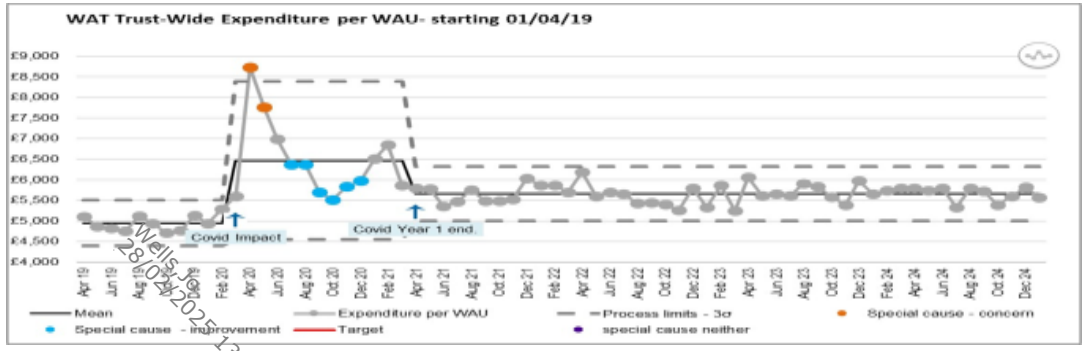
BEST USE OF RESOURCES – INCOME & EXPENDITURE

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	Jan-25 Plan £'000	Jan-25 Actual £'000	Jan-25 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	59,768	63,368	3,600	603,293	617,945	14,652
Other operating income	2,744	2,898	154	27,133	31,137	4,004
Employee expenses	(38,025)	(39,684)	(1,659)	(386,828)	(391,072)	(4,244)
Operating expenses excluding employee expenses	(22,728)	(24,824)	(2,096)	(226,593)	(241,818)	(15,225)
OPERATING SURPLUS / (DEFICIT)	**1,758**	**1,758**	**(0)**	**17,005**	**16,192**	**(813)**
FINANCE COSTS						
Finance income	88	188	100	1,164	1,681	517
Finance expense	(934)	(933)	1	(9,340)	(9,324)	16
PDC dividends payable/refundable	(467)	(438)	29	(4,673)	(4,019)	654
NET FINANCE COSTS	**(1,313)**	**(1,183)**	**130**	**(12,849)**	**(11,662)**	**1,187**
Other gains/(losses) including disposal of assets	0	(19)	(19)	0	(476)	(476)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**445**	**556**	**111**	**4,156**	**4,054**	**(102)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**445**	**556**	**111**	**4,156**	**4,054**	**(102)**
Remove capital donations/grants/peppercorn lease I&E impact	11	14	3	115	(125)	(240)
Remove PFI revenue costs on an IFRS 16 basis	3,451	3,590	139	34,418	34,029	(389)
Add back PFI revenue costs on a UK GAAP basis	(4,363)	(4,159)	204	(43,608)	(42,876)	732
Adjusted financial performance surplus/(deficit)	**(456)**	**1**	**457**	**(4,918)**	**(4,918)**	**0**



- New Cost per WAU method and visual developed across the Foundation Group to allow comparable reporting

Performance and Actions

At the end of Month 10 we report a year to date (YTD) breakeven position against the revised plan.

Income is £18.7m favourable YTD – favourable variances include Non PbR Drugs (£9.3m) and Non PbR Devices (£1.2m), £1m of additional E&T funding to offset the higher intake of trainee Medics in August, £1.9m API over delivery, £0.5m 23/24 ERF overperformance, £1.7m additional ICB income, £0.3m of Industrial Action funding, £1.3m of Cancer Alliance income offsetting non pay costs, £0.8m of income released into the position supporting CPIP delivery and £0.3m of income relating to the costs of A&E flooring. Favourable variances partially offset by adverse variances of £0.5m relating to SR21 income, £0.3m car parking income and £0.3m of Diagnostic risk.

Employee expenses are £4.2m adverse YTD – adverse variances relating to CPIP under delivery of £1.8m, Industrial Action costs £0.4m, Histology Reporting growth of £0.5m, additional temporary Medics supporting flow of £0.5m, additional ED Consultant costs of £0.6m, £1.2m of winter pressures and A&E Flooring Costs of £0.2m (offset by income). These are partially offset by favourable variances in; Dermatology of £0.9m due to vacancies (offsetting insourcing spend) and £0.9m on CDC due to the 5th Endoscopy room not yet being open.

Operating expenses excluding Employee Expenses are £15.2m adverse YTD - this includes adverse variances of £12.9m on Non PbR Drugs and Devices (leaving a pressure on the H&W ICB fixed price contract of £2.3m), activity related spend of £1.5m in Specialty Medicine, tariff Drugs spend of £0.3m, Radiology reporting of £0.4m and Dermatology insourcing costs of £1.3m, the remainder being activity related spend on clinical supplies of £3.2m. This is partially offset by underspends relating to utility costs of £0.8m (excluding £1.1m declared as CPIP YTD), and insourcing reserves of £2.2m as well as £1.4m over delivery on CPIP.

Risks

The challenge of meeting all of the requirements of 24/25 plan across operational performance, workforce and finance should not be underestimated given our underlying exit deficit position from 2023/24. There remains a significant level of risk associated with delivering the plan, for which mitigations continue to be sought.

