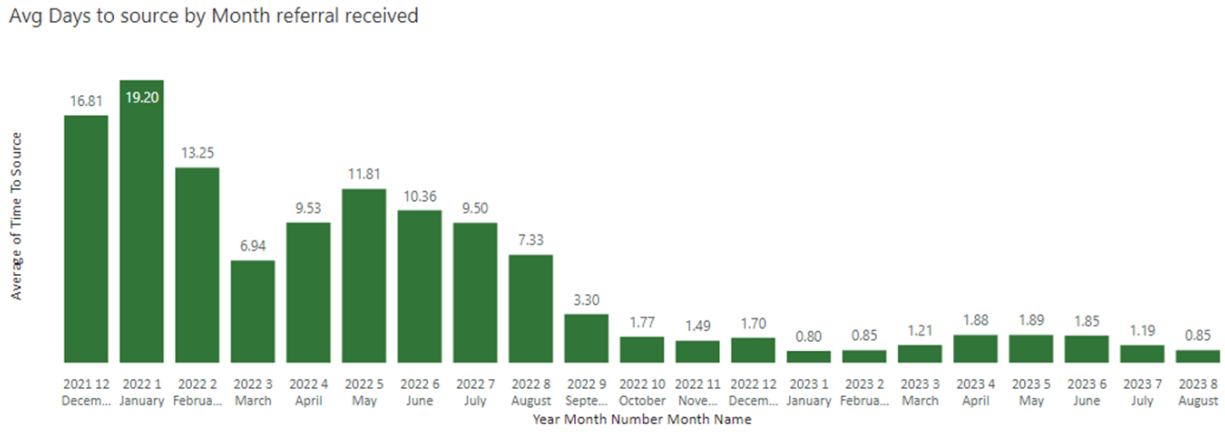
Increasingly, General Practitioners (GPs) are contacting our specialists for Advice and Guidance (A&G) prior to referral. This also can be assisted by technology to route calls or emails directly to the right team and then on to 'straight to test' pathways if required. There has been a suggestion nationally that these 'A&G' pathways could become the only elective referral route for GPs in the future. Whilst this may be advantageous, it also runs the risk of encouraging inappropriate use of Accident and Emergency (A&E).

The expansion of Same Day Emergency Care (SDEC) services has also changed the profile of outpatient referrals. Ideally SDEC should be a better alternative to admission for patients who present as emergencies. I do have a concern that this could become a means of fast-tracking

outpatient referrals, particularly where routine waiting times are stretched. To avoid this, we should ensure that there are a suitable number of 'hot clinic' slots in appropriate specialties which can offer an appointment within a few days of assessment by our acute medical teams or on the advice of our specialist teams.
This impact of all these initiatives should be that we require fewer follow up outpatient slots and less physical outpatient capacity. The manpower that this frees up can initially be directed to tackling the non-admitted care backlog. But in the long run we should consider whether a switch to supporting Urgent and Emergency Care (UEC) pathways may deliver even more value. We will therefore need to carefully model our demand assumptions.

Integration Frontrunner

This Warwickshire-wide project is being led by South Warwickshire University NHS Foundation Trust (SWFT) in collaboration with Integrated Care System (ICS) partners. The objective is to increase the capacity and responsiveness of the Domiciliary Care sector to ensure that we can effectively deliver the levels of Discharge to Assess (D2A) Pathway 0 (rehabilitation and assessment at home) to meet need. The approach includes making commitments to suppliers in advance of need (pre-booking) and adding enhanced therapy support delivered by NHS staff. The approach has significantly reduced the time between the identification of need and the delivery of the care package. The chart below shows the average time to source packages in days, charting the period from December 2021 through to August of 2023. These are very encouraging results which we will be seeking to maintain over the coming winter.



1) NHS Finances

Additional NHS funding which the Prime Minister announced in September 2023 for 'winter' will be used to cover Trusts' additional costs linked to strike action, and hence will not be available to support new initiatives. It comes amid growing concerns over national finances this year after the positions reported by ICSs in the four months to August 2023 were around £800m worse than planned. The overspending against the plan is significantly worse than any comparable figure reported by the sector at this point in the year during the last decade. The impact of strikes, inflation and other pressures including prescribing and continuing healthcare costs mean that most areas have struggled to keep to their spending plans. There is further concern that many other systems, including Coventry and Warwickshire and Herefordshire and Worcestershire are currently off plan but are not yet reporting that they will miss their targets. NHS England (NHSE) plan to hold the

additional funding back and use it later in 2023-24 to cover costs expected to be caused by industrial action.

NHSE is still considering how to distribute the money, but it is still anticipated that it will be allocated locally later in the year, rather than used for central costs. At this stage it is unclear how this will be allocated. It is clear that strike action has affected different trusts in different ways. It is also clear that some trusts have been more aggressive in-patient cancellation ahead of strike action. Rates of reimbursement to other clinicians providing enhanced cover during strikes has also been quite variable, including application of the British Medical Association (BMA) 'rate card'. In my view it would be wrong to simply reimburse trusts based on their stated costs as this could inadvertently penalise organisations which have worked harder to minimise the impact of strikes on patient care. It may therefore be more sensible to use a formulaic approach to allocating appropriate shares of the funding.

More from our great teams

Alex Theatres

September saw the opening of two brand-new operating theatres at the Alexandra Hospital.

The state-of-the-art theatres are part of our wider plans to develop the Alexandra Hospital as a surgical centre of excellence. They will allow a dedicated team of specialist medical and nursing staff to provide care to around 2,300 patients a year once fully operational. The theatres are providing additional capacity to help the Trust with Elective Recovery and the delivery of improved waiting times.

The £18m facilities are being used to treat general surgery and gynaecology patients requiring day case or inpatient surgery and bring the total number of theatres at the Alexandra Hospital to nine.

The development is a purpose-built modular building for theatres and is linked to the main hospital via a traditional build, which includes staff changing facilities and a dedicated theatre recovery space. These additional facilities are due to open in December following a further phase of work.

Sterile Services

Sterile Services have also recently had an investment to update aging infrastructure with the replacement of two washers to support the new theatres. A new traceability system enabling equipment to be tracked through all stages and locations within the sterilisation process has also been implemented across all sites in CSSD and theatres to support more efficient management of equipment availability.

Issues and options

Recommendations

The Trust Board is requested to

- Note this report.

Appendices – None

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

10 Point Plan

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Board Workshop	19 September 2023	Approved

Recommendations	Board members are asked to approve the refocus of priorities.

Executive summary	Following discussions at our previous Board development session and engagement with staff in a number of different forums, including our most recent Senior Leaders' Brief, we have developed a 10-point plan for the Trust which aims to simplify and clarify our immediate shared priorities. Experience tells us that in challenged organisations, there can often be a proliferation of priorities and a related exponential growth in the number of meetings at which those priorities are discussed. While both of these are understandable, they can also detract from a focus on outcomes as well as obstructing, rather than facilitating, the delivery of urgent improvements which everyone recognises are needed. The plan will help our executive directors and other senior leaders to focus their time, energy and considerable skill and experience on those things which we know will drive the most important improvements in quality, safety and efficiency over the next few months. While it may not be an exhaustive list of all of our 'must do's' it will contribute directly to their delivery (for example, while it does not specifically reference our finances, it is clear that addressing issues around flow, optimising use of elective capacity and improving recruitment, retention and staff satisfaction all bring with them significant financial benefits as well as improvements in quality, safety and patient experience). The plan will also help staff in all parts of the organisation to understand the part they have to play in delivering and sustaining those improvements, as well as signalling to them that we are committed to addressing the problems that impact on their daily experience of coming to work (including the widely known issues of car parking and site access). The plan also signposts the start of some potentially significant shifts in our longer-term direction of travel and strategic intent. While these will be shaped by

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
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	further conversations with our patients, public, partners and staff the principles include a greater focus on prevention and population health and wellbeing, more collaborative working across Worcestershire all of which we will revisit as a Board in future. Once the wording of the plan is finalised, a more visually appealing version will be produced and shared.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 12:

Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	x
Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes.									

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

Recommendation
Board members are asked to approve the refocus of priorities.

Our 10-point plan

The aim of this plan is to set out clearly to colleagues and partners our Trust's immediate priorities for the next few months and to help our teams understand where their focus needs to be.

It also reflects a commitment by the Trust's senior leaders to simplify and clarify key areas of work so that we can address the most pressing challenges we face a well as starting a conversation with our people, our partners and our patients about how we can change what we do and how we work to seize the opportunities that the future holds.

Focus on Flow

Our most immediate priority is improving patient flow across all parts of our urgent and emergency care pathway. We will work together across our Trust to make sure that patients in need of urgent care do not spend a minute longer in any part of our hospital than they need to. That includes tackling long ambulance waits outside our emergency departments which are an unacceptable cause of harm to some our sickest patients.

We will improve our hospital pathways for general acute patients, including patients with frailty. This will reinforce our zero tolerance of avoidable delays at any stage of a patient's journey to reduce harm, deliver a better patient experience and ease pressure on our staff. This will be underpinned by a 'whole hospital' approach, a refresh of our internal professional standards for all clinical teams and a Trust wide commitment to getting the basics right.

Home First Mindset/There's No Place Like Home

Improving urgent flow will help to protect our patients from harm but helping them to avoid coming into hospital at all will keep them even safer, protecting them from hospital acquired functional decline, infections and the risk of falls.

A greater focus on the wellbeing of our population, working on prevention in the communities we care for and increased use of same day emergency care services will all help us to keep people out of our hospitals and safely at home. In familiar surroundings they are more easily able to maintain their physical and mental wellbeing and spend more time with their family, friends – even their pets.

Elective care – planning for no delays

We will make best and most efficient use of our services and facilities to make sure that every patient on our waiting list gets the most timely treatment possible, building and protecting our own elective capacity, adopting a 'no cancellation' policy and ending our reliance on insourcing from external providers.

Staff Experience

Making our hospitals even better places to work helps us to attract, and keep, the best people and deliver even better patient care. We will strive to be a very flexible employer and tackle the issues that we know impact on our people every day – that includes basics like getting to and from work easily and being able to park. We will encourage our staff to raise concerns through formal and informal channels.

Leadership and Structure We will empower leaders at all levels of the organisation, and help them to support and lead their teams, by giving them fewer priorities, clearer expectations and genuine accountability, underpinned by more effective structures. Immediate changes include bringing together our Urgent & Emergency Care and Specialty Medicine clinical divisions to support our focus on patient flow.
Governance We will spend less time in meetings and ensure that any meetings which do take place are kept short and have a clear purpose for everyone involved. Our revised performance and accountability framework will support the delivery of sustainable quality, safety and efficiency improvements.
4ward Improvement System We will make our improvement system simpler, more accessible and more relevant to our staff and focus on its practical application to deliver our priorities, improve quality and safety and drive efficiency and cost improvement.
Think (and Act) as a Lead Provider Looking beyond the walls of our hospitals we will actively work with partners across our health and care system to improve wellbeing of people in the communities we serve, deliver better health outcomes and reduce pressure on our services.
Tertiary partnerships Working regionally and with Group colleagues we will build productive, supportive partnerships which improve care for our patients and secure a sustainable future for our more challenged or fragile services.
Big Moves We will embrace the opportunities open to us as members of the Foundation Group family. We will test and refine our priorities (with our patients, our partners and our people) to make sure that we are meeting the immediate needs of our patients while also delivering improvements that move us closer to achieving our Group's shared long term strategic objectives and 'Big Moves' (including our environmental commitments as a major employer and user of resources)

Putting Patients First 4ward

NHS Worcestershire Acute Hospitals NHS Trust

Integrated Performance Report

September 2023

TRUST BOARD | FINAL | Up to Aug-23 data

Last updated 17th October 2023

MANAGING DIRECTOR – EXECUTIVE SUMMARY

Dr Christine Blanshard

Chief Medical Officer / Deputy CEO

Neil Cook

Chief Finance Officer / Deputy CEO

We present the Executive Summary in our joint role as Deputy CEOs, until our new Managing Director, Stephen Collman, takes up his post next month.

We continue to focus on improving urgent and emergency flow through the hospital as our number one priority, both to improve safety and quality of services for our patients and to ensure success of our new emergency department which opened on 16th October. The bright spacious department, with modern equipment and beautiful artwork will provide a much better environment for our patients and staff and enable more efficient working with our assessment areas and imaging. To prepare for the opening of the new department we undertook a multiagency discharge event (MADE) with our system partners, in order to discharge as many patients as possible and free up capacity. Whilst we did not achieve our discharge target with this event, we had excellent support and engagement from system partners and internal colleagues, and we learned a lot about things we can do internally to embed “standard work” (best practice) to ensure patients are not in hospital one second longer than they need to be.

We had further industrial action to contend with - junior doctors (20th-23rd September) and consultants (19th-21st September) The joint action on 20th September meant Christmas day levels of cover only were provided by both trainees and consultants. Clinical and operational managers worked hard to ensure safe levels of cover were provided but there was a further impact on elective activity and agency spend. On a positive note, our two new West theatres opened at the Alex in September, bringing much needed additional capacity online.

Also, in September we implemented our new Electronic Patient record for ITU (ICCA) which has saved two hours of nursing time per day and prevented on average 2.5 prescription errors per day.

In Aug we overspent against our plan by a further £1.8m bringing our cumulative overspend against plan to month 5 of £8.2m. Of this overspend £1.6m is driven by budgetary phasing associated with late agreement of the plan with the ICB and £2.1m is due to one off items of expenditure that we could not have foreseen at the time of writing the plan the majority of which relates to the cost of Industrial Action. The balance of £4.6m relates to pressure on budgets due to high levels of demand for services and patient acuity together with a lag in delivery of our Productivity & Efficiency Programme of £2.5m.

OUR OPERATIONAL PERFORMANCE

Helen Lancaster

Chief Operating Officer

Our focus remains on delivering improvements in hospital flow, and Elective and Cancer recovery as our top operational delivery priorities so that patients requiring access to emergency care and those on our waiting lists can do so without unacceptable delays. As I wrote last month, this continues to be a significant challenge for our operational and clinical teams, working together with our system partners.

Our number one priority remains hospital flow. At the time of writing this, we have postponed the planned opening of our new Emergency Department on the Worcestershire Royal site because of the joint industrial action in early October by British Medical Associate Consultants and Junior Doctors. As I wrote last time, industrial action continues to have a significant impact on our ability to deliver the timely care we want for our patients. Not only as a direct result of workforce availability during the industrial action but the residual impact on capacity and demand as well as the knock-on impact to the whole of our workforce

In August we saw a reduction in the percentage of ambulance handovers completed within 15 minutes, alongside an increase in the number of delays over 60 minutes. Clearly this isn't what we want for our patients. Our overall Emergency Access Standard remains an area of concern, with too few patients leaving the department within four hours of arrival. The reasons for this are multifactorial and our Patient Flow Improvement Programme continue to focus on making the necessary improvements including maximising the use of assessment areas and other alternatives to Emergency Departments, improvements in clinical site management and ward systems and processes. We have also linked in with Foundation Group colleagues and are working with the ICB to develop and implement a new Integrated Frailty Model and are focussing on reducing the length of stay for patients admitted as an emergency.

Our efforts continue in delivering the improvements we need to make for our patients on our elective and cancer waiting lists and whilst we have made significant progress in reducing the number of patients waiting over 78-weeks there is still more work to do. As a result of our positive progress, the Trust has been stood down from the national Tier 1 oversight arrangements which is a testament to the efforts of our operational teams. At the end of August there were 61 patients waiting more than 78-weeks for their treatment and four over 104-weeks. At the time of writing the number over 104-weeks has reduced further. Clinical divisions have refreshed their delivery plans, and we are working with them to go further and faster in operationalising these. In line with the details shared with the board last month, we are on target to ensure that the majority of patients who could be waiting over 65-weeks at the end of the year, will have been seen for their first outpatient appointment by the end of October. Our plans to ensure that every patient waiting over 12 weeks is contacted continue to progress and we are working on the longer-term plans for our ongoing validation programme.

Cancer delivery remains an area of challenge with Recovery Action Plans in place in number of specialties to support our delivery of the Faster Diagnosis Standard, 31-day treatment and 62-day referral to treatment standards. Our biggest areas of concern continue to be Urology and Dermatology. In Urology, our team are working with partners from Wye Valley and Northampton General Hospital who are providing additional capacity for diagnostics and robotic surgery to bring down our waiting times for both diagnosis and treatment. In Dermatology, a mixture of mutual aid, insourcing and outsourcing arrangements are maintaining service provision in the short term, whilst we work with the ICB and Foundation Group partners to develop and implement a sustainable system wider service that continues to delivery high quality care for our local population.

There is more to do on our operational productivity in theatres and outpatients – where we have established transformation programmes - that will support our delivery of our activity plan and meeting the waiting time targets and we are working with the ICB and other system partners to explore opportunities to do things differently. We are due to shortly open new theatres at the Alexandra Hospital, that will provide an additional 20 theatres sessions per week. Our investment in insourcing and outsourcing capacity continues to support our delivery this year.

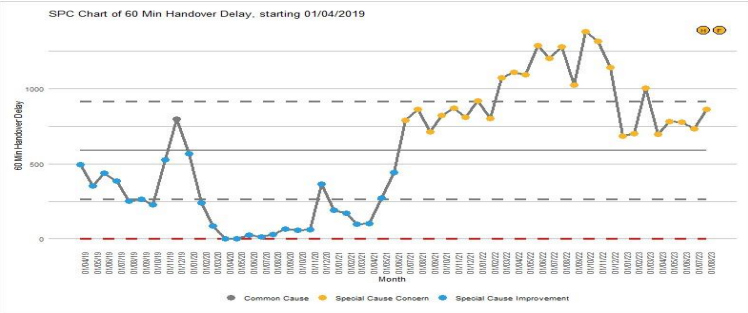
OUR OPERATIONAL PERFORMANCE - URGENT CARE

We are driving this measure because

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

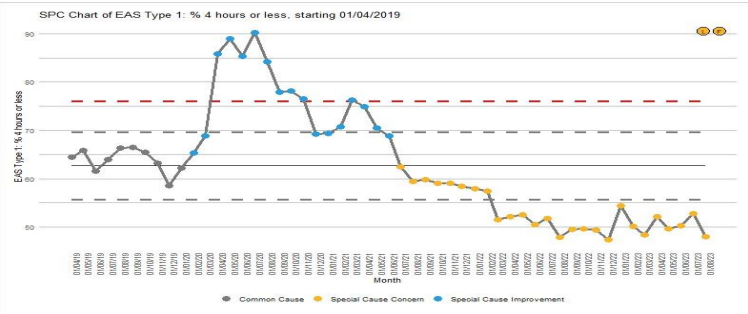
Assurance F **Variation** H

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



Assurance F **Variation** L

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



Performance and Actions

11,985 patients attended The Trust's Emergency Departments in August 2023. 48% of those were treated and either admitted or discharged within four hours of arrival against an expected end of March 2023/24 performance of 76%.

Of the 3,923 patients who arrived by ambulance, 38% were handed over within 15 minutes and 863 who waited longer than 60 minutes prior to handover. 1,769 patients (15%) spent 12 or more hours in our emergency departments.