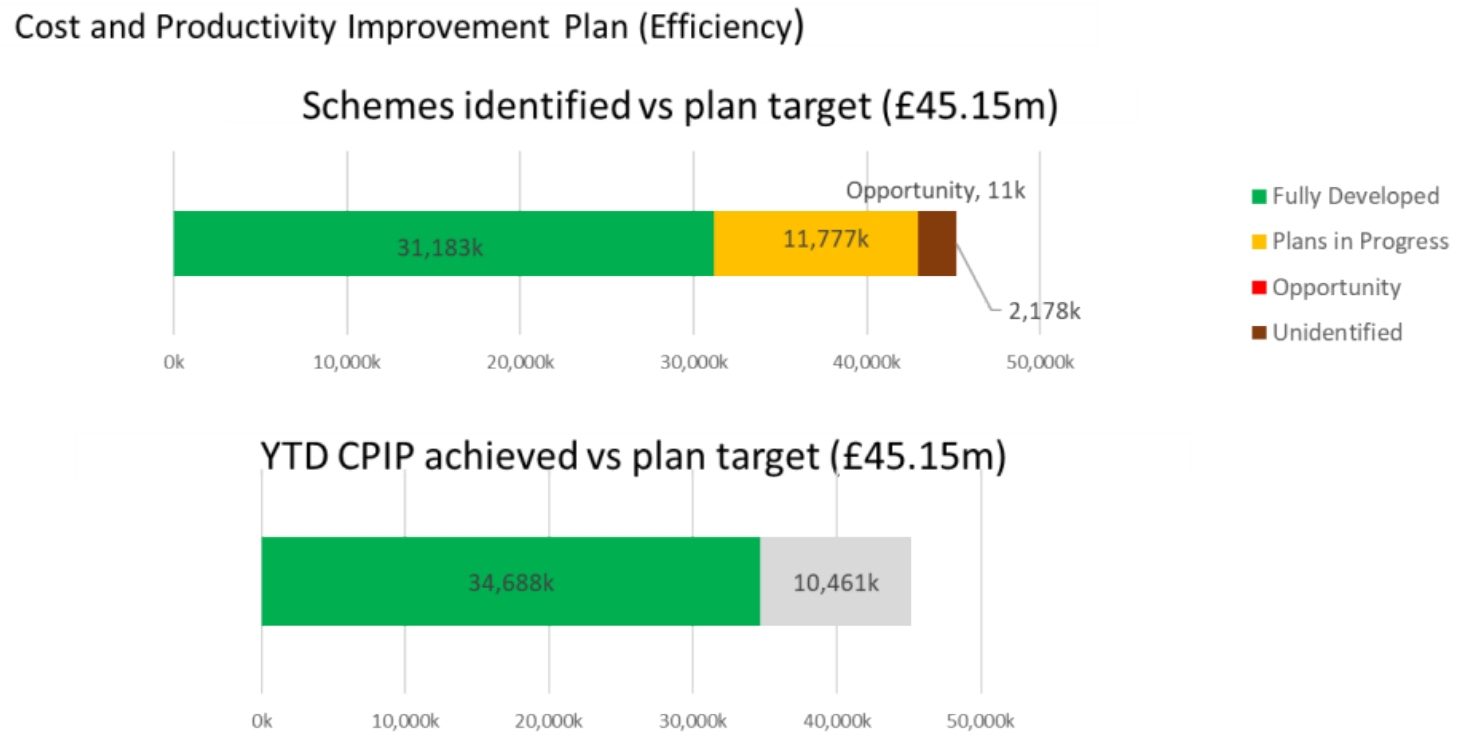
What the charts tell us

For January, our **Cost per WAU is 4.3% lower than December**. **When working days are factored in for Elective its 0.2% lower**. This means we are delivering more activity per spend than in the previous month and since April 2021 the Cost per WAU has remained consistent and needs some changes in spend or activity volumes to impact it. **Expenditure is 1.1% higher than December**, and the **activity WAU 5.6% higher or 1.3% higher when working days are factored in for Elective.**

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 Trusts 24/25 target as submitted to NHSE in June is £45.15m
- M10 Plan figure was £4.24m
- M10 Actuals delivered £3.97m, an under delivery of £0.27m
- M10 Actuals comprise £3.18m recurrent and £0.80m non-recurrent
- The forecast to EoY is £42.97m. A shortfall of £2.18m against the £45.15m target. (M9 forecast was £41.91m so an overall improvement)
- A summary of the highest underperforming schemes by value, YTD Actual vs YTD Plan comprise:

Ref	Description	YTD Actual to Plan variance
PE-2425-210	Closure of PDU	-£337,079
PE-2425-102	Ophthalmology Day Case	-£229,167
PE-2425-186	Spire Contract for Histology	-£187,227
PE-2425-211	Reduction in sickness (UC)	-£166,667
PE-2425-101	Pathology SLA's	-£166,667

Risks

- Delivery of the 24/25 target is challenging, but work is continuing to develop existing schemes as well as identifying further cost saving and productivity savings to bridge the gap to target (GTT).

What the charts tell us

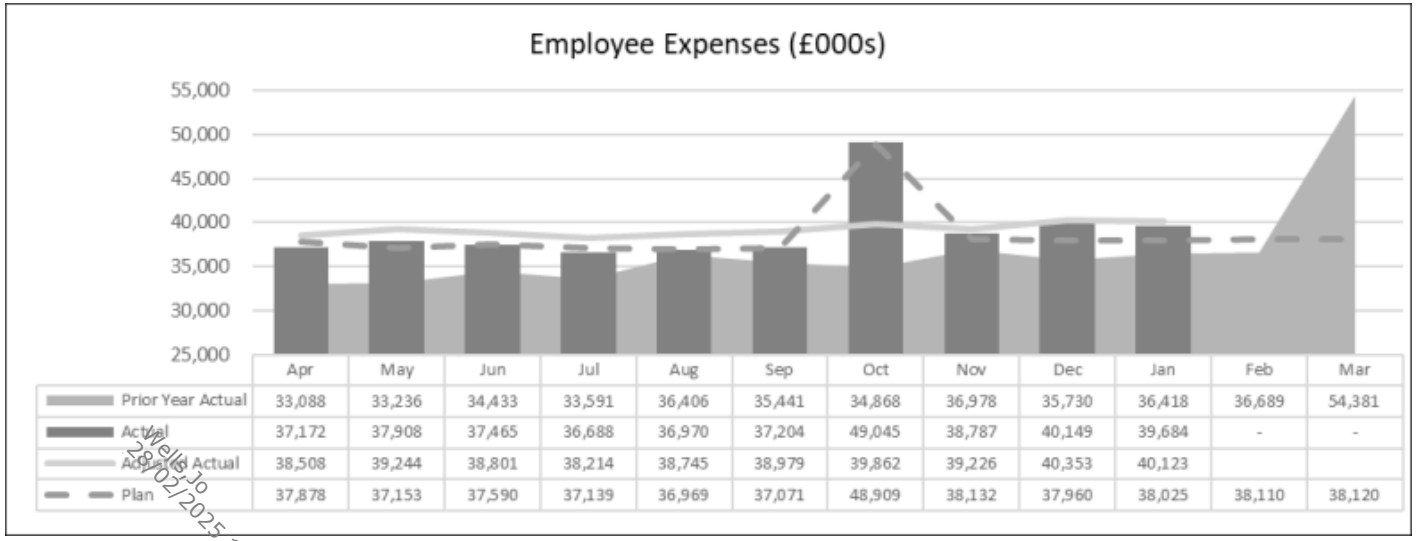
M10 delivered actuals of £3.97m against a plan of £4.24m, an under delivery of £0.27m. M10 actuals comprise £3.18m recurrent and £0.8m non-recurrent. Year to date (YTD) actuals are £34.69m compared to a Plan of £35.30, an under delivery of £0.61m. The YTD recurrent actuals comprise £27.12m and non-recurrent comprise £7.57m. Work is continuing to focus on delivery of the CPIP schemes for 24/25 through the Trust maturity levels. 'Check and Challenge' style sessions are taking place fortnightly for assisting with monitoring and measuring performance to improve development of existing plans as well as delivery against fully developed plans. These sessions also provide the means to challenge Divisions on plans to bridge any GTT. Requests for CPIP schemes for 25/26 have been issued to the Divisions and Corporate teams as part of Annual Planning and the associated targets were issued as draft on 11 February.