Actions

- 'Perfect week' to test revised Standard Operating Procedures (SOPs) ahead of new Emergency Department completed – revisions to SOPs being made based on outcome of exercise.
- Increased SDEC opening hours to maximise opportunity to stream patients to alternative to Emergency Department
- Review and relaunch of Internal Professional Standards
- No Delay Today events in August and September, with MADE event in October 2023, prior to new Emergency department opening
- New Integrated Frailty Service development with support from Foundation Group members – expected phase 1 launch November 2023
- Review of Length of stay completed – highlighted significant increase in non-elective length of stay (see Hospital Flow section). Divisional action plans being developed and will be followed up through Hospital Flow Delivery Group
- Virtual Ward programme in development – Respiratory, General Medicine and Breast and gynaecology
- Winter assurance visit from NHS England on 29 September 2023
- Business cases for Winter funding submitted to NHS England – funding secured to support four priority programmes

Risks

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

What the charts tell us

4 hour and 60-minute ambulance handover performance has been a significant cause for concern since Jul-21.

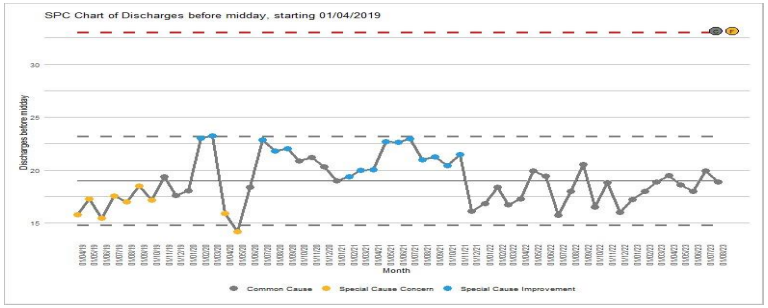
OUR OPERATIONAL PERFORMANCE – PATIENT FLOW

We are driving this measure because

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

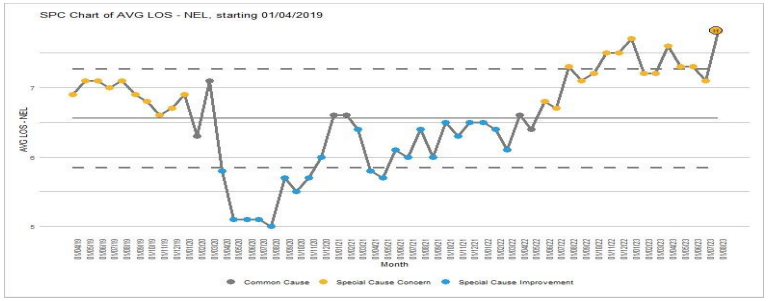
Assurance **Variation**

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



Assurance **Variation**

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



Performance and Actions

Discharges before midday dipped in August compared to July, having improved in July compared to June. However, the change is within the normal control limits. There has been no sustained improvement in the percentage of discharges before midday, which is impacting on the Trust's ability to deliver effective hospital flow and ensure timely admission for patients from the Trust's Emergency Departments (and other emergency admissions).

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

The Patient Flow Programme actions supporting hospital flow, and improvement in the specific metrics here are led by the Trust's Deputy Chief Operating Officer and Deputy Chief Medical Officer, include:

- Review and relaunch of internal professional standards
- Review of length of stay completed – divisional action plans being developed and will be followed up through Hospital Flow Delivery Group
- Relaunch of SAFER and standard Board rounds
- Virtual Ward programmes development - Respiratory, General Medicine and Breast and gynaecology
- Long Length of stay review process
- Criteria Led Discharge

The programme is overseen by the Hospital Flow Delivery Group, reporting to the Trust Management Board.

Risks

- Industrial Action
- Patient Acuity
- Clinical engagement

What the charts tell us

3,010 patients were discharged from G&A beds and 561 (19%) were before midday. The average LOS for a non-elective patient was 7.9 days; when you exclude patients for a zero LOS, this increases to 8.4 days.

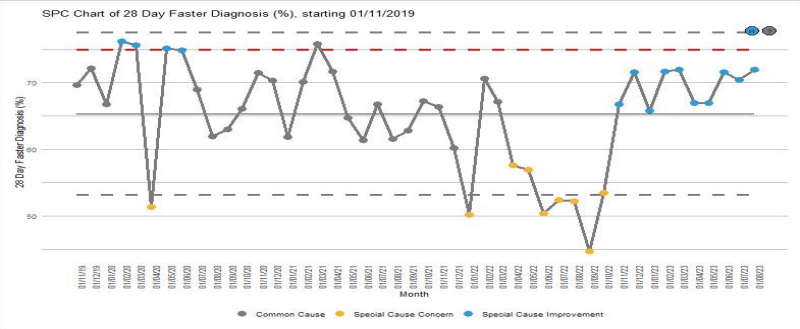
OUR OPERATIONAL PERFORMANCE - CANCER | 28 DAY FASTER DIAGNOSIS STANDARD

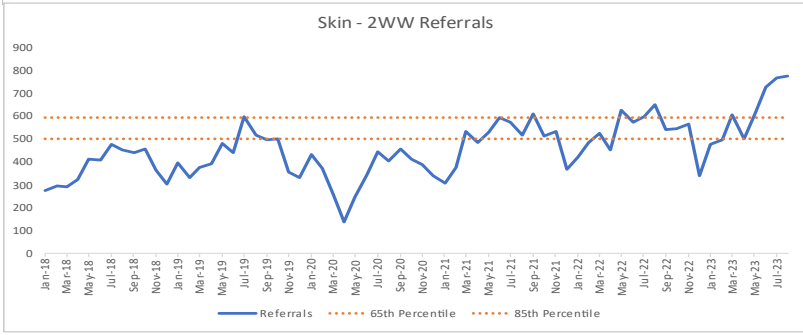
We are driving this measure because

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

Assurance **Variation**

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





Performance and Actions

There were 2,749 new GP referrals for suspected cancer in August 2023. This included the continuation of very high volumes of skin cancer referrals at 778, which is the highest on record.

Trust unvalidated performance against the 28-day Faster Diagnosis Standard is currently 72.3%. This is above the planned performance of 69.4% but below the national standard of 75%, which is expected to be achieved by the end of the financial year.

Main issues impacting performance and actions:

- Access to diagnostics, particularly on the Urology and Colorectal pathways remains a concern. In the short term, additional diagnostic capacity for cystoscopy and LATP is being provided through mutual aid by Foundation Group members. In the medium to long term, a business is being developed to increase clinical workforce to undertake these diagnostics locally. Demand for CT colonoscopy has increased due to changes in FIT referral criteria.
- Histology capacity remains a concern. This services is supported with outsourcing of reporting to backfill vacancies and maintain waiting times. A specific recovery action plan is being developed to address histology waiting times.
- Outpatient capacity for post diagnostic / MDT for review and conversation with patient to confirm diagnosis
- Industrial action has led to delays in cancer pathways for some patients due to cancellations of clinics and MDT meeting. Whilst these have been minimal it has had a direct impact on the 28-day standard. Where possible, MDT meetings have been re-provided within 5 working days to mitigate the impact.
- Exploration of introduction of standard Trust communications for patients with confirmed non-cancer diagnosis to be presented to Trust Cancer Board in October 2023.

Risks

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

What the charts tell us

Although performance is below the target of 75% it has improved significantly since Nov-22.

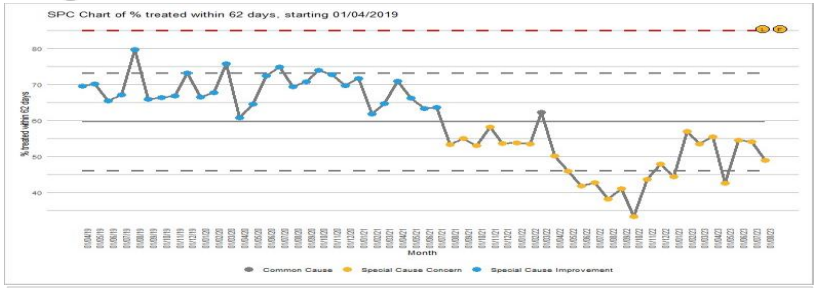
OUR OPERATIONAL PERFORMANCE - CANCER | 62 DAY START OF TREATMENT STANDARD

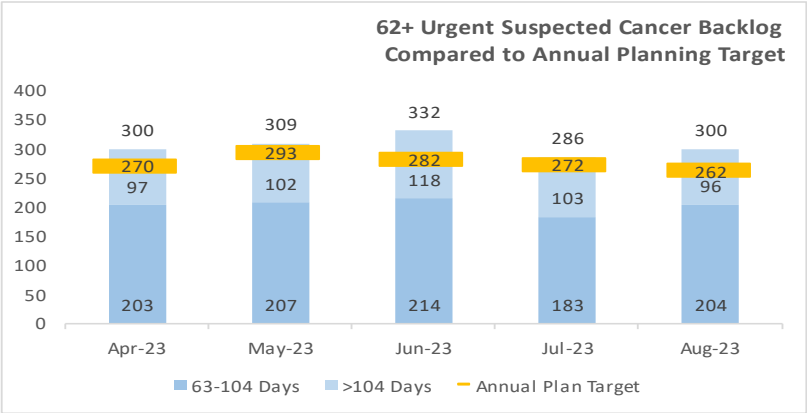
We are driving this measure because

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

Assurance **Variation**

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





Performance and Actions

The Trust unvalidated position for 62 days cancer waiting time performance in August 2023 is currently 48% with 98.5 patient breaches.

At the end of August there were 300 patients waiting over 62 days (against a planned position of 262). Of those patients waiting, 96 were waiting over 104 days. The Trust target for the end of the 2023/24 is to have no more than 190 patients waiting more than 62 days, with a target of 0 patients waiting more than 104 days.

Cancer waiting time standards have recently been revised (with effect from October 2023) – a briefing paper will be presented to Trust Management Board in October setting out the changes before more widely socialising with operational and clinical team.

Many of the drivers for performance align to the FDS performance. In addition, there are challenges with treatment capacity in some specialties driven by a combination of access to appropriate theatre capacity and clinical vacancies. In addition, a number of patients are dependent on treatment at tertiary centres – our focus for these patients is to ensure timely transfer of care to the appropriate tertiary provider.

Each specialty has a recovery action plan in place to address the drivers of performance to support the Trust to deliver more timely treatment to patients referred on a suspected cancer pathway.

Specific Task and Finish Groups are in place to focus on delivery of Urology Cancer pathways and Skin Cancer pathways.

Risks

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

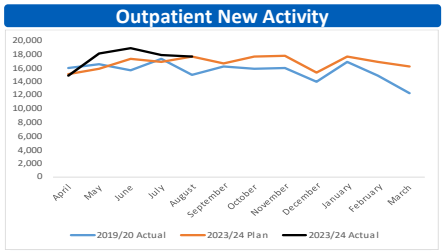
What the charts tell us

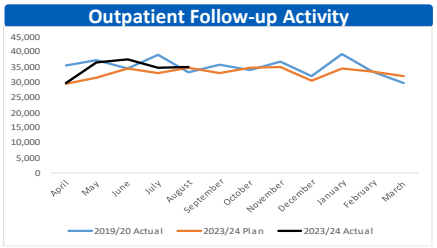
Performance against the cancer waiting times standard has never achieved the 85% target and has been below 50% for 12 of the last 24 months.

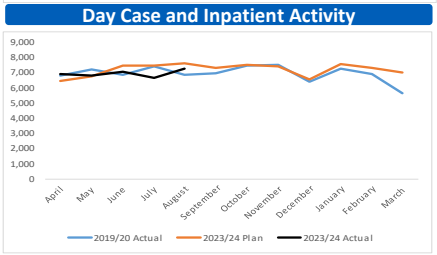
OUR OPERATIONAL PERFORMANCE - ELECTIVE RECOVERY

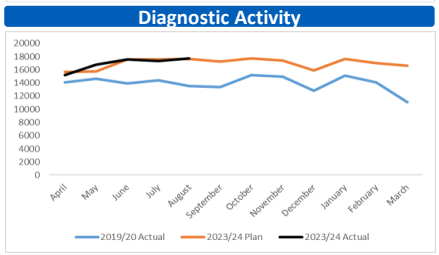
We are driving this measure because

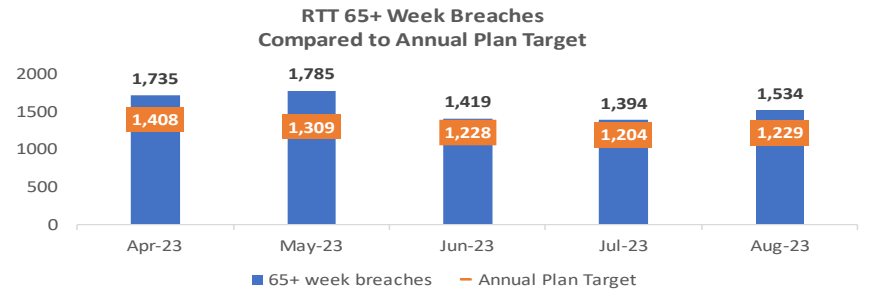
Elective recovery is a key priority to ensure that patients can access the treatment they need in as timely a manner as possible. To reduce the impact of waiting for non-urgent, consultant-led treatment, the Trust made a commitment to deliver a maximum wait of 65 weeks by the end of the 2023/24 as part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











Performance and Actions

In August 2023, the Trust delivered 17,736 new outpatient appointments (0.1% below plan) and 35,463 follow up appointments (1.8% over plan). Inpatient and day case activity was 4.6% under plan, with day case activity 221 spells under plan and elective inpatients under plan by 132.

Factors impacting the shortfall in elective activity include:

- Oral and Maxillofacial surgery – gaps in available consultant workforce
- Endoscopy – included insourced activity in plan, which commences in September.
- Ophthalmology – driven by workforce vacancies. Increased in activity expected from September and October, with further consultant start dates in January 2024.

As at end of August there were 1,534 patients waiting over 65 weeks, including 61 over 78 weeks and 4 over 104 weeks which is an increase in actuals and remains over plan.

Actions

- Ongoing validation of RTT waiting list in line with national guidance
- Finalise booking of all patients at risk of waiting over 65 weeks at end of March 2024, to ensure they have an appointment before end of October 2023 (unless they choose to wait longer). Based on length of wait from first outpatient to treatment this is seen as an enabler to delivery of 65-week maximum wait by end of March 2024
- Annual plan reprofiled and revised activity forecasts base on core and additional capacity completed. Divisional teams developing recovery plans at speciality level, with a focus on these scheduled for late October Performance Review round.
- Continued use of additional capacity (waiting list initiatives, insourcing and outsourcing, mutual aid)
- Focus on theatre productivity to maximise throughput through core capacity
- Opening of additional theatres to increase core capacity
- Use of locums to cover hard to fill vacancies

Risks

- Urgent care demand impacting physical capacity and staffing
- Ongoing Industrial action
- Workforce challenges
- Casemix of long waiters compared to 19/20 impacting value weighted activity

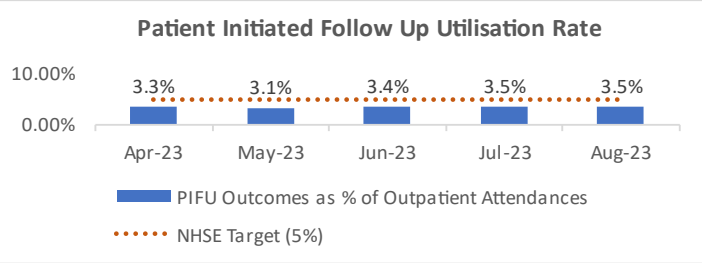
What the charts tell us

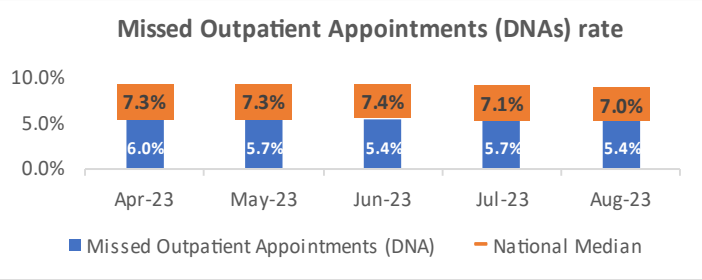
Outpatient New activity is above plan by 21 appointments and follow-ups were higher than plan, by 830 appointments. This was ~2,100 more than Aug-19. Day case and elective inpatient activity remains below plan and diagnostic activity is above plan in Aug-23 (CT, NOUS, Flexi Sigmoidoscopy and Gastroscopy achieved plan. MRI, Colonoscopy and Echocardiography did not achieve plan).

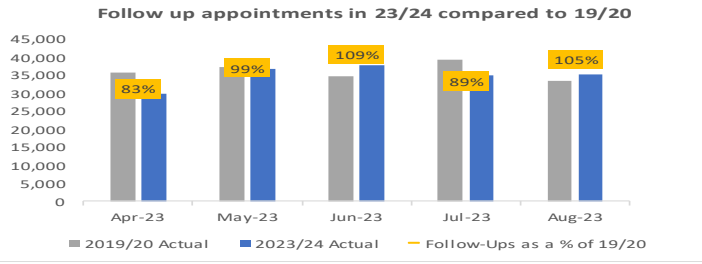
OUR OPERATIONAL PERFORMANCE - OUTPATIENT TRANSFORMATION

We are driving this measure because

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







Performance and Actions

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

Performance in Patient Initiated Follow Up (PIFU) remains static at 3.5%, which is under the 5% national target. However, a large percentage of specialties are delivering PIFU more than the national median at a specialty level.

Trust wide DNA rate in July was 1.5 percentage points below the national median though at a specialty level there is some variation. Whilst national median for August is not available at time of writing, the Trust rate has improved by 0.3 percentage points compared.

Actions

- Divisional teams to develop plans to achieve 85th percentile performance of PIFU
- Recent introduction of two-way SMS has led to reduction in volume of DNAs
- Revision of information shared with primary care to support both referral avoidance and streamlined pathways for patients who are referred (reducing follow ups) – known as common conditions
- Review of follow up waiting lists for PIFU pathway opportunities aligned to national best practice
- Specialty Deep dives by Trust's Outpatients Transformation Programme lead to identify further opportunities for pathway transformation including one-stop clinics, referral guidance for primary care to support direct access
- Access to GIRFT Further, Faster workbooks requested from NHSE
- Audit of DNA to understand reasons for individual DNAs to be undertaken to understand broad drivers and put in place appropriate actions
- Review and ongoing management of list of patients with repeat DNAs in line with patient access policy
- Review and appropriate revision of outpatient booking process to ensure appropriate patient choice and reasonable notice

Risks

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

What the charts tell us

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

Digital - Data Quality

Vikki Lewis

Chief Digital Information Officer

Our Data Quality Maturity Index value of 92.5 (in the latest published data – May 2023) remains higher than national average (80.8). Improvement opportunities for the Emergency Care Dataset are dependent on implementation of EPR Phase 7 – Emergency Care; and work continues with the Digital Midwives looking at improvements using Badgernet and its supporting operational processes for improvement in the Maternity Dataset.

The current confidence level as published in the national tool 'LUNA' for our RTT PTL (Referral to treatment patient tracker list) is 99.48%, with 4.64% of pathways identified as having a possible data quality error. This tool and the internally built data quality dashboard is supporting the validation of the Incomplete PTL both for alignment to the Trust Access Policy and the management of the waiting lists. In conjunction with the data quality improvements, the Trust Validation Team are supporting a robust response to the recent national requirement to communicate with all patients on the Incomplete PTL who have been waiting over 12 weeks, and then at regular intervals along their pathways. We have actively contacted all patients waiting over 12 weeks and had not yet had their first outpatient appointment (or did not have a future date), we are now actively progressing remaining cohorts.

A particular project being undertaken is the data quality assurance of an Active Monitoring report, which operational and clinical teams will use to ensure that patients have been booked and seen by their target dates.

In support of the above and the developing Patient Portal (self-service access to records for patients) we are also embarking on a project to ensure that we improve our mobile phone and email population in active patient records, this will support the enablement of ongoing and future Digital communications.

The Data Quality team are integral to the successful implementation of the EPR also, as they have the critical role in ensuring that the data transferred to the data warehouse that is then used in reporting, directly reflects the data as created in the user facing front end of Sunrise. The team work closely with the EPR Programme to resolve issues as they are identified and to create seamless reporting for the future phase releases. The current area of focus is therapies reporting and quality metrics.

OUR QUALITY & SAFETY

Dr Christine Blanshard

Chief Medical Officer / Deputy CEO

The Trust's mortality indicators remain within acceptable ranges during August 2023. The Summary Hospital-level Mortality Indicator (SHMI) remains within the expected range, both at Trust and individual site level. Across the Trust, 68 incidents potentially resulting in moderate harm or above to patients were reported in August, with 20 meeting criteria for Externally reportable Serious Incident (SI) Investigation, of which 8 were probably HCAI's and one was a Never Event (retained foreign object post procedure). The Never Event investigation is under way, led by the Patient Safety team.

The Never Event declared at the end of June 2023 regarding misplaced Nasogastric tube has been investigated; actions to be taken include a review of LocSSIP and reviewing/addressing of "essential to role" competency training for doctors undertaking this procedure.

Performance against the sepsis bundle being given within 1 hour decreased in July to 65.2% and remains non-compliant with the 90% target. A sepsis workshop with Divisional teams has been organised for October 10th to identify the causes behind the deteriorating picture and the required actions for improvement.

Our fractured neck of femur pathway showed a deterioration in August, achieving only 50% compliance with best practice tariff indicators (target 85%). Capacity, both in terms of bed availability and theatre were the most common reason for delays. A working group has been set up to focus on an improvement plan which has been created at Directorate level. The crude mortality rate for this condition continues to benchmark well within the Midland cluster at 10.34%.

Sarah Shingler

Chief Nursing Officer

We are currently compliant with the in-month infection targets for Klebsiella but not compliant with any of the other year-to-date targets. However, C-Diff, E-Coli and MRSA are all showing special cause variation of concern. There continue to be 6 active Covid 19 outbreaks, and 3 in the monitoring phase as of 11th September: with outbreaks of CPE (3) C-Diff (4), Pseudomas (1) and MRSA (1). Actions are the monitoring of 28-day MRSA screening compliance with feedback to wards with missed screens, this is in response to an MRSA BSI infection where the 28-day screen was omitted. A full RCA is in progress with initial learning points shared to Divisions. All our high impact intervention audits were compliant in Jul 23.

Our total number of HAPUs for Aug-23 dropped to 24, bringing the current total for 2023/24 to 104. This is a reduction from the same period last year when the total was 114. The total number of HAPUs as a % of Emergency Admissions also dropped to 0.72% in Aug (from 0.78% in Jul). There were zero HAPUs causing harm in Aug-23. The TVN team continue to support teams with education training programmes, and interventions in the correct choice of available resources; pressure relieving equipment and wound dressings.

Regarding complaints, the compliance target to close within 25 days has increased again this month to 76.1% but this is the 14th consecutive month that the target has been missed. The Trust had 147 complaints still open at the end of August (an increase of 17 from last month) and there were 65 new formal complaints received. Of these 147 complaints, 76 have breached 25 days (10 of which have been reopened) The Surgery Division accounts for 91 of the Trust's total open complaints and 69 of the complaints which have breached 25 days, 7 of which have been reopened.

- 25 Surgical cases are now approaching and over 6 months past their received date.
- 27 surgical cases are between 2 and 5 months overdue.
- 17 surgical cases are between 0 days and 2 months overdue.

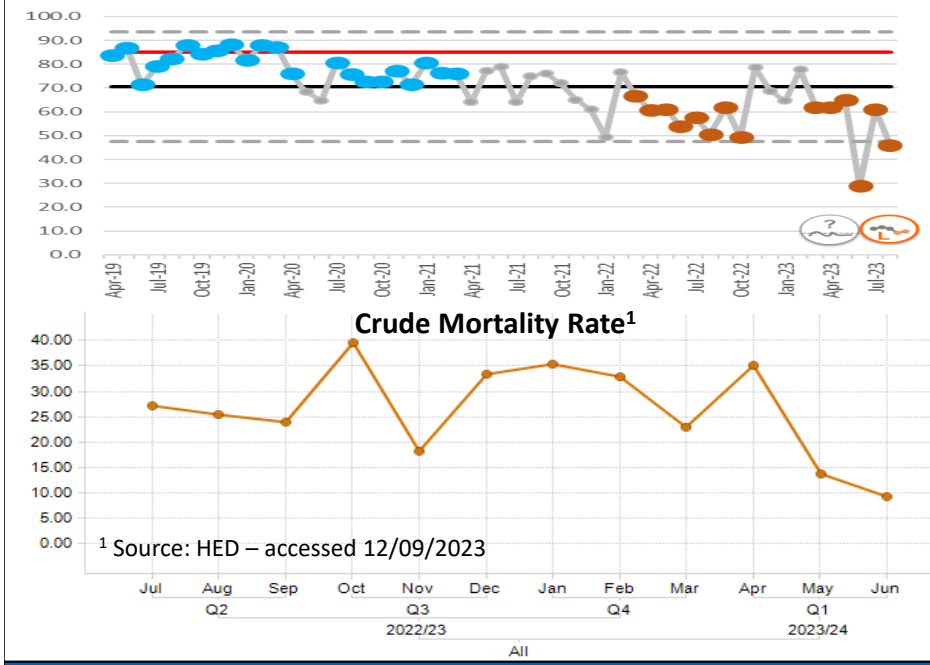
OUR QUALITY AND SAFETY – FRACTURED NECK OF FEMUR

We are driving this measure because

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

Assurance **Variation**

This metric is **deteriorating.** The target (95%) lies within the process limits so we know that the target **may or may not** be achieved.



Performance and Actions

- #NOF compliance dropped to 50% (BPT), and 46% (All) in Aug-23.
- The #NOF target of 85% has not been achieved since Mar-20.
- There were 54 (BPT) and 72 (All) #NOF admissions in Aug-23.
- There were a total of 27 (BPT) and 39 (All) breaches in Jul-23.
- The primary reasons for BPT delays were;
- 40.7% (11 patients) due to theatre capacity
- 25.9% (7 patients) due to bed issues
- The average time to theatre in Aug-23 was 42.1 hours (BPT) and 45.6 hours (All).

Actions

- Running a third trauma list on as many dates as possible to facilitate additional throughput
- Working with the site team to improve patient flow of complex discharges to ease bed pressures
- #NOF working group set up to focus on improvement plans

Risks

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

What the charts tell us

The Trusts Crude Mortality Rate for the period Jul-22 to Jun-23 for the diagnostic group of #NOF is 10.34% (In-hospital 3.54% & and Out of hospital 6.8%).
The Trust has the 4th lowest rate in the Midlands (out of 22 Trusts)

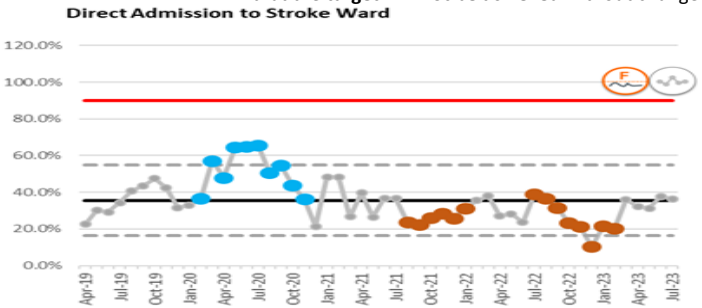
OUR QUALITY AND SAFETY – STROKE

We are driving this measure because

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

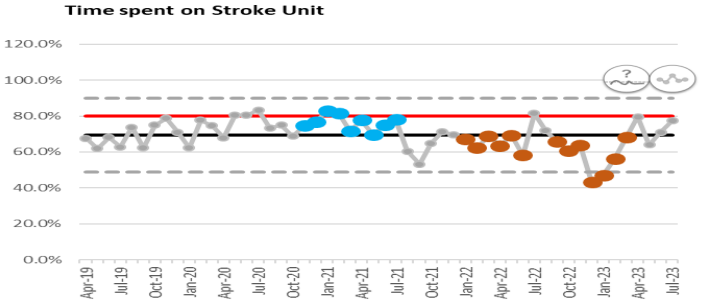
Assurance **Variation**

This metric is **not changing significantly.** It shows the level of natural variation you can expect to see. The target (90%) lies below the process limits so we know that the **target will not be achieved** without change.



Assurance **Variation**

This metric is **not changing significantly**. It shows the level of natural variation you can expect to see. The target (80%) lies within the process limits so we know that the **target may or may not** be achieved.



Performance and Actions

Actions

- The 20 bedded stroke unit remains ring-fenced for stroke and neurology patients.
- To facilitate flow, two boarding spaces have been created on the ward. One of these spaces remain free to ensure that there is always a bed available to thrombolise a patient if required.
- To promote flow throughout the stroke pathway, the on-call Stroke team continues to assess patients alongside the therapy teams, if appropriate, to prioritise discharging patients directly home from ED/AMU. Ongoing investigations are then requested on an out-patient basis. This ensures that ASU beds are only used for those patients who are not medically fit for discharge.
- The stroke service is currently trailing pre alert with WMAS by receiving alerts directly to the stroke unit via the red “alert” phone as well as the alert to the emergency department.
- During the most recent industrial action (Junior Doctor strikes August 2023), the Stroke Consultants have created and managed a local rota whereby they offered 24 hour on-site cover for any Stroke referrals improving early access to the stroke team and early decision making regarding ongoing care.

SSNAP

Published data for Q1 2023/24 shows the Trust maintaining a level B but improving the score from 72 to 78 points. Improvements were seen in all Domains except Scanning and Discharge Processes.

	Q4 22/23		Q1 23/24	
Domain	Score	Grade	Score	Grade
1) Scanning	94.0	B	93.0	B
2) Stroke unit	25.4	E	35.0	E
3) Thrombolysis	50.5	D	59.0	D
4) Specialist Assessments	91.1	A	98.0	A
5) Occupational therapy	69.4	C	76.0	B
6) Physiotherapy	80.6	B	84.0	B
7) Speech and Language therapy	73.2	B	76.1	A
8) MDT working	84.7	B	84.9	B
9) Standards by discharge	90.8	B	97.0	A
10) Discharge processes	97.0	A	95.0	A
Combined Total Key Indicator score	72	B	78	B
Case ascertainment band	90%+	A	90%+	A
Audit compliance band	87.7%	A	92.90%	A
SSNAP score	72.0	B	78.0	B

Risks

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

What the charts tell us

Direct admission to a stroke ward is still showing that it will consistently fail to hit the target, and with the target being outside the control limits it is unlikely that this will change without a refocus on, or change in, processes.

OUR QUALITY AND SAFETY – INFECTION PREVENTION AND CONTROL

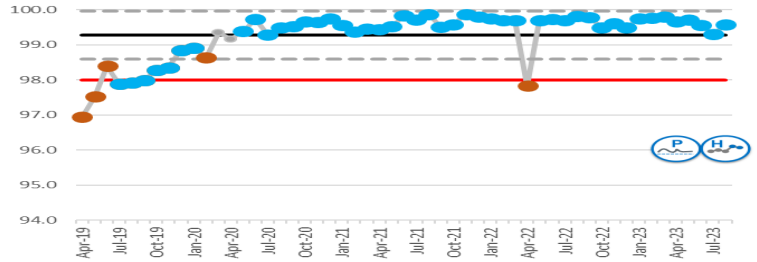
We are driving this measure because

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

Assurance **Variation**

This metric is **improving.** We are **consistently achieving** the target (98%) because the current range of performance is above the target.

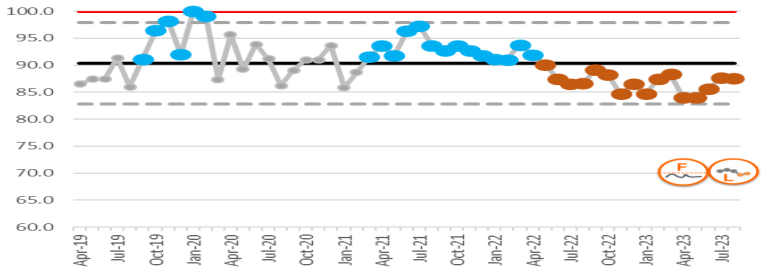
Hand Hygiene - Compliance



Assurance **Variation**

This metric is **deteriorating.** The target (100%) lies above the process limits so we know that the **target will not be achieved** without change**.**

Hand Hygiene - Audit Participation



Performance and Actions

- We were compliant with the in-month infection targets for Klebsiella only.
- We are not currently compliant with any of the year-to-date targets.
- C-Diff, E-Coli and MRSA are all showing special cause variation of concern.

- There are currently 6 active COVID outbreaks, and 3 in monitoring (11/09)
- There are also CPE (3), C-Diff(4), Pseudonamas (1) and MRSA (1) outbreaks.

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

	Aug (Actual vs Target)	Year to Date (Actual vs Target)
C.Diff	15/6	56/32
E-Coli	8/6	45/30
MSSA	5/3	18/8
MRSA	1/0	2/0
Klebsiella	2/2	12/10
Pseudomonas	3/1	8/5

Actions

Monitoring of 28-day MRSA screening compliance is being undertaken with feedback to wards with missed screens, this is in response to an MRSA BSI infection where the 28-day screen was omitted. Full RCA in progress with initial learning points shared to divisions.

PVD task and finish group in place with an audit of PVD insertion pack usage underway.

The fundamentals of infection prevention and control was launched at the September IPC link worker meetings which focused on: hand hygiene, Peripheral Vascular access Devices care, cleaning of commodes, mattresses and bed frames.

Risks

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

What the charts tell us

- Hand Hygiene Compliance has exceeded the target for the (98%) for the past 16 months and is showing special cause variation of improvement.
- However, Hand Hygiene Audit participation (see SPC) is still not compliant with the target (100%) and is showing special cause variation of concern.

OUR QUALITY AND SAFETY – ANTIMICROBIAL STEWARDSHIP

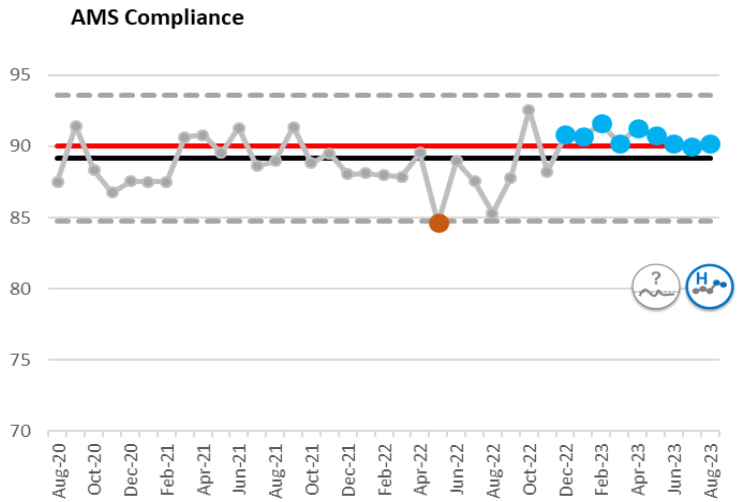
We are driving this measure because

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

Assurance 

Variation 

This metric is **improving.** The target (90%) lies within the process limits so we know that the **target may or may not** be achieved**.**



Performance and Actions

- A total of 215 audits were submitted in Aug-23, compared to 199 in Jul-23.
- Antimicrobial Stewardship overall compliance increased slightly in Aug-23 to 90.2% and achieved the target of 90%.
- Patients on Antibiotics in line with guidance or based on specialist advice increased in Aug-23 and achieved the target.
- Patients on Antibiotics reviewed within 72 hours also increased in Aug-23 and achieved the target.
- Of the 8 elements of the audit, 3 have failed to reach the target this month.
- Medication incidents causing harm dropped to 4.95%

Actions

- Divisional AMS clinical leads will promote participation in the Start Smart Then Focus monthly audits and identify actions to drive improvement in quality (KPIs)
- Continuing to monitor the compliance with antimicrobial guidelines and antimicrobial consumption with a view to achieving reduction targets specified in standard contract for Watch and Reserve categories.
- Focusing on learning from C diff case reviews where antibiotics may be implicated & developing actions pertaining to AMS (and Prof Wilcox's report)
- Promoting IV to oral switches of antibiotics and reducing length of course.
- Recruitment to the vacant AMS lead pharmacist post

Risks

- Unable to appoint an AMS lead pharmacist – limits resource available for AMS support
- Operational pressures and medical industrial action prevent necessary attention to AMS

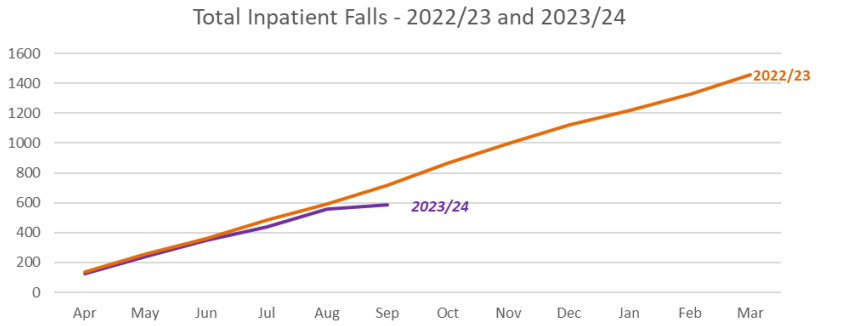
What the charts tell us

This metric has shown special cause variation of improvement for the past 9 months.

OUR QUALITY AND SAFETY - FALLS

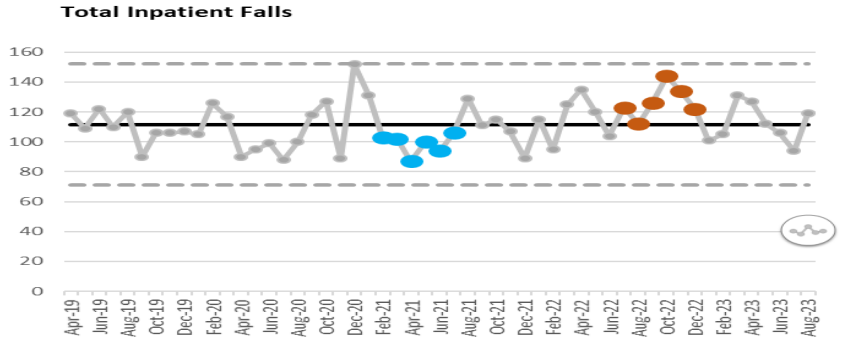
We are driving this measure because

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



Assurance **Variation**

This metric is **not changing significantly.** It shows the level of natural variation you can expect to see. There is no target for this metric.



Performance and Actions

Total Inpatient Falls

- The total number of falls rose (119) for the 1st time since May-23.
- Of these 119 falls the harm caused was: 36 Insignificant, 79 Minor, 2 Moderate & 2 Severe.
- We were on trajectory in Aug-23 with 4.89 Total Falls per 1,000 Bed Days.

Inpatient falls resulting in Serious Harm

- There were 0 SI falls in Aug-23.
- An SI fall previously reported in Apr-23 has been downgraded.
- This means there have been a total of 2 SI falls to date in 2023/24.

Actions

- Continue to monitor all falls and falls with harm on a weekly basis identifying hotpot areas where quality improvement projects (QIP) may be required.
- Encourage registered staff to complete the national falls e-learning available on ESR and revisit essential to role criteria to support compliance.
- Trial new falls governance process in line with PSIRF within SpMed before trust wide launch which will allow a more effective means of learning from falls incidents.