BEST USE OF RESOURCES – EMPLOYEE EXPENSES

We are driving this measure because

The Employee 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.

Employee Expenses	Year to Date			WTE		
	Plan £000s	Actual £000s	Variance £000s	Funded WTE	Contracted WTE	Worked WTE
Medical & Dental	(125,525)	(128,300)	(2,775)	934	876	997
Nursing & Midwifery	(150,505)	(153,635)	(3,130)	3,570	3,377	3,859
Scientific, Therapeutic & Technical	(50,572)	(48,001)	2,571	1,186	1,110	1,146
NHS Infrastructure Support	(58,875)	(59,688)	(812)	1,717	1,654	1,665
Other Pay	(1,350)	(1,448)	(98)	0	0	0
Grand Total	**(386,828)**	**(391,072)**	**(4,244)**	**7,407**	**7,018**	**7,666**



Note: The actuals in the above graph have been adjusted to spread the backdated pay award paid in October and November over the prior months as well as normalising for the 23/24 junior doctor pay award in November, provision releases and credit notes.
In 2023/24, M12 one offs include: Notional Pension Contribution £15.1m; Band 2 to 3 uplift £2.4m; Pay Award £0.3m.

Performance and Actions

Employee expenses £4.2m adverse to plan YTD - adverse variances relating to CPIP under delivery of £1.8m, Industrial Action costs £0.4m, Histology Reporting growth of £0.5m, additional temporary Medics supporting flow of £0.5m, additional ED Consultant costs of £0.6m, £1.2m of winter pressures and A&E Flooring Costs of £0.2m (offset by income). These are partially offset by favourable variances in; Dermatology of £0.9m due to vacancies (offsetting insourcing spend) and £0.9m on CDC due to the 5th Endoscopy room not yet being open.

Currently the level of YTD underspends on the UIC business case (£0.1m) and Surgical SDEC/SAU (£0.4m) are offsetting overspends on TIF in Surgery (£0.1m) where Agency staffing is more than the budget set and in E&F (£0.4m) where no budget was set.

Spend on temporary Nursing cover for sickness, specialist care and maternity has increased to £1m this month which is £0.1m per month higher than 23/24 (an average 210 WTE).

Risks

Non delivery of the CPIP schemes relating to employee expenditure will add to the pressure reflected in the Trust's overall financial performance. Emergency pressures also continue causing additional capacity to remain open incurring agency costs, and higher than planned sickness levels also impact our ability to remove temporary staffing.

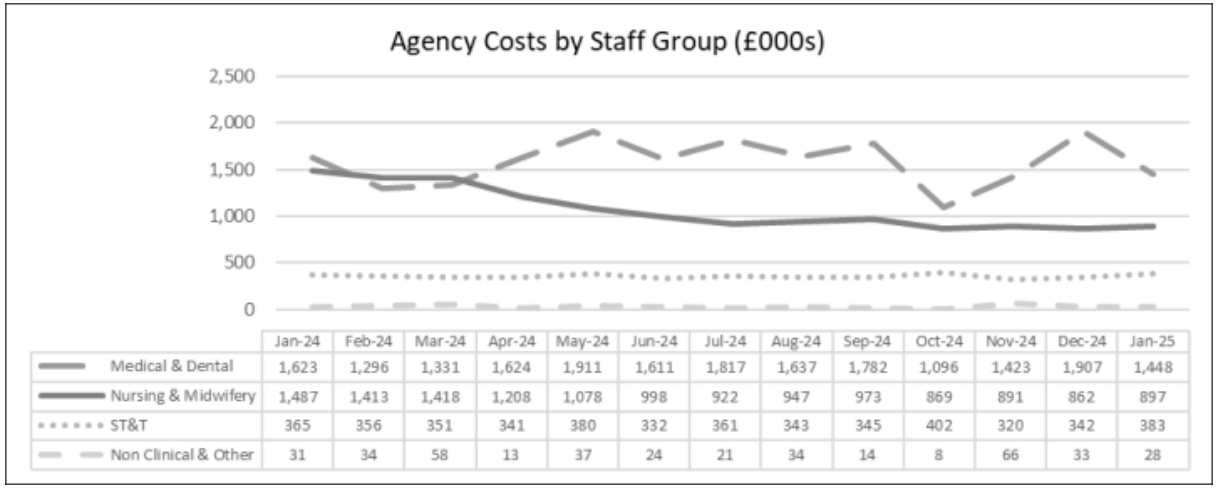
What the charts tell us

Employee expenses of £39.7m in month 10, a decrease of £0.5m compared with December with Retro benefits on Agency Medics of £0.4m and lower Bank holidays of £0.2m partially offset by £0.2m increase in Medical