Risks

N/A

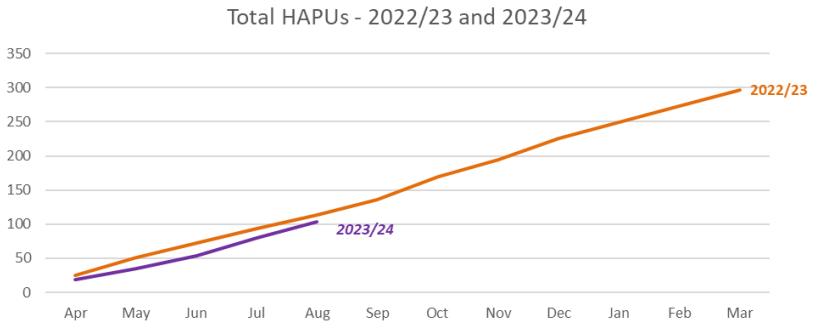
What the charts tell us

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

OUR QUALITY AND SAFETY – PRESSURE ULCERS

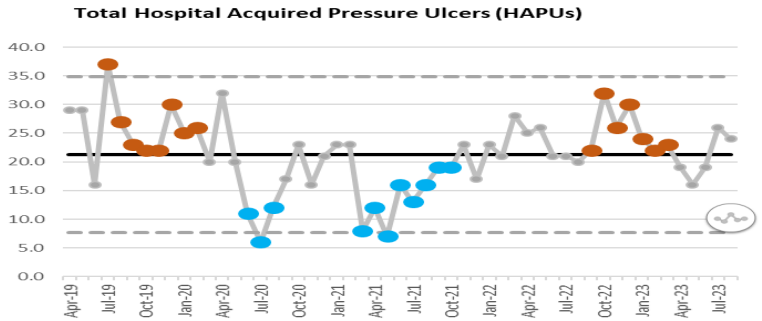
We are driving this measure because

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



Assurance **Variation**

This metric is **not changing significantly.** It shows the level of natural variation you can expect to see. There is no target for this metric.



Performance and Actions

Total HAPU's

- The number of HAPUs for Aug-23 dropped to 24, bringing the current total for 2023/24 to 104.
- The total is below this point in 2022/23 (114)
- Total HAPUs as a % of Emergency Admissions dropped to 0.72% in Aug (from 0.78% in Jul)

HAPU's causing Harm

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

Actions

- Continue to support divisions with Educational Training programmes training for all health professional
- CQUIN 12 continues . (Documentation of a full pressure ulcer risk assessment (within 6hrs) using a validated scale, such as Waterlow in progress to support Quality and improvement
- Continue to engage and educate clinical staff in correct choices of available resources.
- Educational sessions by TV Team for EPR SSkin bundle completion arranged for staff across WRH and Alex sites.

Risks

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

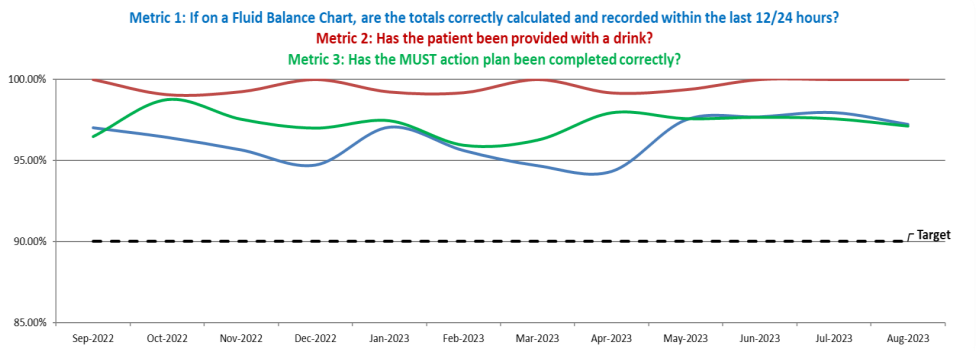
What the charts tell us

Total Hospital Acquired Pressure Ulcers is showing common cause variation.

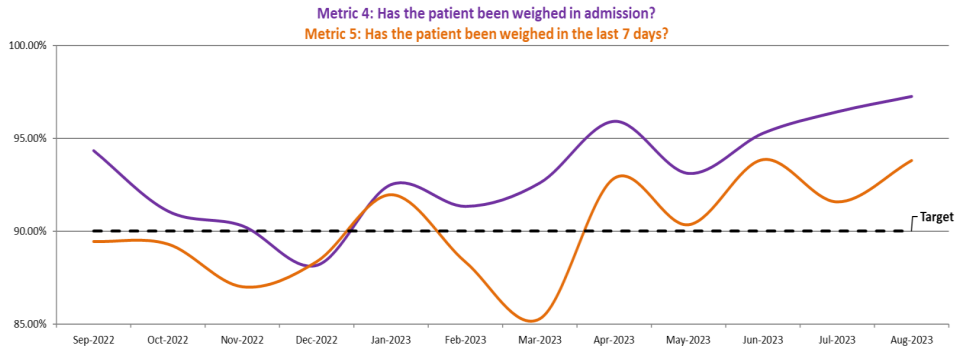
OUR QUALITY AND SAFETY – NUTRITION AND HYDRATION

We are driving this measure because

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



Please note that Y axis does not start at zero.



Performance and Actions

- Metrics 1, 2 and 3 have all been compliant for the last 12 months.
- Metric 4 has been compliant for 11 of the past 12 months.
- Metric 5 has been compliant for 6 of the last 12 months, including the last 5 consecutive months.

Actions

- Ongoing work from the Strategy Task and Finish Group is progressing to create a new Food and Drink Strategy for the organisation, guided by the Nutrition and Hydration Policy and the gap analysis from the National standards for healthcare food and drink
- Substantially improved performance from the Surgical Division in compliance for patients being weighed on admission and at least once per week. This has been a focus of surgical divisional colleagues after some ongoing difficulties, and they have had their best month in the year to date
- N&HSG is looking into concerns on the accuracy of reported fluid balances in the EPR
- N&HSG is working with Patient Safety to support and oversee recommendations made following a recent Never Event related to NGT placement

Risks

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

What the charts tell us

All Metrics were above the target of 90% in July.

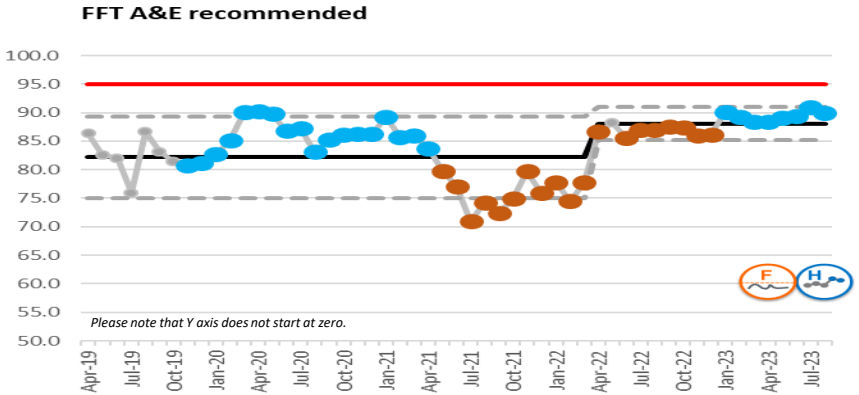
OUR QUALITY AND SAFETY – FRIENDS AND FAMILY TEST

We are driving this measure because

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

Assurance **Variation**

This metric is **improving.** The target (95%) lies above the process limits so we know that the target **will not be achieved** without change.



Performance

- Inpatients has met the 95% recommended target every month since Feb-21
- Outpatients has met the recommended target every month since Aug-22.
- Both Inpatients and Outpatients regularly exceed the response rate targets.
- Although A&E have not met the recommended target, they have been above 85% since Apr-22 and benchmarking[1] for Jun-23 shows the 2nd highest recommended rate for the Midlands. Maternity compliance dropped for the recommended rate to 74% in Aug-23.
- Maternity data for August is primarily from Badgernet, with only 4 responses recorded from other sources. The number of Badgernet responses is also very low, with only 27 recorded for Aug-23. This consisted of; Antenatal 9, Community 1, Labour 8 & Postnatal 9.

Actions

Maternity

- FFT September 2023 card trial launch to support an increase in response rates. Review in October 2023.
- "Anytime" feedback will be promoted across Antenatal services, cards to be handed out on wards and measures in place to ensure those who have experienced long/traumatic births are supported to take feedback home to support reflection.
- Postnatal approach to encourage "on the day of discharge" feedback and a clear processes for collection of cards.

The aim is to go digital with the feedback forms, and there is ongoing work within the trust to achieve this.
Note: Badgernet feedback is not friends and family test compatible, so is currently this method is not being promoted to families.

A&E

An FFT poster with QR code has been designed and will be displayed in A&E (September 2023) departments to promote feedback and offer an alternative method to collect FFT (following Caldecott review).

- Work is in progress to develop a Children/Young People and Families poster.
- Divisions are keen to move away from paper collection and use QR codes. FFT feedback will work alongside the new patient voice and engagement app to be used across the Trust (work in progress)

Risks

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

What the charts tell us

A&E has been showing special cause variation of improvement for the last 8 months and has twice achieved 90% during this time. However, it is still showing that the target (95%) will consistently fail to be met. In addition, as the target is above the upper control limit it is suggested that additional focus on, or revisions to, current processes will be required to achieve it.

OUR QUALITY AND SAFETY - COMPLAINTS

We are driving this measure because

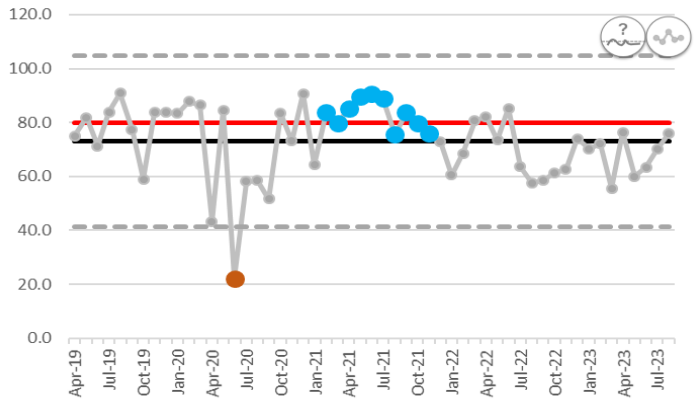
We are aware from public feedback that a prompt, real-time, comprehensive service for the public using the Complaints services can be effective in resolving the majority of complaints, queries or outstanding concerns.

Assurance 

Variation 

This metric is **not changing significantly**. It shows the level of natural variation you can expect to see. The target (80%) lies within the process limits so we know that the **target may or may not** be achieved.

Complaints Responded to Within 25 Days



Performance and Actions

- In total there were 65 new formal complaints received within Aug-23 with 13 (28.3%) called within 5 days to discuss the complaint.
- The Trust had 147 complaints still open at the end of Aug-23, of which 23 have been reopened. Of these 147 complaints, 76 have breached 25 days (10 of which have been reopened)
- The Surgery Division accounts for 91 of the Trust's total open complaints and 69 of the complaints which have breached 25 days, 7 of which have been reopened.
    - **25 Surgical cases are now approaching and over 6 months past their received date**
    - **27 surgical cases are between 2 and 5 months overdue**
    - **17 surgical cases are between 0 days and 2 months overdue**
- Compliance with complaints closed within 25 days increased this month to 76.1%, but this is the 14th consecutive month that the target has been missed.

Actions

- Until the backlog of surgical breach cases has been addressed, it will not be possible to improve performance levels; in fact, if significant progress is made and many breach cases are closed, performance percentage against KPI will likely worsen.
- Breach numbers must be stabilised at ~15 overdue open across the Trust, to ensure >80% closed in month are in time.
- Progress has started to be made with preventing imminent breaches , but this is still slow at the time of reporting.
- A recovery trajectory to resolve the backlog of surgical cases has been agreed with the Division and it is expected that all overdue complaints will be actioned by the end of November 2023.

Risks

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

What the charts tell us

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

OUR WORKFORCE

Tina Ricketts

Director of People and Culture

A key area requiring improvement is to reduce our agency spend to 6% of our total pay bill. Agency cost as a % of gross cost has grown 0.95% in month and stands at 10.21%. This represents a 1.45% increase in comparison with the same period last year. A number of actions are being taken to reduce temporary staffing spend including our PEP programme, revised recruitment plans and improved management of sickness absence. Vacancies have reduced by 67.66 wte in August with an overall vacancy rate of 10.61%.

To meet our workforce plan we need to recruit a further 208 wte new starters by 31st March 2024. We are currently 38.19 wte behind plan as at month 5. Student intake in September, international recruitment, and the opening of the UEC and theatres is expected to improve this position.

Another key area of focus is to reduce our current level of sickness absence. Cumulative sickness absence (rolling 12 months) stands at 5.77%, which is above our revised target of 4%. Monthly sickness absence has increased by 0.10% this month to 5.56%, this represents a 0.44% increase on the same period last year. We are above average in all staff groups. Sickness due to stress and anxiety (S10) increased 0.14% in month to 1.68% and accounts for 30% of the total absence in month. Corporate is the biggest outlier with 39.07% of the divisions in month absence being attributed to S10, followed by Surgery (37.64%), Women and Children (37.54%) and Estates and Facilities (34.94%). Targeted support is being facilitated through Occupational Health. Long term sickness has increased 0.04% to 3.45% and Short Term has improved by 0.02% to 2.32%. Estates and Facilities have the highest long term and short-term cumulative sickness.

We are working to improve our Job planning compliance to above 95% linking job plans to required activity. We have seen an improvement in this metric during August as Consultant job planning compliance has increased to 74% and the Chief Operating Officer and Chief Medical Officer are working with the divisions on their improvement plans.

Mandatory training compliance has decreased slightly to 89% but we still benchmark well both regionally and nationally. Non-medical appraisal has decreased to 78% against a target of 90%. This is 1% higher than the same period last year. Medical appraisal has remained at 91% this month which is above target.

August has remained a challenging month due to the on-going industrial action of Junior Doctors and Consultants. New legislation came into effect to prevent the use of agency workers to cover those taking industrial action. Additional pay costs have been incurred due to the current workforce covering the gaps through additional hours or overtime.

OUR WORKFORCE - VACANCY

We are driving this measure because

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

Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
13.5%	12.3%	11.8%	11.7%	12.0%	12.0%	11.6%	11.6%	12.6%	12.6%	12.3%	11.6%	10.6

Assurance

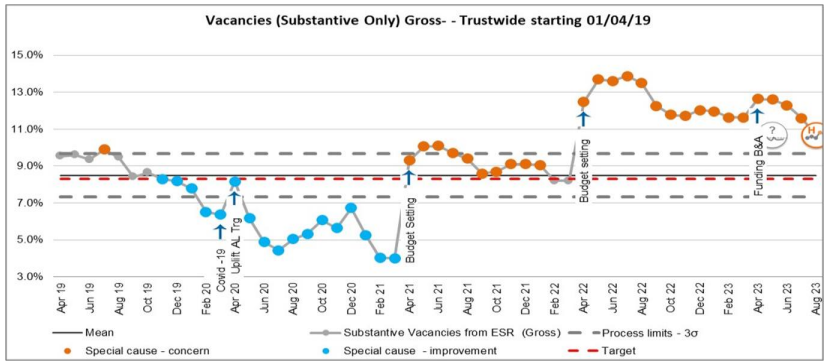
Hit and miss target - Subject to random variation

Variation

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

Data Quality Mark

Reasonable Assurance



Performance and Actions

- **Starters and Leavers** - We have recruited 55 more starters than leavers this month with 247 new starters processed in month (headcount). The numbers are elevated due to junior doctor changeover.
- **Time to Hire** – We have increased capacity in our Recruitment and Medical Resourcing teams and our time to process checks has improved from 48.55 in July 2022 to 39.29 working days
- **HCSW** – We have been actively recruiting HCSWs throughout the year with 44 starting in August (357 new HCSW's in the last 12 months). However, our retention for HCSWs is poor with 245 leavers over the year (25 in August). 99 of the 245 leavers (40.41%) had less than 1 years' service. This means that we are treading water despite high levels of recruitment activity, with only 112 net increase. This impacts our vacancies which are currently sat at 103.04 (10.26% vacancy rate). We continue to proactively recruit to support upcoming vacancy gaps with HCA Assessment Centres.
- **N&M** - We currently have 181.55 wte Registered Nurse vacancies and 31.92 wte midwife vacancies. Our international Nurse recruitment programme is on track to achieve our target of 150 by the end of 2023/24.
- **AHP** – We have 64.15 wte qualified AHP vacancies and 12.09 wte support posts. Our current recruitment for AHPs is barely keeping up with demand with 78 new starters but 72 leavers in the last 12 months (+10 cumulative effect).We are working with NHSE to bring in International Radiographers.
- **M&D** - Divisions have PEPs that require substantive recruitment to long term vacancies to swap out high spend agency locums.

Risks

Clinical vacancies, Band 2 HCSW vacancies

What the chart tells us

The rolling 12-month position is impacted by budget setting each year with a significant increase in April and May 2022 where bank and agency posts that were in the run rate were converted to substantive vacancies. We are on an improving trajectory other than April 2023 budget setting where business cases were transacted into the establishment.

OUR WORKFORCE - SICKNESS

We are driving this measure because

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

Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
5.1%	5.2%	5.7%	5.6%	6.7%	6.0%	5.5%	5.6%	5.4%	5.5%	5.3%	5.5%	5.6%

Assurance

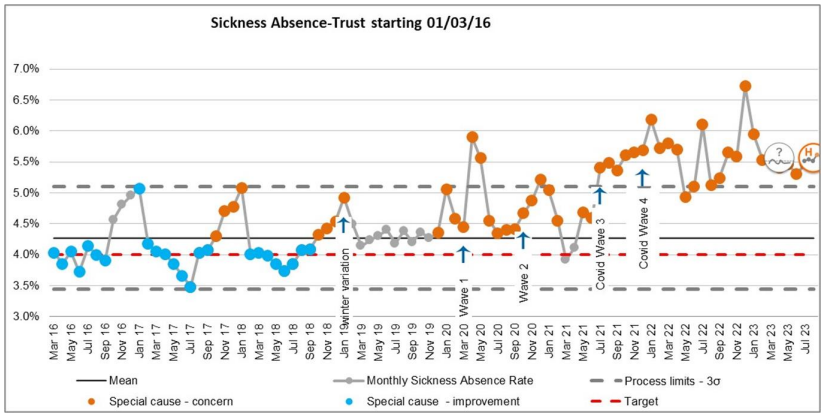
Hit and miss target - Subject to random variation

Variation

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

Data Quality Mark

Reasonable Assurance



Performance and Actions

- Sickness rates have increased by 0.10% to 5.56%, which is 0.44% deterioration on the same period last year. Estates and Facilities continues to present with the highest levels of sickness absence: 7.34% in month and 8.18% 12 month cumulative, followed by SCSD: 5.92% in month and 6.09% cumulative, and Women and Children: 5.21% in month and 6.03% cumulative.
- The biggest in month deterioration occurred in Urgent Care: 1.13% to 5.74%, followed by Specialty Medicine: 0.57% to 5.68%. Stress and Anxiety accounts for over 35% of the in-month sickness absence in Corporate, Estates and Facilities, Surgery & Women and Childrens.
  Long term sickness has increased 0.04% in month whilst short term sickness has improved 0.02%. The highest rates of long-term sickness occur in Facilities and Estates (5.49%), Women and Children (3.99%) and SCSD (3.66%). The highest rates of short-term sickness occur in Estates and Facilities (2.39%), Urgent Care (2.67%) and Specialty Medicine (2.53%).
- Our sickness is benchmarking poorly against national position in most staff groups.
  HR teams continue to sensitively support the management of long and short-term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological wellbeing support for staff.
- The wide range of health & wellbeing initiatives (Hereford & Worcestershire mental health hub, employee assistance programme, NHS apps and support lines, face to face counselling, clinical psychology) are still in place for staff. The close monitoring and management of sickness absence will remain a key priority area for the HR team over the coming year and the target has been reduced from 5.5% to 4%.

Risks

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

What the chart tells us

The elevated period between May 2021 and December 2022 reflects covid impact in addition to other winter pressures such as Flu. Since the peak in sickness absence in Dec 2022 (6.7%), the trajectory has improved but appears to be plateauing about 5.5%. There is much to do to return to pre-covid levels of sickness absence.

OUR WORKFORCE - TURNOVER

We are driving this measure because

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

Jun 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
13.6%	13.8%	13.6%	13.5%	13.0%	13.5%	13.4%	13.0%	12.1%	12.0%	12.0%	12.1%	11.9%	11.9%

Assurance

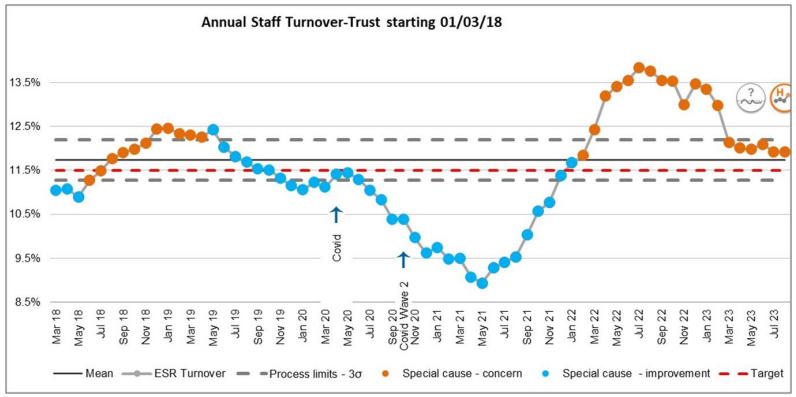
Hit and miss target - Subject to random variation

Variation

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

Data Quality Mark

Reasonable Assurance



Performance and Actions

Our Annual Staff Turnover has reduced by 0.01% to 11.91% which is 1.85% better than the same period last year against a local target of 11.5%. Our latest performance on Model Hospital for Retention rate is 98.3% against an average of 98.4% and Peer Average of 98.6% (March 2022 rates).

Workforce turnover is now at the lowest level for the past year and this is attributable to more concerted efforts by line managers supported by HR in addressing staff turnover. Turnover rates for registered nurses has increased by 0.05% to 10.27% and we are in the best Quartile on Model Hospital for this group.

We have reviewed the benchmarking report from the Electronic Staff Record System comparing us nationally and regionally which demonstrates that we have an issue with turnover in most staff groups, with the exception of Registered Nurses and Healthcare Scientists. A deep dive on our staff retention plan is scheduled for the People & Culture Committee in October.

Our international recruitment programme will continue over the next year considering the national shortage of qualified clinical staff in hard to fill areas. We aim to reduce the number of staff leaving due to Work Life Balance during the next year.

Risks

Medical and Dental, AHP and Estates and Ancillary are Quartile 3 on Model Hospital for turnover.

What the chart tells us

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

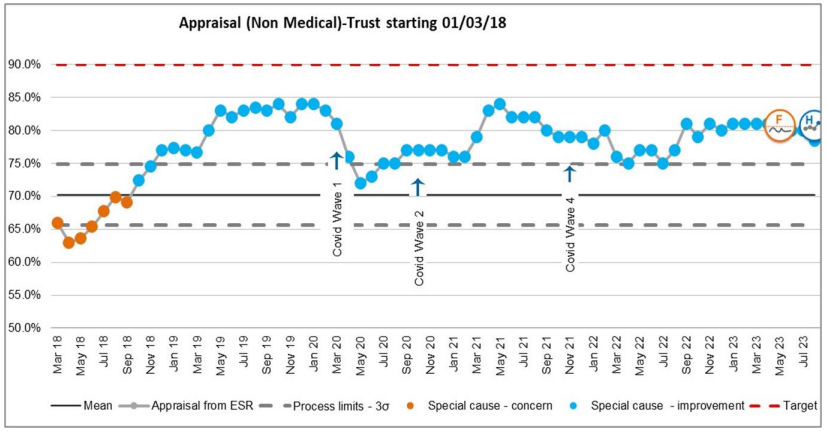
OUR WORKFORCE – APPRAISAL AND JOB PLANS

We are driving this measure because:

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

Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
77%	75.%	77%	81%	79%	81%	80%	81%	81%	81%	81%	81%	80%	78%

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



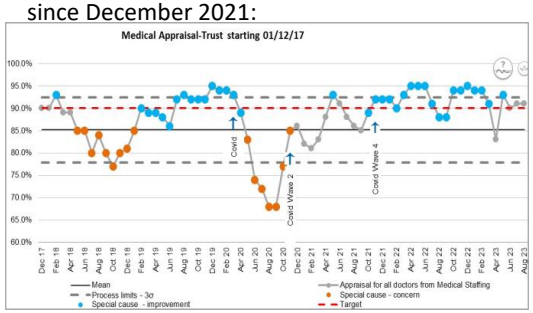
Performance and Actions

Appraisal rates for non-medical staff are currently 78% compared to 77% last year, and a Model Hospital average of 76%.

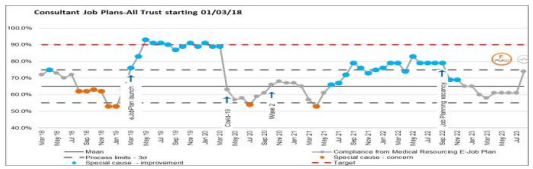
A simplified appraisal form will shortly be launched as well as guidance on wellbeing conversations with staff.

Divisional leaders have been asked via PRMs to ensure outstanding performance appraisals are completed. The lowest rates are in Corporate teams which may indicate that Managers are not conducting appraisals with staff who are hybrid working.

Medical Appraisal is currently at 91% which has been fairly consistently above target of 90% since December 2021:



Consultant Job Planning compliance has increased to 74% - improvement is being made. A corrective action plan will be considered by the Finance & Performance Committee in September 2023.



Risks

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

What the chart tells us

The rolling 12-month position remains fairly consistent across the period between May 2021 and July 2023, although deteriorated in June and July 2023 and is below target.

OUR WORKFORCE – STATUTORY AND MANDATORY TRAINING

We are driving this measure because:

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

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

Assurance

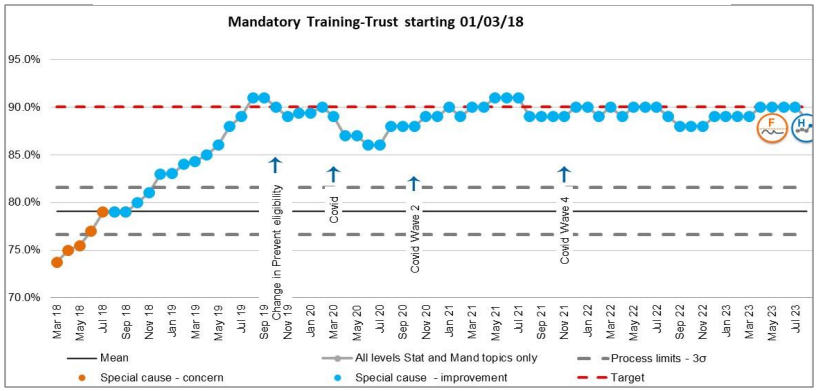
The system is expected to consistently Fail the target

Variation

Special Cause Variation where High requires investigation

Data Quality Mark

Reasonable Assurance



Performance and Actions

Overall **Mandatory Training Compliance** has decreased to 89% against a Model Hospital average of 88.4% (2021/22 is most recent data on model system).

Urgent Care is an outlier at 84%. 3 out of 8 Divisions meet the target. The Medical and Dental staff group remain outliers across all divisions. We have updated the table using the Electronic Staff Record benchmark data which demonstrates that the Trust continues to benchmark well both regionally and nationally.

	2023 / 08			
	Trust	Region	Country	National
Add Prof Scientific and Technic	80.07%	81.23%	75.89%	76.29%
Additional Clinical Services	82.01%	80.21%	77.15%	77.49%
Administrative and Clerical	86.30%	85.31%	79.57%	80.28%
Allied Health Professionals	87.24%	81.20%	77.80%	77.91%
Estates and Ancillary	83.61%	77.60%	74.80%	75.20%
Healthcare Scientists	87.14%	81.90%	78.21%	79.29%
Medical and Dental	67.03%	56.92%	55.72%	54.33%
Nursing and Midwifery Registered	84.52%	79.68%	74.71%	75.40%
Students	86.11%	83.78%	74.96%	75.02%

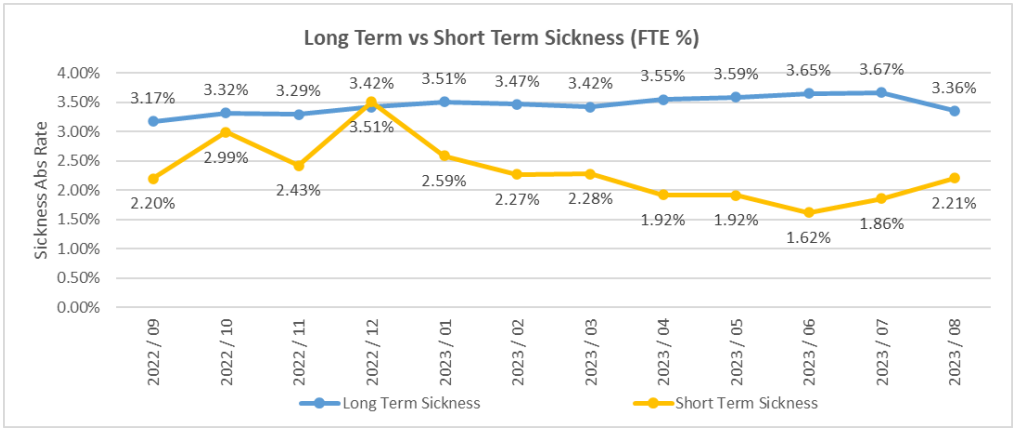
Risks:

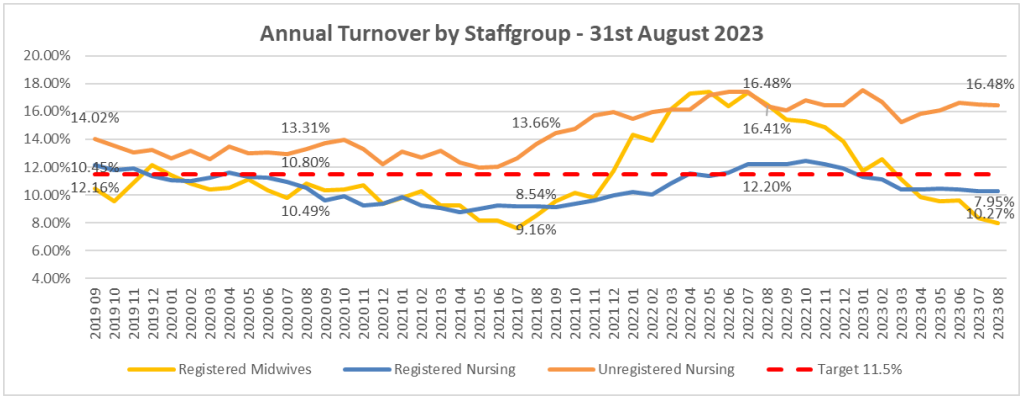
Medics training compliance, and some challenges with legacy IT infrastructure which doesn't support some of the e-learning modules.

What the chart tells us:

The rolling 12-month position remains good with the 90% target in sight. The lowest compliance rate that we have had as a Trust since January 2021 is 89%.

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





Reasons for Sickness

Absence Reason	Corporate	Digital	Estates & Facilities	SCSD	Specialty Medicine	Surgery	Urgent Care	Women & Children	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	2.74%	0.00%	2.00%	8.80%	4.60%	5.47%	2.80%	3.82%	30.21%
S11 Back Problems	0.26%	0.00%	0.82%	2.23%	1.47%	0.42%	0.49%	0.79%	6.48%
S12 Other musculoskeletal problems	0.27%	0.00%	0.84%	5.29%	0.73%	1.72%	1.26%	0.74%	10.85%
S13 Cold, Cough, Flu - Influenza	0.27%	0.01%	0.07%	1.16%	1.12%	0.38%	0.62%	0.15%	3.78%
S14 Asthma	0.00%	0.00%	0.02%	0.06%	0.01%	0.20%	0.00%	0.00%	0.28%
S15 Chest & respiratory problems	0.04%	0.00%	0.31%	0.47%	1.17%	0.18%	0.06%	0.32%	2.54%
S16 Headache / migraine	0.41%	0.00%	0.06%	0.94%	0.86%	0.56%	0.66%	0.18%	3.68%
S17 Benign and malignant tumours, cancers	0.00%	0.00%	0.15%	0.61%	1.28%	1.23%	0.47%	0.42%	4.18%
S18 Blood disorders	0.00%	0.00%	0.09%	0.00%	0.18%	0.00%	0.00%	0.00%	0.27%
S19 Heart, cardiac & circulatory problems	0.00%	0.00%	0.00%	0.08%	0.46%	0.01%	0.31%	0.00%	0.86%
S21 Ear, nose, throat (ENT)	0.09%	0.02%	0.00%	0.26%	0.47%	0.28%	0.05%	0.48%	1.66%
S22 Dental and oral problems	0.07%	0.00%	0.00%	0.41%	0.02%	0.04%	0.01%	0.04%	0.58%
S23 Eye problems	0.04%	0.00%	0.01%	0.18%	0.22%	0.05%	0.00%	0.01%	0.51%
S24 Endocrine / glandular problems	0.04%	0.00%	0.00%	0.01%	0.04%	0.00%	0.00%	0.02%	0.10%
S25 Gastrointestinal problems	0.15%	0.07%	0.24%	2.01%	1.58%	0.39%	0.84%	0.52%	5.79%
S26 Genitourinary & gynaecological disorders	0.18%	0.00%	0.09%	1.26%	1.34%	0.41%	0.44%	0.21%	3.92%
S27 Infectious diseases	0.32%	0.00%	0.10%	0.94%	1.61%	0.71%	0.23%	0.82%	4.72%
S28 Injury, fracture	0.01%	0.00%	0.26%	2.36%	1.19%	0.58%	0.00%	0.37%	4.76%
S29 Nervous system disorders	0.29%	0.00%	0.00%	0.49%	0.43%	0.01%	0.14%	0.00%	1.36%
S30 Pregnancy related disorders	0.54%	0.00%	0.03%	0.51%	1.19%	1.01%	0.59%	0.45%	4.33%
S31 Skin disorders	0.01%	0.00%	0.00%	0.89%	0.04%	0.38%	0.18%	0.04%	1.53%
S98 Other known causes - not elsewhere classified	1.29%	0.00%	0.63%	2.68%	1.46%	0.50%	0.26%	0.80%	7.61%
	7.01%	**0.09%**	**5.73%**	**31.64%**	**21.44%**	**14.52%**	**9.40%**	**10.17%**	**100.00%**

Annual Turnover % by Division and Staff Group

	Corporate	Specialty Medicine	Urgent Care	SCSD	Surgery	Women and Children
Registered Nursing and Midwifery (excluding Midwives)	13.54%	12.12%	9.66%	9.01%	10.07%	8.61%
Registered Midwives						7.95%
HCAs / Support Workers	23.91%	16.09%	18.78%	17.11%	13.53%	18.34%

OUR FINANCIAL PERFORMANCE

Neil Cook

Chief Finance Officer

Financial Plan 2023/24
The final plan reflects a break-even plan for the year including £28m (4.2%) of PEP and £20m of Elective Recovery Fund activity. It is important to note that the recurrent underlying position of the Trust continues to run at a greater level of deficit, once non-recurrent items are removed, and financial controls have therefore been extended as a consequence.

Income & Expenditure Performance
In Month 5 the Trust returned a deficit of £2.7m against a planned deficit of £0.9m, representing an adverse variance of £1.8m. The cumulative deficit to date is £16.3m against a planned deficit of £8.1m deficit, representing an adverse variance of £8.2m.

The following table summarises the key variances against our submitted plan at the end of month 5 into three categories:

- Timing – those items that currently present as a variance due to a difference in the phasing of the plan versus the phasing of the actual expenditure incurred which are largely as a consequence of late revisions to the plan following final agreement of the contract and plan with the ICB.
- Exceptional / Unplanned Items – material expenditure pressures that were not known at the time of the planning submission and typically deemed to be one-off in nature – largely relating to Industrial Action at this point.
- Other variances on core budgets requiring further review and assessment to consider mitigation and determine any recurrent impact to the underlying position.

		Summary of Key Variances													
		Phasing - Bank Holidays/Other	Phasing - ERF	Additional Income - ERF	Patient Care Income	Temporary Staffing / Workforce	Industrial Action	Backdated Pay	PEP	Stretch Income 104%	Tariff Drugs linked to activity	Digital IT contract savings	Overspends on Lifecycle costs/DAFs	Other	TOTAL
YTD M5	Timing	(962)	(648)												**(1,610)**
	Exceptional / Unplanned Items						(1,037)	(384)					(631)		**(2,053)**
	Other			(1,244)	799	(1,374)			(2,482)	(417)	(449)	382		203	**(4,582)**
		(962)	**(648)**	**(1,244)**	**799**	**(1,374)**	**(1,037)**	**(384)**	**(2,482)**	**(417)**	**(449)**	**382**	**(631)**	**203**	**(8,245)**

Note that the additional patient care income is due to the combined impact of (a) a reduction in the elective variable income target and (b) a phasing from NHSE which targets lower activity in Q1 and higher for the remainder of the year and it is therefore expected that the year-to-date benefit will gradually reduce by the end of 2023/24. The weekly Elective Care Recovery Task Force continues to review funding bids associated with the delivery of our 2023/24 plan and considers post implementation reviews of interventions.

Capital
The total capital plan submitted for 2023/24 was £30.089m based on local and national funding streams. This has increased by £750k PDC funding relating to the final part of the Kidderminster Treatment Centre RAAC (roofing) scheme taking the revised total capital plan to £30.839m. Expectations currently outstrip the funds available due to an overspend on the UEC programme impacting on the Trusts ability to undertake backlog maintenance and equipment replacement in line with normal expectations. Discussions are progressing with ICB and NHSE regarding a longer-term brokerage solution to reduce the risk of overspend on the overall capital programme.