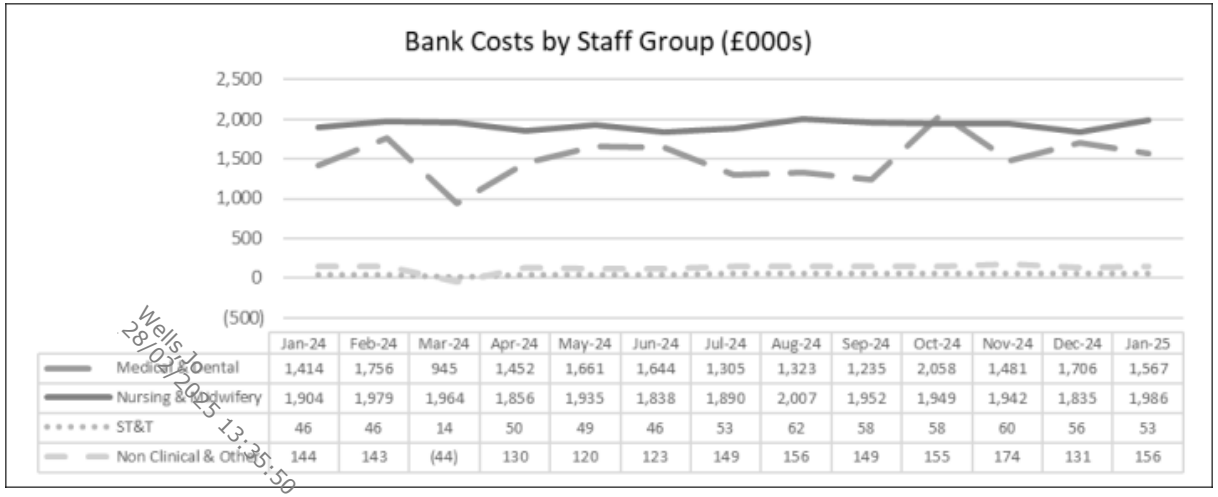
BEST USE OF RESOURCES – BANK AND AGENCY SPEND

We are driving this measure because

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



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Medical & Dental	1,623	1,296	1,331	1,624	1,911	1,611	1,817	1,637	1,782	1,096	1,423	1,907	1,448
Nursing & Midwifery	1,487	1,413	1,418	1,208	1,078	998	922	947	973	869	891	862	897
ST&T	365	356	351	341	380	332	361	343	345	402	320	342	383
Non Clinical & Other	31	34	58	13	37	24	21	34	14	8	66	33	28



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Medical & Dental	1,414	1,756	945	1,452	1,661	1,644	1,305	1,323	1,235	2,058	1,481	1,706	1,567
Nursing & Midwifery	1,904	1,979	1,964	1,856	1,935	1,838	1,890	2,007	1,952	1,949	1,942	1,835	1,986
ST&T	46	46	14	50	49	46	53	62	58	58	60	56	53
Non Clinical & Other	144	143	(44)	130	120	123	149	156	149	155	174	131	156

Performance and Actions

Total agency expenditure in January was £2.8m, a decrease of £0.4m compared with December.

- By staff group agency spend was £1.4m on Medical & Dental (£0.5m decrease compared to month 9 driven by the continued cleansing of historic shift data by the Divisions and NHSP), £0.9m on Nursing & Midwifery (£35k increase compared with month 9 driven by winter costs), £0.4m on Scientific, Therapeutic & Technical staff (£42k increase compared to month 9) and £28k on Non-Clinical staff (a decrease of £5k compared to month 9).

Total bank expenditure was £3.8m in January, an increase of £34k compared with last month.

- By staff group bank spend was £1.6m on Medical & Dental (£0.1m decrease compared to month 9), £2.0m on Nursing & Midwifery (£0.2m increase compared with month 9), £53k on Scientific, Therapeutic & Technical staff (consistent with month 9) and £156k on Non-Clinical staff (an increase of £34k compared to month 9).

Risks

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

What the charts tell us

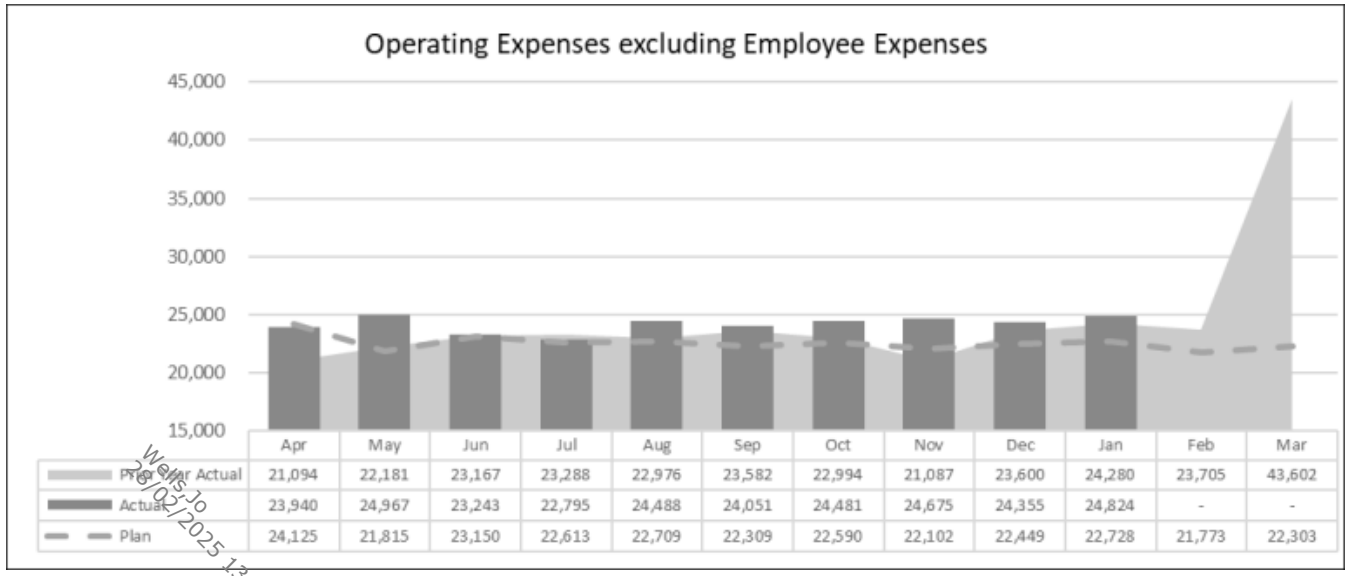
The Nursing and Midwifery trend continues to look positive with a largely falling trend on Agency and a relatively steady trend on Bank. Medical Agency has reduced back to November levels.