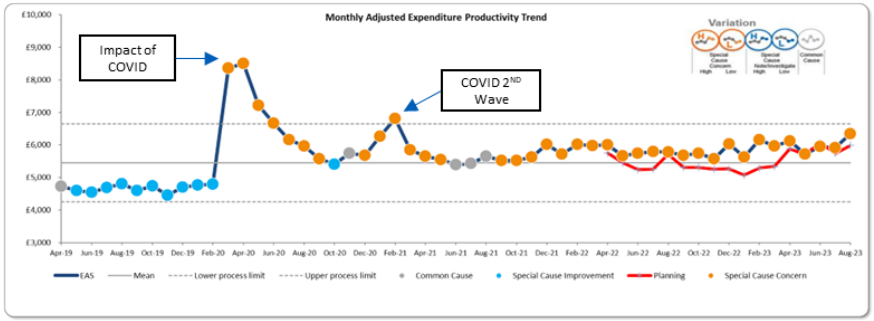
Cash
At the end of August 2023, the cash balance was £5.1m, which was £10.6m below the plan. The Trust has drawn down £407k of the planned external capital funding of £8.7m for the CDC2 (diagnostics) project and £2.54m for Alexandra Theatres. The Trust has had additional PDC approval for the Alexandra Theatres of £1.37m for expenditure up to the end of August, which has been submitted for draw down in September 2023. Further work is progressing on mapping out in detail the cash flow for the next few months given the current revenue run rate and pressure on capital spend. An application for cash support will be submitted for Trust Board approval.

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

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

Statement of comprehensive income	Aug-23 Plan £'000	Aug-23 Actual £'000	Aug-23 Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	53,746	56,166	2,420	260,239	264,748	4,509
Other operating income	2,508	2,523	15	11,790	12,190	400
Employee expenses	(34,058)	(36,406)	(2,348)	(165,103)	(170,753)	(5,650)
Operating expenses excluding employee expenses	(21,039)	(22,976)	(1,937)	(105,143)	(112,705)	(7,562)
OPERATING SURPLUS / (DEFICIT)	**1,157**	**(693)**	**(1,850)**	**1,783**	**(6,520)**	**(8,303)**
FINANCE COSTS						
Finance income	60	115	55	500	571	71
Finance expense	(1,280)	(1,279)	1	(6,400)	(6,395)	5
PDC dividends payable/refundable	(803)	(803)	0	(4,015)	(3,977)	38
NET FINANCE COSTS	**(2,023)**	**(1,967)**	**56**	**(9,915)**	**(9,801)**	**114**
Other gains/(losses) including disposal of assets	0	(22)	(22)	0	(22)	(22)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(866)**	**(2,682)**	**(1,816)**	**(8,132)**	**(16,343)**	**(8,211)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(866)**	**(2,682)**	**(1,816)**	**(8,132)**	**(16,343)**	**(8,211)**
Remove capital donations/grants I&E impact	10	10	0	50	16	(34)
Adjusted financial performance surplus/(deficit)	**(856)**	**(2,672)**	**(1,816)**	**(8,082)**	**(16,327)**	**(8,245)**
Less gains on disposal of assets	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(856)**	**(2,672)**	**(1,816)**	**(8,082)**	**(16,327)**	**(8,245)**



Performance and Actions

At the end of M5 we reported an adverse variance of £8.2m. Of this £1.6m (20%) is deemed to be due to phasing of the plan and therefore by the end of financial year this element of the variance should reduce to nil.

Exceptional items total £2.1m (25%) include additional direct costs resulting from Industrial Action and were similarly not expected at the planning stage. To date this excludes the costs of re scheduling elective activity. Further analysis continues to ensure that all costs associated with Industrial Action have been identified.

Other adverse variances include temporary staffing / workforce costs which are higher in 2023/24 than in 2022/23 (c200 WTE) across all staff groups. This has materialised as a significant variance in Month 5 due to the number of retrospective claims for payment coming through and the increase in cover for nursing staff shifts.

The additional patient care income in the month is largely due to the impact of a reduction in the activity target to 102%, reflecting the impact that Industrial Action has had on capacity and the phasing of activity versus the payment from NHSE.

The weekly Elective Care Recovery Task Force continues to review bids for funding associated with the delivery of our 2023/24 plan and assesses the impact post implementation.

The planning assumption for inflation on Drug costs was 0.9%, but at Month 5, tariff drugs spend is 17% higher than 2022/23 and Non PbR Drug spend is 5% higher contributing to the overspend on non-pay.

Risks

At Month 5 the Trust is reporting a £16.3m deficit averaging £3.26m a month. An initial end of year top-down forecast has been presented to the Finance and Performance Committee and although a slowing in the current run rate is projected the forecast still indicates that we are heading for a material variance against plan that will require mitigation.

It is recommended that the Trust initiates a Financial Recovery Plan (FRP), that will further strengthen grip and control over expenditure and savings schemes to reduce the run rate whilst ensuring we maximise use of core capacity to improve productivity and reduce the cost per WAU.

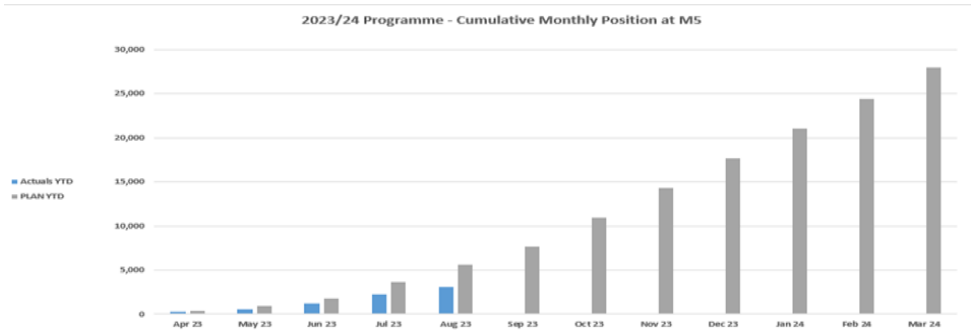
What the charts tell us

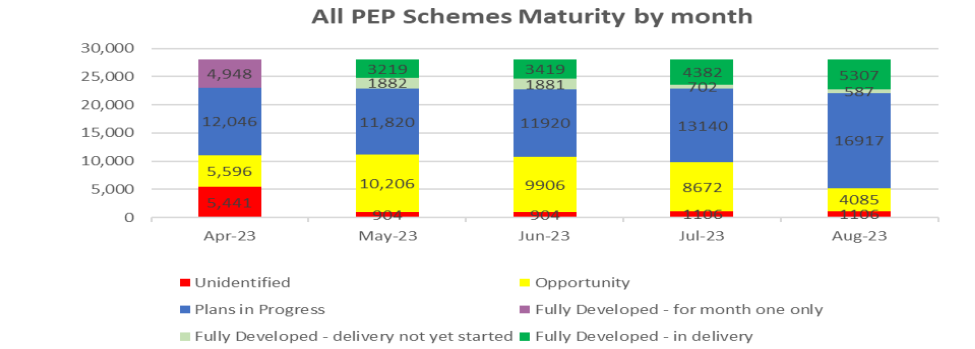
In month 5 our Cost per weighted activity unit (WAU) is 6% higher than plan. This means that we are spending more per activity delivered than was in the operational and financial plan. (Note uncoded activity can impact this position). Expenditure is 7% higher than plan, so we are spending more than plan after inflation. Our WAUs are 1% above plan, so overall we are delivering more weighted Inpatient, Emergency, Outpatient and ED activity. Year to date our Cost per WAU is 2% higher than plan. This is driven by our expenditure being 5% higher than plan. The WAUs are 2% higher than plan, so cumulatively we are delivering just above the planned level of weighted Inpatient, Emergency, Outpatient and ED activity.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

We are driving this measure because

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





Performance and Actions

The Productivity and Efficiency Programme target for 2023/24 as submitted to NHSE in May is £28.0m.

In month 5 we delivered £0.865m of actual savings against which is an adverse variance of £1.082m.

Cumulatively year to date we have delivered actual savings of £3.107m against a plan of £5.589m representing an adverse variance of £2.482m.

The Transformation Delivery Board continues to meet regularly to hold Senior Responsible Officers (SRO's) and Scheme Leads to account for delivery and to provide support where necessary to unblock bottlenecks preventing progress on delivery.

Risks

Slippage on schemes presents a significant risk to achievement of the Trust's planned break-even position if mitigations cannot be found. Mitigations are more likely to be non-recurrent in nature impacting on the Trusts underlying financial challenge.

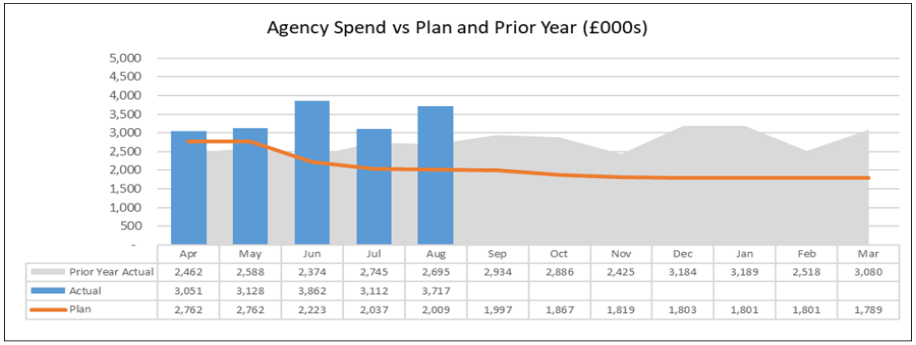
What the charts tell us

The Maturity level of PEP schemes for the Trust is detailed within the graph along with the profile of the savings.

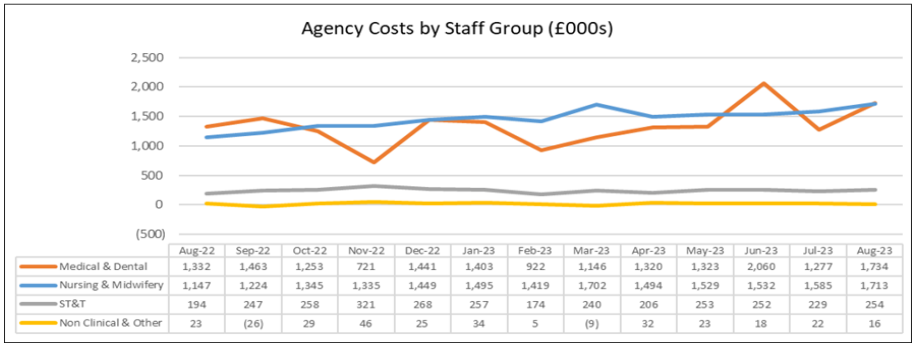
BEST USE OF RESOURCES – AGENCY SPEND

We are driving this measure because

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



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



	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Medical & Dental	1,332	1,463	1,253	721	1,441	1,403	922	1,146	1,320	1,323	2,060	1,277	1,734
Nursing & Midwifery	1,147	1,224	1,345	1,335	1,449	1,495	1,419	1,702	1,494	1,529	1,532	1,585	1,713
ST&T	194	247	258	321	268	257	174	240	206	253	252	229	254
Non Clinical & Other	23	(26)	29	46	25	34	5	(9)	32	23	18	22	16

Performance and Actions

Total agency expenditure in month 5 was £3.7m, an increase of £0.6m compared to month 4. This represents 10.2% of total staff costs compared to 8.8% in the same period last year.

Of the £0.6m adverse movement, £0.4m relates to a retrospective correction of temporary medics data due to delays in the approval of escalated rates and subsequent processing of shifts onto the system.

Medical & Dental represents £1.7m of the spend in month, which is a £0.5m increase compared to M4, Nursing & Midwifery represents a further £1.7m, which is a £0.1m increase compared to M4, and Scientific, Therapeutic & Technical staff represents £0.3m with £16k being spent on Non-Clinical staff. Significant operational pressures due to industrial action, high levels of vacancies and sickness together with an increased number of patients requiring specialing is driving these cost increases.

NHS Professionals have identified potential reasons for the significant increase in retrospective bookings being retrospective escalated rates, rotation and industrial action leading to increase in short notice requests. This has been escalated to the Doctors and Associates Working Group (DAWG) for review.

Risks

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

What the charts tell us

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

Finance & Performance Committee Assurance Report: 27 September 2023

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Jo Wells, Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	7, 8, 13, 16, 18, 19, 20

Executive Summary

The Committee met virtually on 27 September 2023 and the following key points were raised : Escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Scrub Nurses Business Case	Approved	Noting
Productivity & Efficiency Programme 23/24	Significant concerns	Noting
Accountability Framework	Recommended for approval	For approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
ASR Programme Review	Level 7		18, 7, 19, 3, 17, 2, 11, 9, 4, 10, 15, 14
Scrub Nurses Business Case	N/A		2, 4, 7, 9, 14
Integrated Performance Report	N/A		2 3, 4, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Chief Finance Officer Report Month 5	Level 3	Maintained	7,
Productivity & Efficiency Programme 23/24	Level 3		7, 17
Update of 5 Year Financial Strategy	Level 4		7
Accountability Framework	N/A		
Flow Update	N/A		3, 11
Strategic Programme Board Report	N/A		
Insourcing – Kirstenbosch & Portland Clinic	Level 5		11, 18

Finance & Performance Committee Assurance Report: 27 September 2023

Item	Level of Assurance	Change	BAF Risk
Insourcing MRI Radiology CT3	Level 4		11, 18
Roche Immunohistology Pathology	Level 4		3, 4
Insourcing 18 Weeks Endoscopy	Level 5		9, 11, 18
Orthopaedics	Level 6		3, 4
Sutures	Level 6		3, 4
Insourcing 18 Weeks Dermatology	Level 6		11, 18
Insourcing OMFS & Urology	Level 5		11, 18
Cellular Pathology Outsourcing	Level 5		11, 18
Board Assurance Framework	Level 5		7, 8, 13, 16, 18, 19, 20

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 27 September 2023 and the following key points were raised :

Item	Discussion
Updates from External Meetings	Tier 2 meetings relating to elective recovery have been stood down. Cancer review meetings had moved to fortnightly rather than weekly, which signals a better position. Committee were informed that National CFO webinars have taken place. The national position was significantly off track at £0.8bn over plan at month 4. Negotiations with the Treasury were ongoing regarding resourcing industrial action and the recovery of elective activity expectations. There was also an announcement to confirm that shares of the £200m would be to support bottom line and not additional expenditure.
ASR Programme Review	Currie & Brown have been appointed to complete the review. Feedback received was that there has been good engagement. A draft report was due at the end of October and would progress to November Trust Management Executive, Finance & Performance Committee and Trust Board in December. **Committee noted the ASR Review.**
Integrated Performance Report	The UEC challenge is considerable as was ambulance handover delays. Handover delays were becoming a national focus. Teams have been asked to put in a zero tolerance of anything at 3 hours. A plan was in place to reduce delays by 30 minutes week on week. Cancer remains a challenge. Elective recovery was more positive and we have progressed from Tier 2. The route to zero in delivering the 65 week wait position is quite strong. Histology is a challenge as there are challenges with turnaround times due to recruitment gaps. 62 day cancer, when reviewed by speciality, requires more focus on other areas. **The report was noted for assurance.**
Chief Finance Officer Report Month 5	In month 5, an actual deficit of £2.7m was reported against a plan of 0.9m deficit, an adverse variance of £1.8m. Year to date actual deficit of £16.3m was reported against a plan of £8.1m. Adverse variance of £8.2m. Key variances against the plan are being tracked by 3 categories and were noted by Committee. The Trust started with a planned breakeven position but the PEP shortfall is £13m and at risk of further increase. Pass through savings were reported as £1.2m but clarity was being sought from the ICB on any risk associated with this. Stretch income was £1m and was included in the plan. The Trust was not delivering the levels of productivity improvement outlined in the plan so the £1m was a risk. Agency costs have increased and a number of areas are not achieving their vacancy factor. Inflation figures needed to be refined along with the cost of industrial action to ensure everything is captured. PFI inflation was over and above funding and is an impact of £1.1m. Industrial action was in the region of £1.8m. Overall there was a total £24.9m risk to delivery of financial performance. There was £30.9m committed capital spend for this year. A brokerage solution was being sought with ICB/Region. There were concerns that the Trust was not replacing equipment due to the capital programme pressures. **The report was noted for assurance.**
Productivity & Efficiency Programme 23/24	Committee were advised that the programme was not on track. Confirm and challenge meetings are taking place. Schemes proposed to be withdrawn equated to £3m. There was also a Re-forecasted scheme pressure of £6m. The PMO view is therefore that we are projecting a shortfall of -£11.7m. This varies to the financial forecast due to reporting timing differences with the PEP being updated weekly. **Committee supported the following schemes to be taken forward:** **Patient and visitor car parking increase – Increase of 10% car parking tariff.** **Catering restaurants at weekends – Cease the arrangement with River Court Restaurant and provide hot meal vending machines.**
Update on Year 5 Financial Strategy	**Committee noted the next steps and actions on the development of the 5 Year Financial Strategy.**

Finance and Performance Committee Assurance Report

Item	Discussion
Accountability Framework	Committee noted the alignment of objectives from the Board to the ward and the impact on what the organisation needs to deliver. The Framework would provider broader oversight for Executives. The invite list had been expanded to include divisional performance. There had been increased focus on oversight framework to ensure there was more visibility. A tiering system was being introduced for divisions. Operational delivery required a forum for focused work in a formal way. **The Framework was recommended for approval at Trust Board.**
Flow Update	A presentation regarding flow issues and the steps being taken to address were noted. Work was underway to implement an audit of compliance against the standards. Single point of access flow away from the ED was due to start at the beginning of December. **Committee noted the update.**
Strategic Programme Board Report	The update was noted.
Insourcing – Kirstenbosch ENT & Portland Clinic	Committee approved the CAG
OMFS & Urology Insourcing	Committee approved the CAG
MRI Radiology CT3 Insourcing	Committee approved the CAG
Roche Immunohistology	Committee approved the CAG
Orthopaedics	Committee approved the CAG
Sutures	Committee approved the CAG
18 Weeks Dermatology Insourcing	Committee approved the CAG
Cellular Pathology Outsourcing	Committee approved the CAG
Board Assurance Framework	The digital risk has been updated and increased to 16. There were no further escalations.
ICB Finance & Investment Expenditure Forum ToR	Committee noted the Terms of Reference and minutes.