BEST USE OF RESOURCES – OPERATING EXPENSES

We are driving this measure because

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

Operating Expenditure excluding Employee Expenses	Year to Date		
	Plan £000s	Actual £000s	Variance £000s
Purchase of services from NHS bodies outside of the system	(4,710)	(5,096)	(386)
Purchase of services from non NHS bodies	(9,494)	(8,171)	1,323
Drugs Costs	(48,759)	(61,146)	(12,387)
Supplies and services	(71,449)	(80,302)	(8,853)
Other Operating Costs	(92,181)	(87,103)	5,078
Operating Expenditure Total	**(226,593)**	**(241,818)**	**(15,225)**



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

Performance and Actions

Operating expenses excluding Employee Expenses £15.2m adverse YTD – this includes adverse variances of £12.9m on Non PbR Drugs and Devices (leaving a pressure on the H&W ICB fixed price contract of £2.3m), activity related spend of £1.5m in Specialty Medicine, tariff Drugs spend of £0.3m, Radiology reporting of £0.4m and Dermatology insourcing costs of £1.3m, the remainder being activity related spend on clinical supplies of £3.2m. This is partially offset by underspends relating to utility costs of £0.8m (excluding £1.1m declared as CPIP YTD), and insourcing reserves of £2.2m as well as £1.4m over delivery on CPIP.

Included in the above variance is £0.2m relating to Microsoft licenses where budget was reduced due to expected savings from centralised procurement by NHSE. Digital have confirmed they are part of the national contract to which these savings applied but have so far not identified any savings.

Risks

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

What the charts tell us

Operating expenses of £24.8m in month, an increase of £0.5m compared with December. Increases of £0.8m on Non PbR Drugs and Devices partially offset by £0.3m of lower insourcing in Surgery and of £0.1m normalisation of the Redair system purchased in M9.

BEST USE OF RESOURCES – CAPITAL

We are driving this measure because

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

Workstream	Scheme	Adjustments for External Plan - Month 10	Revised 24/25 External plan £'000	Total YTD Valuation - YTD Month 9 £'000	Total YTD Valuation - YTD Month 10 £'000	Movement Month 9-10 £000's
P&W	Additional P&W Schemes		2,597	850	1,684	834
P&W	Generators (East and West, No 1 & No 2)		60	52	53	1
P&W	Upgraded Fire Compartmentation		343	945	597	(348)
P&W	HV Works - DNO Substation and Site ISS)		832	609	585	(24)
P&W Total		**0**	**3,832**	**2,456**	**2,919**	**463**
Digital	Xerox Scanners	-	54	54	56	2
Digital	Xerox - Kainos Upgrades	-	26	(5)	(5)	0
Digital	Additional Digital schemes		2,113	36	58	22
Digital	Phase 2 - Digital System Production Environment		314	314	314	(0)
Digital	Phase 2 - Telephony Systems Critical Upgrades		267	(7)	5	12
Digital	LIMS - Infrastructure		546	492	492	0
Digital Total		**0**	**3,320**	**884**	**920**	**36**
Equipment	Equipment Schemes		1,290	653	789	136
Equipment Total		**0**	**1,290**	**653**	**789**	**136**
Strategic	Urgent Emergency Care - Additional	-	570	453	449	(4)
Strategic	Aconbury 0		420	339	400	61
Strategic	Cath Lab/IR Feasibility		862	74	75	1
Strategic	Acute Service Review - Maternity		533	7	7	(0)
Strategic	Linac Replacement		75	1	2	1
Strategic	Prior Year Strategic Schemes		53	25	25	(0)
Strategic Total		**0**	**2,513**	**899**	**959**	**60**
IFRIC 12 PFI	IFRIC 12 PFI Lifecycle replacement	600	3,600	1,009	2,981	1,972
P&W	Donated P&W Schemes	-	4	4	4	-
Equipment	Donated Equipment Schemes	56	304	247	303	56
Contingency	VATrecovery across schemes reallocated		(1,274)	(1,274)	(1,274)	-
Leases	Lease Additions and Remeasurements		1,221	497	672	176
Other Total		**656**	**3,855**	**483**	**2,687**	**2,204**
Workstream total	**Internal Funded**	**656**	**14,810**	**5,375**	**8,274**	**2,899**

Workstream	Scheme	Adjustments for External Plan - Month 10	Revised 24/25 External plan £'000	Total YTD Valuation - YTD Month 9 £'000	Total YTD Valuation - YTD Month 10 £'000	Movement Month 9-10 £000's
Digital	Front Line Digitisation	-	1,000	921	982	61
Digital Total		**0**	**1,000**	**921**	**982**	**61**
Strategic	Additional Capacity - TIF	-	144	50	144	94
Strategic	RAAC Works at KTC	-	2,270	796	875	79
Strategic	AHR Fire External Funding		6,000	-	0	0
Strategic	Fire Safety External Funding		864	-	0	0
Strategic	Catering Replacement - PDC Funded		98			0
Strategic	Pharmacy Cold Room ALX - PDC Funded		50			0
Strategic	NEEF	1,626	1,626			0
Strategic Total		**1,626**	**11,052**	**846**	**1,019**	**173**
						0
Workstream total	**External Funded**	**1,626**	**12,052**	**1,767**	**2,001**	**234**
	Total Capital Plan	**2,282**	**26,862**	**7,142**	**10,274**	**3,132**

Performance and Actions

The capital YTD spend at month 10 is £10.3m. This is an overall increase of £3.1m from M9 capital expenditure of £7.1m on the following schemes: Fire Compartmentation £516k and other P&W schemes. The actuals of £10.274m exceeded the projected spend of £10.247m for month 10.

In month 10 the Trust has received notification of an additional £1.626m of external funding for the National Energy Efficiency and Renewable Energy Scheme (NEEF). The plan for IFRIC 12 replacement schemes has increased by £600k, along with receiving charitable funded equipment worth £56k. The plan at M10 is now £26.8m.

Projected spend in month 11 is £3.9m and £12.6m in month 12. The latter being of significant risk of slippage given the amount of spend in the final month of the year. However, we are still receiving positive weekly assurance from all capital workstream leads that they are on track to reach their target spend by the end of the financial year.

Risks

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

- With only 2 months to go until the end of the financial year the Trust has spent £10m of the £26.8m allocation with winter ahead of us. Mitigations have been put in place and weekly assurance sought from Capital workstream leads on project spend status
- The completed UEC build has been complex and there is a risk that consequential losses relating to remedial flooring works to the UEC will not be covered by the contractor in full, this scheme is not yet completed.

What the charts tell us

Ongoing capital expenditure on internal schemes continue to impact and delay a significant proportion of spend on backlog maintenance and equipment replacement. The finance team will continue to work with the workstream leads to ensure all expected costs are identified at this stage.

BEST USE OF RESOURCES – CASH

We are driving this measure because

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

Performance and Actions

The Trust cash position at the end of month 10 was £14.106m. The Trust received deficit funding from the ICB of £4.154m, which is the balance of the original deficit phasing up to and including month 10 - £44.907m. The balance of £6.749m is to be paid as per the original phasing of the deficit in months 11-12. The Trust also received £1.7745m in January towards the 2024/25 Pay Awards for all staff categories, a total of £14.168m to-date. The ICB will be paying the balance of £3.549m for Pay Awards in months 11-12 (£1.7745m per month). The amount the ICB have agreed to fund, which is based on contracts, is £1.28m below what the Trust requested.

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

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

Risks

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

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

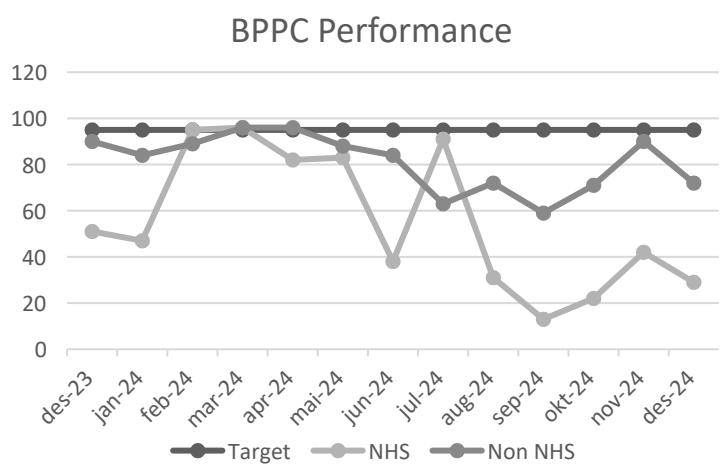
Assumptions made for the above cashflow

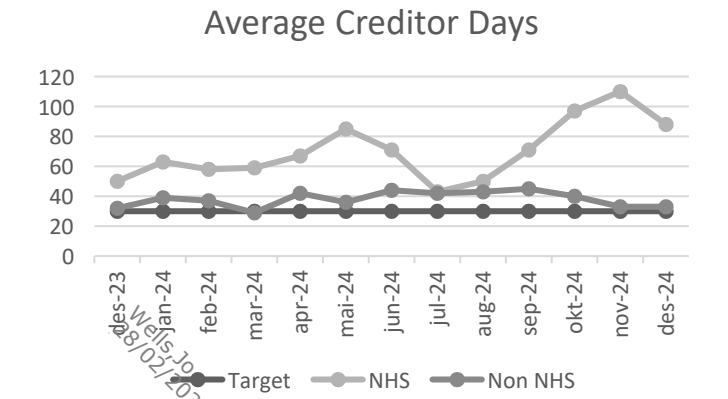
- IFRIC12 Lifecycle cashflow estimates of £3m yet to be factored in but can be managed from the PDC allocation.
- The pay award of 5.5% has been factored for pay expenditure.
- Non-Pay costs are as per plan, with amounts for payment of creditors set at £2m per run (2 per week), if the costs are not reduced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

BEST USE OF RESOURCES – CASH

We are driving this measure because

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





Performance and Actions

The BPPC performance for the <u>month</u> of January is 67% (77% in December) based on volume of invoices paid and 67% (69% in December) based on value;

- 6,375 invoices paid out of 9,548 due.
- £21.729m worth of invoices out of £32.676m were paid on time this month.

As at month 10, the Trust has received £17.75m from NHSE for Provider Revenue Support and £44.907m from the ICB for deficit funding, which has been phased as per plan, totalling £51.656m. The balance of £6.749m will be received in months 11 and 12, phased as per plan, £3.154m of this balance has been received in February 2025.

Month	Applied £m's	Received £m's	Shortfall £m's	Date Received
April	0.00	0.00	0.00	
May	8.50	4.25	-4.25	20-May-24
June	7.50	6.00	-1.50	17-Jun-24
July	7.50	7.50	0.00	01-Jul-24
August	4.75	10.00	5.25	01-Aug-23
September	7.50	7.50	0.00	23-Sep-24
October	15.22	15.22	0.00	1 & 15-Oct-24
November	2.64	2.64	0.00	01-Nov-24
December	5.40	5.40	0.00	02-Dec-24
January	4.15	4.15	0.00	02-Jan-25
Total to date	63.15	62.66	-0.50	
February	3.15	3.15	0.00	03-Feb-25

Risks

The BPPC performance fell in January due to the level of cash available, which has been phased to the end of the financial year to ensure that the Trust payroll and associated costs are factored into the cash flow, and the Trust balance at the end of the year is positive.

Supplier payments are being monitored and payments made to avoid any supply issues and financial risk to our suppliers.