Quality Governance Committee Assurance Report – 28 September 2023

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore – Non-Executive Director	Dame Julie Moore –Non-Executive Director	Jo Wells, Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**QGC BAF Risks**	2, 3, 4, 11, 17, 18, 19, 20

Executive Summary

The Committee met virtually on 28 September 2023 and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
IPC Update	Visibility of key issues	Noting
Paediatric Audiology	Visibility of key issues	Noting
Responsible Officer Report	Assurance	Review for assurance
Cancer Services external review	Visibility of key issues	Noting

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Maternity Safety Report	Level 5	Maintained	2, 4, 9, 10
Paediatric Audiology	N/A		4, 11, 15
Neonatal Safety Report	Level 5		4
Responsible Officer Report	Level 5	Maintained	4
Harm Review Process Change Proposal	N/A		4
IPC Update Q1	Level 4		3
Safeguarding Report Q1	Level 6		4
Controlled Drugs Report Q1	Level 5		4
Integrated Performance Report	N/A		2, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Medicines Optimisation Report Q1	Level 5		4

Quality Governance Committee Assurance Report – 28 September 2023

Item	Level of Assurance	Change	BAF Risk
Cancer Services Assurance Report	N/A		3, 4
Patient Experience & Engagement Report Q1	Level 5/6		2, 4, 11
Learning from Deaths Q1	N/A		3
Research & Innovation Report Q1	Level 5		3
Clinical Effectiveness Report Q1	Level 4		3

Quality Governance Committee Assurance Report – 28 September 2023

Executive Summary

The Committee met virtually on 28 September 2023 and the following key points were raised:

Item	Discussion
Action log	The actions were reviewed and updates were provided. No other matters were escalated.
CNO/CMO escalations	There was combined industrial action by both Consultants and Junior Doctors on 2nd-4th October. The doctors would be providing Christmas Day cover only and will have an impact on elective activity both for inpatient and outpatients. Regular planning meetings were in place. The Trust has experienced 4 of the biggest attendance days in recent weeks. There is a rising length of stay, particularly within medicine of 9 days. There were issues in terms of managing same day emergency care and managing the GIM specialty. Changes were being made which will impact on flow. There had been in increase in Covid-19 cases and was currently the highest it had been since May with 58 cases. An increase in staff absence was also being seen. Mask wearing had been reintroduced in inpatient and outpatient areas.
Paediatric Audiology	It was reported that 16 children were reported to have suffered severe harm and 7 with moderate harm. 462 patients had been reviewed. 71 were identified with possible with hearing loss and 42 identified with hearing loss. 6 patients require a further review. 106 patients would be recalled for testing. The UK accreditation service had visited and completed an independent review. Verbal feedback had been received and there were no immediate clinical concerns. The formal report was awaited.
Patient Story	Noted
Maternity Safety Report	Escalations on the report were noted and discussed in detail. The position regarding scrub midwives was noted. Future reports would include neonatal information and incidents would be split to allow the report to be presented in Public Trust Board. A Practice Development Midwife was now in place to support Maternity Care Assistants. An internal quality assurance visit had taken place and positive feedback received.
Neonatal Safety Report	The service is fully established and all shifts were declared safe. The report would be merged with the Maternity Services Safety Report going forward.
Responsible Officer Report	A new lead appraiser had been appointed and was ensuring that doctors are appraised appropriately. Only 14 were reported to have had an unauthorised delayed appraisal. The MHPS policy needs to be applied fairly and there are some changes to reporting in progress. The report would be presented to Trust Board.
Harm Review Process Change Proposal	Harm reviews were being carried out with accordance with the SOP. It had been found that very few incidents have been identified despite the huge volume of activity, therefore clinical resource could be better deployed. A different approach to harm reviews was proposed to target areas considered to be at higher risk of harm. The Trust was required to undertake reviews of cancer pathways delays, which will continue.
Safeguarding Report Q1	Safeguarding training compliance was above 90%. The Trust had met statutory obligations and continue in accordance of Prevent. 1 escalation was reported which related to the number of Mental Health Act attentions which is above agreement.

Quality Governance Committee Assurance Report – 28 September 2023

Executive Summary

The Committee met virtually on 28 September 2023 and the following key points were raised:

Item	Discussion
IPC Update Q1	The Trust was now experiencing the third consecutive day of increase. 9 outbreaks had been reported which impacts on flow. Extensive issues were reported with Laurel 3. Multiple organisms had been identified and a deep dive completed as a result. An action plan was in place. C-diff numbers remained a concern. 67 cases had been reported YTD. There is a national picture of rising cases. No 955 cases have been reported since last year. UHCW have reported cases therefore a Regional alert is being drafted. 0 MRSA cases were reported for first Quarter but in July, 3 cases were reported. An RCA had been undertaken and has identified inadequate cleaning.
Controlled Drugs Report Q1	It was reported that there had been an improvement in the completion of controlled drugs audits from 36% to 84%. Gaps in the Kidderminster site would be addressed with training.
Medicines Optimisation Report Q1	The report was noted. No concerns were highlighted.
Cancer Services Assurance Report	Committee were advised that there would be changes to the targets with effect from 1st October. Changes were being made to Faster Diagnostics, 62 day and 31 day. There was a significant backlog of 62 day patients of around 300 across all specialties but focus was on dermatology and urology. Dermatology is a fragile service and will be supported by Wye Valley.
Integrated Performance Report	An investigation had been completed following a never event that occurred in June. Actions were in place and additional training had been undertaken. The sepsis bundle has decreased to 65%. Once the EPR module is in place, performance should improve. Concerns remained regarding the neck of femur pathway compliance. Outcomes however were reported as good. The number of hospital acquired pressure ulcers had decreased in August. There were 0 hospital acquired pressure ulcers resulting in harm. Complaints compliance target has improved slightly. 76 complaints remain open and have breached 26 days. 69 of these sat within the surgery division. Additional support had been introduced within surgery to assist with the backlog and new complaints received. The trajectory for achieving compliance is the end of November. Weekly monitoring was in place Committee received a presentation regarding flow and areas of focus to improve.
Patient Experience & Engagement Report Q1	The Big Quality Conversation has been launched and will run until January. The Patient and Public Forum have visited KTC and supported an additional 13 visits including quality assurance visits. BSL cards had been launches to support patients and Healthwatch have been complementary with the scheme. Volunteers had increased by 10% and the Trust now had 144 active volunteers. Friends & Family Test response rates are achieving.
Learning from Deaths Q1	SHMI remains in the expected range. Deaths in ED continue to be an issue. Issues had been encountered with the bereavement app. Issues with EOL and RESPECT forms were highlighted. A new issue had been reported regarding the timely completion of medical certificates, which should be completed within 5 days of death. Issues had only been report at the Worcester site and it was likely that it was related to the new ED build. The team were seeking a resolve.

Quality Governance Committee Assurance Report – 28 September 2023

Executive Summary

The Committee met virtually on 28 September 2023 and the following key points were raised:

Item	Discussion
Research & Innovation Report Q1	Committee noted the data in terms of the number of studies the Trust had recruited to. One concern was highlighted in relation to the research building roof which was in poor condition. The team have been moved and housed in temporary accommodation.
Clinical Effectiveness Report Q1	Committee noted the report and the change made to the reporting of clinical audits in line with others.

People & Culture Committee Assurance Report – 3 October 2023

Accountable Non-Executive Director	Presented By	Author
Karen Martin –Non-Executive Director	Karen Martin –Non-Executive Director	Jo Wells, Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	9, 10, 11, 14, 15, 17, 22

Executive Summary

The Committee met virtually on 3 October and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
No escalations made		

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Director of People & Culture Report	N/A		
Learning from the Lucy Letby Case	Level 5		4, 11, 18
Well-Led – Improvement/4Ward Improvement Systems Benefits Realisation	Level 3		9,
Job Planning Compliance	Level 3		9, 10, 18
Integrated People & Culture Report	Level 5	Maintained	9, 10, 14, 15
WRES. WDES & Gender Pay Reports	Level 5		9, 10, 14, 15
Fit & Proper Persons Audit	Level 6		9
Safest Staffing Report: Adult/Nurse Staffing	Level 5		9
Safest Staffing Report: Midwifery Staffing	Level 6		9
People & Culture Risk Register	Level 6		All
Board Assurance Framework	Level 6		All
Terms of Reference	Level 6		All

People & Culture Committee Assurance Report – 3 October 2023

Executive Summary

The Committee met virtually on 1 August and the following key points were raised:

Item	Discussion
Staff Story	The Head of Fundraising provided an update of work underway in regard to the Trust Staff Awards
Director of People & Culture Report	Updates were provided in a number of areas including a Sexual Harassment Framework which was being adopted locally, Winter Planning, pension drawdown and use of agency staffing in relation to industrial action.
Learning from the Lucy Letby Case	The learning from the case was reviewed. There had been an increase in cases reported to the Freedom to Speak Up Guardian. An external review had been commissioned to review a racial discrimination case that was deemed to have not been handled well and the learning and recommendations would be presented to the next meeting.
Well-Led – Improvement/4Wrad Improvement Systems Benefits Realisation	The Trust had been asked to score ourselves in regard to improvement culture. RPIWs were underway and good progress was being made but more needed to be done to embed continuous improvement into everything we do. The Trust had been working with Virginia Mason for the last 19 months and were looking at what could be done differently moving forward.
Job Planning Compliance	Issues had been identified regarding agreement of job plans, a lack of knowledge and experience in undertaking job plans and a lack of consistency in job plans. Additional job planning capacity has been identified and resource was being introduced during October. A dep dive report will be presented to the next meeting and job planning compliance and quality will be a regular agenda item going forward.
Integrated People & Culture Report	A review had been undertaken in regard to the people and culture priorities and their alignment to the 10 point plan. It was identified that the people and culture function will need to free up capacity to support future organisational change programmes. Our recruitment and retention plans are starting to make a difference. The heat map enables the identification of areas which required further leadership support and the OD team were assisting those teams using best practice. Time to hire was reducing as were vacancy rates and turnover. The exit interview process had been updated and was seeing an increased return rate.
WRES, WDES and Gender Pay Reports	The workforce race equality standards, workforce disability equality standards and gender pay reports and associated action plans were presented to the Committee for review before being published. It was recognised that our Equality, Diversity and Inclusion 7 point plan was key to addressing the issues highlighted in the reports.
Fit & Proper Persons Audit	New guidance was being implemented in regard to Fit & Proper reporting and the policy was being updated.
Safest Staffing Report: Adults	The report was taken as read and assurance provided that staffing levels were safe in month 6.

People & Culture Committee Assurance Report – 3 October 2023

Item	Discussion
Safest Staffing Report: Midwifery	Focus was on reducing turnover. A new Maternity Support Worker Lead was in post. 1:1 care in labour was met but the supernumerary status was not met. The Scrub Nurse Business Case had been approved at Finance & Performance Committee and recruitment for those posts would commence with a view to being in place by February 2024.
People & Culture Risk Register	There were 2 recommended increases in risk rating: 1. In relation to the job planning risk giving the issues identified in the earlier report 2. In relation to the culture within the surgery division
Board Assurance Framework	A reduction in the level of assurance for workforce was proposed from a 5 to 4. It was recommended that the industrial action assurance rating was increased to 5. It was suggested that the BAF included a risk in relation to mental health related sickness absence
Committee Workplan	The proposed Workplan for the Committee was reviewed and approved.
Terms of Reference	Minor changes had been made following a review. A further review would take place in 6 months time. The Terms of Reference were approved.

Assurance levels Nov 2020

NHS Worcestershire Acute Hospitals NHS Trust

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Maternity Safety Report – August 2023

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

Accountable Director	Sarah Shingler – Chief Nursing Officer		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Justine Jeffery, Director of Midwifery Susie Smith, Governance Lead

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

Report to be reviewed by		
Committee/Group	Date	Outcome
Maternity Governance		
Quality Governance Committee	28/09/23	Noted for assurance

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

Executive summary	The purpose of the paper is to provide a monthly update on key maternity safety initiatives which will support WAHT to achieve the national ambition. The report will also provide evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. The KPI for booking before 12+6 weeks' gestation remains below 90%. There are 2 ongoing HSIB cases that were referred in February 2023 (both early neonatal deaths). There was one stillbirth and 1 neonatal death in August 2023. There was 1 moderate harm incident reported in month. There is no essential to role (MMT, PROMPT etc) training scheduled in August therefore the figures have not altered. Medical and midwifery safe staffing remains positive and minimum safe midwifery staffing achieved on all shifts. Supernumerary status of the

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shift leader was not met in August however 1:1 care in labour was achieved.

Summary of Key Performance Indicators (August 2023)

Metrics	Target	Current position
Booking completed by 12+6	90%	80%↔
ATAIN	6%	2%↓
PMR (MBRRACE 2020)	<4.86 per 1000 births	3.88
Stillbirth rate	<3.33 per 1000 births	2.45
NND rate	<1.53 per 1000 births	1.43
SI reported	-	1
Moderate or above incidents	-	2
Sickness rate (MWs)	4%	5.96%
Turnover rate (rolling) (MWs)	11.5%	7.95%↓
Vacancy rate (MW)	7%	14% ↑
Sickness rate (MSWs)	5.5%	7.67%↓
Turnover rate (rolling) (MSWs)	11.5%	23.49%↑
Vacancy rate (MSW)	7%	7%↑
Maternity role specific MT Midwives	90%	29% ↔ (in year)
Maternity role specific MT – MCA's and MSW's (SBL only)	90%	30% ↔(in year)
Maternity role specific MT Obstetricians (SBL only)	90%	44% ↔(in year)
PROMPT – Human Factors & Maternity Emergencies	90%	82% ↔(in year)
PROMPT – Neonatal Life Support	90% (figures for Drs are currently not available)	89% ↔(in year)
Fetal monitoring	90%	95% ↑(in year)
Trust Mandatory training (Non-medical))	90%	86% ↑
Trust Mandatory training (Medical)	90%	69%↓
PALS	-	9↓
Complaints	-	3↑

CQC must do's and should do actions progressing – escalation policy due for sign off and mandatory and essential to role training compliance expected to show further improvement each month – trajectories met. PDRs remain challenging.

COSMOS position improving each month with a focus on CNST and Saving Babies Lives in September.

NHSE have confirmed that the Trust can now exit the support programme and the sustainability plan will be overseen by the ICB.

The suggested level of assurance is 5. An increase in the level of assurance will be recommended when the KPI for maternity bookings, workforce KPIs and training KPIs are met.

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

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

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

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

Maternity Safety Support Programme	Yes	

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

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

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1. Introduction/Background

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

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

2. KPI Booking by 12+6 weeks' gestation

The KPI for booking by 12+6 weeks' gestation has increased in month due to ongoing workforce challenges in community teams. The work around single point of access has now begun.

The table below shows the breakdown, by week of gestation, in August demonstrating that 92% of women are booked by 14 weeks and 96% of women are booked before 20 weeks.

Bookings (Count of Women)

	Gestational age at booking (weeks)					
Month	< 10	< 12	< 13	<= 14	< 20	All booked
Aug-23	127	339	414	447	466	486
Total	127	339	414	447	466	486

In June the digital midwifery team completed an audit of the total number of women who were not booked by 12+6 weeks. The audit was completed to identify whether any groups of women were disproportionately represented. Of the 71 women who were not booked by 12+6 weeks' gestation:

14 (20%) were non-white British
13 (18%) primary language was not English
6 (8%) required any interpreter and
5 (7%) IMD (Top 10% most deprived only)

This data will be monitored quarterly until the KPI is met.

3. Perinatal Mortality Rate (PMR)

Following the publication of the MBRRACE report into Perinatal Mortality Surveillance (2020); the newly updated national average for stillbirth rates is 3.33 per 1000 births and 1.53 per 1000 births for neonatal death rates is now presented in the dashboard.

The national extended perinatal mortality rate is now 4.86 per 1000 births. Rates are adjusted for a variety of characteristics such as socio-economic deprivation, maternal age, ethnicity etc, which the figures below are not; these are the crude figures. It is important to note that neonatal deaths (up to 28 days' post birth) are counted at place of birth, rather than place of death. This includes for those babies diagnosed with congenital anomalies and complex cases requiring surgery at tertiary centres.

3.1 Local Rates

Overall the crude extended perinatal mortality rate for WAHT for September 2022 – end August 2023 was 4.11 per 1000 live births. The crude stillbirth rate for this period is 2.47 per 1000 births which is lower than national rate. The crude neonatal death rate is 1.64 per 1000 births, which is just above the national rate. As can be seen from the graph below, the trajectory for perinatal mortality rates is decreasing.

It is important to note that these figures will change when they are reviewed by MBRRACE. It is again important to note that small monthly variations (including an increase or decrease in the number of live births) can have a significant impact on the overall numbers and rating. The Trust board is required to have oversight of all deaths reviewed and consequent action plans. The quarterly reports should also be discussed with the Trust Executive and Non- Executive Board level safety champions and this will be added to the safety champions agenda going forwards.

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

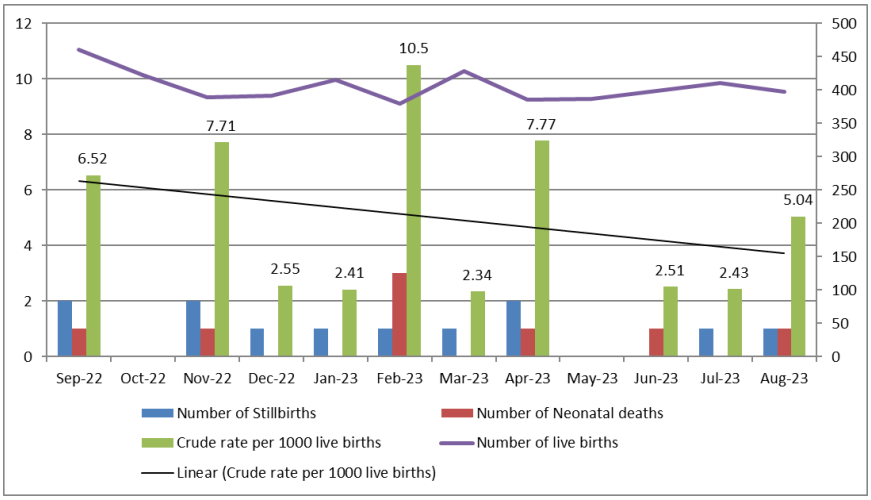


Figure 1. **WAHT Perinatal Mortality Rates**

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

The table below presents the annual local data for stillbirths, neonatal deaths, maternal deaths and babies transferred for therapeutic hypothermia from 2018 and demonstrates that the PMR is consistently within the national average for the last 4 years; 2022 and 2023 figures are crude data.

This table also reports term babies transferred for therapeutic hypothermia; it must be noted that not all referrals result in a diagnosis of Hypoxic-Ischaemic Encephalopathy (HIE).

Year	Births	Stillbirths		Neonatal deaths		Maternal deaths	Validated data by ONS & MBRRACE	Term babies transferred for therapeutic hypothermia
		Count	Rate per 1000 births	Count	Rate per 1000 births			
2018	5248	17	3.40	6	1.14	0	YES – stabilised and adjusted	Not available
2019	5200	20	3.05	9	1.29	2	YES – stabilised and adjusted	6
2020	4941	17	3.25	7	1.18	2	YES – stabilised and adjusted	4
2021	4996	16	3.26	6	1.09	1	YES – stabilised and adjusted	4
2022	4847	17	3.51*	6	1.24*	1	NO – due late 2024	4
2023	3203	7	2.19*	7	2.18*	0	No – due late 2025	1 (also NND)

3.3 Perinatal Mortality Summary for August 2023.

There was one reported stillbirth and one neonatal death in August 2023. Both cases will be reviewed via the PMRT process.

3.4 Neonatal deaths review – cases for 2023

At Quality Governance Group, there was a discussion regarding the Trust's in year neonatal mortality rate. In light of recent events it was agreed that a detailed summary of the neonatal deaths for babies born in 2023 would be shared with the Board (in private to maintain the anonymity of the families) to provide assurance. To summarise there have been 3 babies born with congenital anomalies, 2 babies who sadly died from complications of prematurity and 2 cases being investigated by HSIB of which the cause of death is currently unknown.

4. Healthcare Safety Investigation Branch (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 HSIB (Appendix 1) and are reported in detail to the Board alongside all maternity Serious Incidents:

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

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

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

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

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

Current HSIB cases:

There were 2 ongoing HSIB cases in August 2023 that were referred in February 2023 (both early neonatal deaths). One case has been formally paused while the final post-mortem is completed and the report published; for the other case some additional interviews with staff members were required and have now been completed.

HSIB Quality Review Meetings

The maternity governance and leadership team along with the Chief Nursing Officer, continue to attend the HSIB QRM meetings; the meeting on 8th September was to be cancelled as there were no new referrals since the previous meeting.