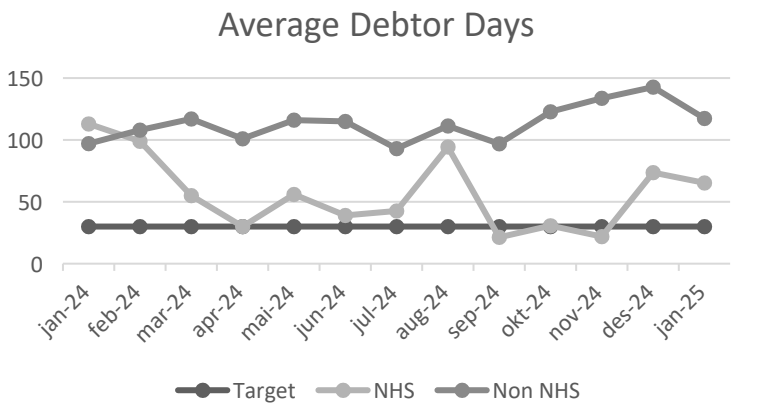
What the charts tell us

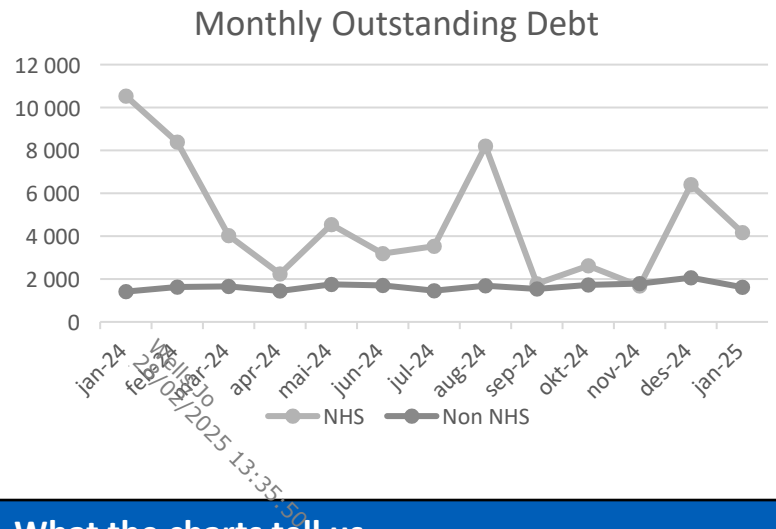
- Better Payment Practice Code (BPPC) overall performance for the <u>year</u> to month 10 is 65% (64% in December) based on volume of invoices paid and 74% (75% in December) based on value against a target of 95%.
- The BPPC chart above details invoices paid based on value for NHS and Non-NHS, which for month 10 is 58% (29% in December) and 67% (72% in December) respectively.
- The Average Creditors Days chart above shows the average invoice date to payment date of invoices, which for month 10 is 41 days for NHS (88 days in December) and 34 days for Non-NHS (33 days in December) – the target is 30 days.
- It is to be noted that the Trust is liaising with NHS Trusts that have outstanding debt with the Trust to resolve issues to enable the movement of cash between Trusts.

BEST USE OF RESOURCES – CASH

We are driving this measure because

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





Performance and Actions

The Trust terms of credit for invoiced income is 30 days from date of invoice. For month 10, the average days for invoices outstanding are 65 days for NHS (74 days in December) and 117 days for Non-NHS (143 days in December).

The Non-NHS debtor days is distorted by accounts that have been sent to EDR (external debt recovery) and accounts/customers that have a repayment plan – 216 invoices, which is 30% of the total. Debt that is over 90 days totals £1.775m (472 invoices, which includes the 216 invoices as above). In January 2025, an additional 12 repayment plans were set up and 32 invoices referred to EDR.

Non-NHS oldest invoices are £100k for Breast Unit which is under query, but progress is being made to resolve. £280k at month 10, (£252k month 9) relates to invoices being chased under EDR, £34k (£41k at month 9) for Private Patients where collection is in progress or in dispute and DMC Health Care pathology balance of £51k has been reduced by £25k as a payment on account until the issues are resolved. (information has been provided again to enable it to be checked and verified and the Trust is in communication with the to resolve. A partial credit has been agreed as there is no SLA in place, the balance is still in discussion with DMC).

NHS Gloucestershire ICB debt had now been resolved and the balance of £284k is due to be paid in February 2025.

Risks

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

The Trust has monthly meetings with the SBS Collections team, who have been implementing changes in the way the debt is collected and have assured us that there will be an improvement in the next quarter. It is also to be noted that Trust staff also contact customers trying to resolve queries etc. to ensure that the debt is collected.

We continue to work with SBS to ensure they are actively chasing and recovering outstanding debtors as per the SBS contract.

What the charts tell us

Average Debtor Days – 65 days for NHS (74 for month 9) and 117 days for Non-NHS (143 for month 9) – this is the time from when the invoice is raised to when it is paid by the customer. The Trust has been working with other NHS Trusts to resolve and collect cash.
Monthly Outstanding Debt – at month 10, the amount of outstanding debt is £5.787m (month 9 - £8.471m).

Worcestershire Acute Hospitals NHS Trust

Trust Key Performance Indicators (KPIs) - up to Jan-25 data

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

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

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

Example

Data Quality Assurance Questions

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

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

Quality of care, access and outcomes		Responsible Director	Standard	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Latest Month: Numerator	Latest Month: Denominator	Year to Date (v Standard if available)	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	75%	63.1%	69.5%	76.9%	73.4%	80.0%	78.3%	80.8%	80.4%	80.0%	82.5%	77.6%	77.3%	-	1,938	2,508	78.9%		78.1%				
	2 Week Wait all cancers	Chief Operating Officer	93%	87.9%	88.9%	86.0%	86.0%	89.0%	85.4%	93.0%	96.2%	96.5%	94.6%	92.0%	88.4%	-	2,016	2,281	91.2%		88.4%				
	Urgent referrals for breast symptoms	Chief Operating Officer	93%	77.8%	32.0%	16.8%	35.0%	27.4%	30.0%	67.0%	89.8%	94.0%	96.6%	61.5%	26.7%	-	23	86	57.4%		71.3%				
	Cancer 31 day diagnosis to treatment	Chief Operating Officer	96%	87.2%	88.5%	87.2%	85.3%	87.1%	85.6%	82.4%	78.5%	79.9%	83.1%	78.7%	81.8%	-	275	336	82.6%		92.3%				
	Cancer 31 Days Combined (new standard from Oct 23)	Chief Operating Officer	96%	87.3%	90.5%	87.5%	84.5%	86.8%	87.4%	83.6%	84.0%	84.3%	84.5%	78.0%	82.7%	-	425	514	84.0%		91.5%	Dec-24			
	Cancer 62 days urgent referral to treatment	Chief Operating Officer	85%	42.3%	44.1%	50.6%	57.9%	54.4%	60.4%	67.5%	65.7%	68.4%	65.7%	59.6%	55.9%	-	105	188	61.8%		66.4%				
	Cancer 62-Day National Screening Programme	Chief Operating Officer	90%	44.4%	67.8%	61.9%	65.8%	59.4%	66.2%	70.6%	59.0%	79.3%	50.0%	28.6%	27.0%	-	10	37	56.1%		67.3%				
	Cancer consultant upgrade (62 days decision to upgrade)	Chief Operating Officer	85%	78.1%	81.9%	79.5%	82.7%	77.2%	82.6%	84.6%	77.2%	77.8%	76.2%	73.5%	80.8%	-	78	97	79.3%		80.8%				
	Cancer 62 days Combined (new standard from Oct 23)	Chief Operating Officer	85%	51.4%	56.7%	58.4%	63.6%	60.9%	66.9%	71.3%	68.3%	72.0%	67.0%	60.3%	59.8%	-	193	323	65.7%		71.3%				
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	Plan	409	366	141	159	176	145	151	177	172	177	137	144	145									
Urgent and emergency care	% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	82.6%	82.3%	84.7%	85.6%	85.5%	85.4%	87.2%	87.4%	87.5%	85.5%	84.5%	83.7%	83.0%	2,792	3,364	85.5%		92.2%	Feb to Jan			
	A&E Activity (any type)	Chief Operating Officer	Plan	17,647	17,190	18,537	18,677	19,875	19,293	19,351	18,672	18,444	19,292	18,654	18,348	17,439			188,045						
	Ambulance handover within 30 minutes	Chief Operating Officer	98%	53%	55%	64%	64%	60%	64%	71%	65%	54%	46%	51%	42%	54%	1,993	3,724	57%		73%	July			
	Ambulance handover over 60 minutes	Chief Operating Officer	0	1,072	1,029	869	836	922	784	639	784	1085	1268	1158	1458	1134			10,068		12%				
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	Plan	116%	111%	112%	130%	119%	104%	123%	113%	123%	134%	126%	130%	111%	3,672	3,318	120.6%						
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	>40%	43.8%	41.3%	41.9%	42.2%	41.7%	38.2%	35.2%	28.8%	29.9%	31.8%	17.5%	15.0%	14.7%	531	3,615	29.5%		36%	Feb to Jan			
	A&E - % of patients seen within 4 hours (any type)	Chief Operating Officer	76%	60.5%	61.0%	68.0%	64.4%	66.3%	67.9%	66.2%	67.8%	68.5%	65.1%	54.4%	53.0%	58.7%	7,211	17,439	63.4%		72%	Nov-24			
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer	-	19.3%	18.5%	15.8%	16.6%	16.3%	15.4%	14.5%	14.8%	17.0%	17.8%	19.7%	22.0%	21.3%	2,629	12,350	17.5%		16%	Feb to Jan			
	A&E - Time to treatment	Chief Operating Officer	-	161	166	143	158	150	146	145	136	135	157	156	135	111			143		01:41				
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	<15 minutes	16	16	14	14	15	15	15	15	16	16	90	39	18			25		00:22	Feb to Jan			
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	0	316	304	301	248	271	307	270	335	369	487	305	605	713			3,910						
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	3%	6.7%	7.2%	7.5%	6.8%	7.4%	7.5%	7.5%	7.7%	7.7%	7.2%	12.9%	12.6%	12.5%	1,545	12,350	9.0%		8%	Feb to Jan			