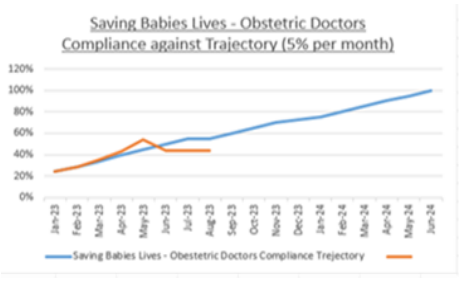
5. Incidents reported moderate or above

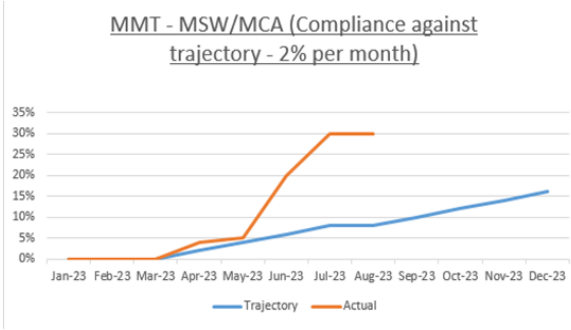
There was one moderate incident reported in August 2023. Web204478 concerns a woman who returned to theatre post-birth. This is under review.

6. Training Compliance

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

The expected trajectories for compliance (based on previous guidance) are presented below. There has been no training in August 2023 and monitoring continues.





Fetal monitoring training compliance is showing improvement again this month with obstetricians now at 100%. PROMPT training (obstetric emergency skills and human factors training) also continues monthly with an on track plan to achieve 90% compliance for all staff groups by December 2023.

Neonatal Life Support training figures are also an integral part of the MIS/CNST scheme. This is included as part of the PROMPT training for midwives however neonatal nurses and neonatal doctors access the training differently. There are no figures currently available for the doctors training compliance – this has been requested and remains unavailable.

Course	Staff Group	Compliance	Comments
Maternity Mandatory Training – (3 yearly)	Midwives	29% ↔	No training in August 2023
Maternity Mandatory Training – (3 yearly)	MCA/MSW (SBL only)	30% ↔	No training in August 2023
Maternity Mandatory Training – (3 yearly	Obstetricians (SBL only)	44% ↔	No training in August 2023
Annual fetal monitoring training (K2)	Midwives	90% ↑	
Annual fetal monitoring training (K2)	Obstetricians (all on rota)	100% ↑	
PROMPT training (Human Factors/MDT Obstetric Emergency	Midwives	95% ↔	
PROMPT training (Human Factors/MDT Obstetric Emergency	MSW's	67% ↔	No training in August 2023
PROMPT training (Human Factors/MDT Obstetric Emergency	Obstetricians (all on rota)	79% ↔	No training in August 2023
PROMPT training (Human Factors/MDT Obstetric Emergency	Anaesthetists (all on rota)	86% ↔	No training in August 2023
Neonatal Life Support	Midwives	95%↔	
Neonatal Life Support	Neonatal Drs	No data	No data available from Paeds team
Neonatal Life Support	Neonatal Nurses	81% ↓	
Trust Mandatory Training	Obstetricians	69%↓	
Trust Mandatory Training	Midwifery Staff	86%↑	

Figure 2. Training Compliance

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7. Safe staffing

Safe midwifery staffing is monitored monthly by the following actions:

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

There were 387 births in August. The escalation policy was enacted to reallocate staff internally as required. The community and continuity teams were required to support the inpatient team in month. Minimum safe staffing levels were maintained on all shifts in August.

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service. Again the rates reported demonstrate an improvement in fill rates for registered midwives however there is a reduction in maternity support workers fill rates due to sickness, maternity leave and vacancies. MSW & MCA recruitment was successful and further recruitment events planned.

There has been a focus on sickness absence management for this group which has improved attendance. A substantive, full time MSW/MCA Practice Development Midwife lead is now in place and there will be a focus on staff development, support and health and wellbeing.

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

The supernumerary status of the shift leader was not achieved in August however 1:1 care in labour was achieved in month. Sickness absence rates for midwives and non-registered staff improved in month.

The rolling turnover rate for midwives has decreased further however for non-registered staff there has been a significant increase. Further recruitment is planned and support from the PDM for MSWs development and retention.

7.2 Medical Staffing including Consultant attendance

Consultants

The consultants at WRH work either a 1:10 Obstetric on call or a 1:20 on call depending on whether they are also on the Gynaecology on call rota. There are 8 consultants purely on the Obstetric on call rota and 6 who do both Obstetrics and Gynaecology.
Current vacancies include a substantive Consultant who is on a phased return following a period of long term sickness. This vacancy is being filled by a long term locum consultant. We also have a consultant who is off night on call duty due to health issues.

Unfortunately, we did not appoint at our recent interview for a 12 month fixed term locum so we have gone back out to advert which closes the week commencing the 11th September.
We have been successful in raising an ATR for 1 new Substantive post to aid the Gynaecology recovery and are hoping to be successful in a bid to get approval for 2 more.

Registrars

The registrars work a 1:9 on call rota. We are currently over established with 22.8 WTE (funded for 19.6 WTE), with 20.8 WTE on the rota. We have 2 registrars off on long term sick. We also have an SAS doctor on extended leave until the 16th October.

A new clinical fellow commenced in post on the 7th August. We have also just successfully recruited for a Speciality Doctor post and are looking at converting two of our other clinical fellows onto permanent contracts.

Junior Grades

The junior tier works a 1:9 on call rota. We currently have a 11 WTE, giving us a vacancy rate of 6.0 WTE. This enabled us to over establish at middle grade level.

We have a Physicians Associate starting in post in September.

Consultant Attendance

In August consultant presence was achieved 100% (3/3) of the time for cases mandated by the RCOG and demonstrates compliance for MIS safety action 4.

8. Service User Feedback

8.1 Maternity Voice Partnership

The MVP continues to work with the maternity directorate on a number of action plans in response to numerous surveys. The IOL video is now complete and will be available for sharing next month.

8.2 Picker Survey

The previously agreed action plan (Appendix 3) has been reviewed to ensure that the actions remain SMART. The most recent Picker survey results are expected in September.

8.3 Complaints and PALS feedback

The directorate monitors all complaints received on a weekly basis at the QRSM. PALS are handled by the clinical team and Matrons and themes noted and discussed as required. In August 2023, 9 PALS queries were received as below.

ID	First	Specialty	Subject (primary)	Sub-subject (primary)
75840	09/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
75988	14/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
76073	16/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
75963	14/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
76649	31/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
75958	11/08/2023	Maternity (formerly Obstetrics)	Trust Admin Policies & Procedures (Incl. Patient Records Management)	PALS – Access to Health Records
75938	11/08/2023	Maternity (formerly Obstetrics)	PALS - Signposting	Message Directed to Other Department
76470	29/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient
76298	23/08/2023	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient

The most common theme concerns communication/communication with patient – on further review however, there are no common themes as the PALS queries concerned requesting debrief appointments, arranging a tour of the unit, requesting an email address for a different service.

In addition, there were 4 formal complaints received in August 2023. The complaints are being investigated in accordance with the Trust complaints process.

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
75939	11/08/2023	Maternity (formerly Obstetrics)	Clinical Treatment	Injury sustained during treatment or operation
76594	30/08/2023	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure to diagnose (inc e.g. missed fracture)
75801	08/08/2023	Maternity (formerly Obstetrics)	Communications	Communication failure within department
76105	15/08/2023	Maternity (formerly Obstetrics)	Trust Admin Policies & Procedures (Incl. Patient Records Management)	Accuracy of health records (e.g. errors, omissions, other patient's records in file)

9. Safety Champion escalations

The escalations from the August Safety Champion minutes (Appendix 4) are as follows:

1. Theatre scrub business case – progressed to advert
2. Reporting process for Saving Babies Lives – reported as part of COSMOS. Progress presented in section 14 and completed toolkit to be shared in the safety report once validated by the LMNS.

9.1 Claims scorecard review in conjunction with incidents and complaints

A deep dive into historic claims is underway and will be available in the next Safety Report (October 2023).

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

The directorate have a number of CQC must do's and should do's that are monitored via the Trusts RAIT tool (Appendix 5).

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

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

1. Escalation Policy – draft escalation policy progressing and will be tabled at next governance meeting for sign off. Delay due to revised regional policy circulated.
2. Appraisal rates (non-medical) – 71% - reduction in month
3. Trust Mandatory Training rates – 76% - decrease in month due to rotation of junior doctors

11. Coroner Regulation 28 made directly to Trust

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

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

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

The current expected positon is outlined below:

Element	Current Status	Actions
1. PMRT		Quarterly reporting in place. Q1 report presented in Julys report.
2. MSDS		Ethnicity issue resolved and MCoC to be included. No issues currently identified and verified externally.
3. ATAIN		Quarterly reporting in place. Q1 report presented in Julys report.
4. Clinical Workforce		To merge neonatal and maternity safety reports to ensure all workforce data reported monthly and sighted at Board – plan for Septembers report.
5. Midwifery Workforce		Monthly staffing report presented in appendices SN status of the shift leader not met in July or August.
6.Saving Babies Lives		Q1 2023/2024 reports for elements 1-5 shared in Julys safety report. Element 6 due to be presented at August governance. SBLV3 Implementation Toolkit update will be available in Septembers report.
7.MVP		Evidence of wider engagement required
8.MDT Training		Training plan meeting current trajectory overall. Training Policy and TNA to be agreed with LMNS in September. Documents shared in Julys report
9. Safety Champions		Information required available within report and appendices.

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

13. MSSP Report

NHSE have confirmed that the Trust is now in a position to exit the support programme. A sustainability plan is currently being drafted and will be overseen by the ICB.The current progress report is presented in appendix 6. Progress on the following is required:

1. RN scrub cover for emergency caesarean sections/surgical cases
2. Escalation policy
3. Recruitment of maternal medicine midwife
4. Recruitment of Lead PMA role.

The business case for theatre staffing was presented at the Trust Management Executive Committee in August and the recruitment process for 4 WTE scrub practitioners was agreed. The escalation policy will be ratified in September and the 2 outstanding posts will also be advertised in September.

14. COSMOS

COSMOS is a local acronym for CNST, Ockenden 1, Single Delivery Plan, Maternity Self-Assessment Tool. Ockenden 2 and Saving Babies Lives. The recommendations/actions from all of these national documents have been captured within a TEAMs platform to ensure that the directorate can track the progress of completion, communicate with leads and demonstrate monthly position/compliance. The most recent positon is presented below.

4th Sept 2023		Compliant	In progress	Overdue	Not Started	Total	Full Compliance
C	CNST	6	20	5	8	39	15%
O	Ock 1	32	9	6	2	49	65%
S	SDP	2	17	0	25	44	5%
M	MSAT	96	22	21	17	156	62.00%
O	Ock 2	57	37	0	5	99	57%
S	SBL V3	48	45	0	32	125	38%
S	SBL V3	Implementation tool (Interventions only)					56%

The directorates monthly progress is presented below:

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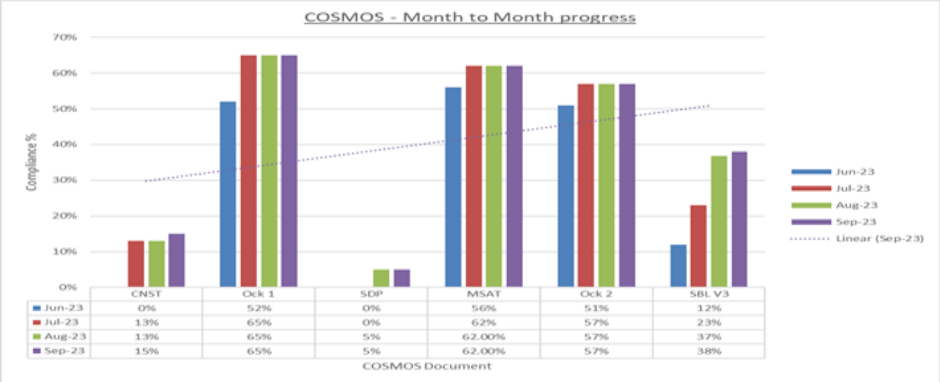

Conclusion

This report provides a monthly update on key maternity 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 directorate to collate evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

Recommendations

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

Appendices

1. HSIB Monthly Progress Report
2. Staffing Report
3. Picker Action Plan
4. Safety Champion minutes
5. RAIT Tool
6. MSSP Report
7. HEE Quality Report & Action Plan

NHS
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Bed Cleaning Recommendation- Infection Prevention Control

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

Accountable Director	Sarah Shingler: Chief Nursing Officer: Executive Director of Infection Prevention and Control		
Presented by	Sarah Shingler: Chief Nursing Officer	**Author /s**	Emma Fulloway IPC Nurse Manager/Julie Booth DDIPC

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Given the outputs from the benchmarking exercise and the sustained non-compliance of clinical cleans from ward and department staff the Chief Nursing Officer's recommendation is that the Trust focusses on the education of clinical teams regarding their ward ownership of beds, their cleaning responsibilities, use of bed space check list and that assurances are sought through peer review checks of bed cleanliness on top of current assurance processes with Infection, Prevention and Control and Micad audits. In parallel, the learning from South Warwickshire University NHS Foundation Trust will be explored further in relation to AMS and the outputs from the macerator trial will also be considered and appropriate actions taken depending on the outcome of the results. If there is no improvement in bed cleaning audits over the next 6 months then the option of a dedicated bed cleaning team will be considered, however the ward and department teams will need to consider how such a team would be funded out of existing resources.

Executive summary	Since 23rd September 2021 there has been an open action on the Trust Infection Prevention and Control Committee C.diff action plan for a designated bed cleaning facility to be introduced at each Trust inpatient location. In 2021 a specification for a bed cleaning facility was agreed with IPC and nursing colleagues. Feasibility costs identified that capital investment would be required with indicative costs between £1.5 million and £3

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	million, caution was advised around the costs given that locations had not been identified on any of the sites. Bed cleaning facilities are not currently included within the Capital Prioritisation List and no capital bid has been placed for dedicated bed cleaning facilities. The feasibility plan was reviewed by the previous Chief Operating Officer who stopped progression of a capital bid due to the cost and lack of suitable locations being identified; Café Are on the Worcester site was put forward as a potential site for the bed cleaning facility, however this was deemed unsuitable as would impact on staff not having a suitable area for meals and breaks. The Director of Estates presented a paper to QGC on the 31 August 2023, this paper stated that a dedicated bed cleaning facility is not required. Due to the length of time that this action has been open the Chair of QGC requested that a paper be presented to the Board with a recommendation from the Chief Nursing Officer as to whether dedicated bed cleaning facilities are required.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*4*

Assurance Level (x)	0		1		2		3		4	x	5		6		7		N/A	
Financial Risk	Dedicated bed cleaning facility on both sites will require significant capital investment.																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y					
Are the actions identified starting to or are delivering the desired outcomes?			N			
If no has the action plan been revised/ enhanced	Y					
Timescales to achieve next level of assurance	**6 months**					

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Introduction/Background

- Since 23rd September 2021 there has been an open action on the Trust Infection Prevention and Control Committee (TIPCC) C.diff action plan for a designated bed cleaning facility to be put into place at each Trust inpatient location.

- The Trust is second highest in the Midlands region for cases and is sitting in the top quarter of trust nationally for our C.diff rates.

- This paper identifies bed cleaning requirements from national guidance, outlines the Trust policy for bed cleaning, assurance and monitoring processes. It benchmarks the Trust against other Trusts within our Foundation Group and locally in the region to identify if we are an outlier for being over trajectory for C.diff and not having a bed cleaning facility. It also states what else needs to be done in order to reduce C.diff cases at the Trust as stated by Mark Wilcox (UKHSA C.diff expert) November 2022.

1. Bed Cleaning National Guidance

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. Criterion 2 states:

'*there are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies*'

Dedicated bed cleaning facilities are not a requirement of the Health and Social Care Act.

National Standards of Healthcare Cleanliness 2021
Dedicated bed cleaning facilities are not referenced in the National Standards of Healthcare Cleanliness. The standard states the frequency for cleaning beds to be:

- Full clean frame top daily
- Full clean frame bottom weekly

Cleaning responsibility recommended:

- Bed frame: cleaning team

2. Current Trust Policy for bed cleaning

- Full clean frame top daily-Clinical Team using Green universal clinell wipes (non sporicidal)
- Full clean frame bottom weekly-Facilities Team using Tristel-chlorine dioxide (Sporicidal)

This frequency is in line with National Standards of Healthcare Cleanliness 2021 as per functional risk area.

In addition, there is also a minimum annual strip down and deep clean of the bed as part of a red clean by the facilities team. These cleans are tracked by the bed asset number and regularly reviewed. Any beds that do not present themselves for a red clean in a 12-month period are captured at the annual servicing of that particular bed, trolley or incubator.

Discharge cleaning of beds:

Non-infected beds: the bed and mattress is completely cleaned by the clinical team using green universal clinell wipes (Green Clean). Clinell wipes are not effective to deactivate C.diff spores, but will remove gross body fluid contamination and will physically remove spores in the cleaning process.

Infected bed: the bed is green cleaned by clinical staff (as stated above) and then cleaned by facilities as part of an Amber (Tristel, Chlorine dioxide) , Violet (VUc) and Red (Hydrogen Peroxide) cleaning process. The foam mattresses are left in the room if a Red clean is completed or sent to a mattress decontamination facility, for decontamination if Amber/violet clean completed. Electronic mattresses are returned to the supplier for full decontamination.

The Trust has a policy in place that reflects the national recommendations as set out in the National Standards of Healthcare Cleanliness 2021.

However, there are gaps in compliance with this policy (as highlighted in the next section), barriers could be use of agency staff and clinical staff capacity to clean beds thoroughly due to time constraints.

3. Assurances/Monitoring off Bed cleaning

Monitoring of compliance:
The IPC team undertake audits which include assessment of bed frame cleanliness, the audits are completed on an adhoc basis: when wards are in outbreak or when C.diff cases are identified. Areas of noncompliance are raised to ward manager, matron and director of nursing and facilities staff via email and during outbreak meetings. Common areas of noncompliance include:

- Failure of staff to remove bed boards under mattress to dust frames.
- Failure of staff to remove inside cover of bed sides.

Facility audits:
Micad audits are undertaken by the Trust monitoring team on a monthly basis, these audits are reviewed at the Patient Environment Action group (PEOG) and TIPCC by exception. Results highlight sustained failures with clinical cleans.

NHSE Visits:
During the last 2 years NHSE IPC leads have visited the Trust on several occasions and have not identified beds with heavy soiling or body fluids present, dust has been found on

bed frames (C.diff spores can survive in dust for several months). The Trust has not to date received a report from NHSE where bed cleaning is raised as a concern, however NHSE have verbally stated during visits that beds are dusty.

4. Bench Marking

A bench marking exercise was completed to ascertain what other acute Trusts are doing in terms of bed cleaning in the region. Seven Trusts were approached for information, all have responded as set out in table below.

Trust name	**Bed cleaning facility in place?**	**How beds are cleaned Frequency Who clean the beds**	**C.diff status: under trajectory/ on trajectory/ over trajectory**
WAHT	No	Beds are cleaned within the ward environment. **Cleaned daily** by clinical team using green clinell wipes, **cleaned weekly** by Facilities team using Tristel **Discharge: Non infected** full bed clean nursing using green clinell wipes **Discharge infected** clinical team for completion of green clean followed by facilities full clean either Amber, Red and Violet.	Over trajectory
Wye Valley NHS Trust (foundation group member)	No	Beds are cleaned within the ward environment **Cleaned with :** Clinell disinfectant wipes or Tristel fuse dependant on infection risk **Frequency**: daily and between patient use **Discharge cleans** : **Non infected**: Clinell disinfectant wipes **Infected** Tristel fuse	Over trajectory
George Elliot Hospital Trust (foundation group member)	Yes	Beds which have been used for patients with infections/heavily soiled are initially cleaned on ward and then sent to bed cleaning facility. Non infected/soiled beds are cleaned at ward level with Tristel	Over trajectory
South Warwickshire University NHS	No	Beds are cleaned within the ward environment	Under trajectory