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks)	Chief Operating Officer	**92%**	56.6%	56.0%	54.3%	54.8%	55.9%	56.1%	55.9%	55.6%	56.3%	56.9%	56.5%	55.5%	55.3%	30,709	55,581			58.9%						
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		59,900	61,458	61,753	61,740	62,118	62,152	61,348	61,862	60,779	59,873	58,765	57,382	55,581					7.46mil						
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	2,746	2,672	2,536	2,204	2,089	1,980	1,891	1,804	1,604	1,576	1,465	1,178	1,024					200,375	Dec-24					
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	891	766	587	472	464	402	357	300	105	57	23	40	39					15,568						
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	109	68	27	13	14	4	0	0	2	1	0	3	3					2,059						
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	0	0	0	0	0	0	0	0	0	0	0	0	1					155						
	GP Referrals (electronic referrals ONLY. Includes RAS even if rejected)	Chief Operating Officer	**2019/20**	9,156	9,374	8,711	9,438	9,533	8,546	9,787	8,699	8,978	10,138	9,354	8,269	10,073			92,815								
	Outpatient Activity - New attendances (% v 2019/20)	Chief Operating Officer	**2019/20**	110%	120%	136%	118%	112%	119%	123%	129%	128%	148%	131%	134%	128%	21,688	16,940	127%								
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	105%	104%	103%	106%	88%	84%	101%	93%	96%	100%	90%	105%	99%	21,688	21,830	96%								
	Total Outpatient Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	104%	116%	123%	113%	108%	110%	113%	118%	117%	133%	115%	118%	113%	63,425	56,359	116%								
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	111%	111%	107%	119%	99%	92%	111%	99%	106%	107%	95%	106%	102%	63,425	62,155	103%								
	Total Elective Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	105%	107%	129%	110%	105%	109%	115%	114%	115%	115%	107%	111%	113%	8,269	7,297	111%								
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	101%	102%	104%	97%	102%	98%	117%	99%	110%	111%	99%	100%	99%	8,269	8,366	103%								
	BADS: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end)	Chief Operating Officer	**Actual**	84%	84%	84.2%	84.0%	83.8%	84.0%	84.2%	-	-	-	-	-	-	5818	6921	-		81%	Dec					
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	82%	81%	82%	82%	83%	82%	83%	82%	84%	84%	83%	82%	83%			83%		78%						
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	**85%**	84%	83%	85%	84%	86%	85%	86%	84%	87%	87%	86%	84%	86%			86%		82%	February					
	Cancelled Operations on day of Surgery for non clinical reasons (hospital attributable)	Chief Operating Officer	-	59	40	57	37	49	40	38	42	40	59	59	38	45			447		21,053	Q4 23-24					
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	**Plan**	117%	115%	118%	115%	119%	115%	111%	112%	113%	105%	103%	112%	109%	7,080	6,486	111%								
	Diagnostic Activity - Endoscopy	Chief Operating Officer	**Plan**	92%	96%	85%	115%	112%	97%	109%	103%	99%	112%	100%	104%	91%	1,358	1,488	104%								
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	**Plan**	97%	86%	89%	100%	105%	96%	101%	116%	120%	106%	94%	94%	89%	2,094	2,365	102%								
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<15%**	25.2%	19.5%	25.8%	27.4%	29.7%	34.3%	31.1%	34.7%	29.2%	22.9%	22.6%	17.0%	24.4%	2,224	9,116			22.8%	Dec-24					
Maternity	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	87%	88%	87%	83%	85%	86%	88%	88%	84%	90%	90%	90%	89%	463	521	87%								
	Caesarean section rate for Robson Group 1 women (rolling 6 month)	Chief Medical Officer	**TBC**	4.4%	4.4%	4.7%	5.5%	6.5%	7.2%	7.6%	8.1%	8.4%	8.8%	8.9%	9.4%	-					8.8%						
	Caesarean section rate for Robson Group 2 women (rolling 6 month)	Chief Medical Officer	**TBC**	59.5%	59.6%	59.2%	59.3%	60.1%	60.7%	62.1%	63.1%	63.9%	63.8%	63.0%	62.9%	-					63.3%	Dec-24					
	Caesarean section rate for Robson Group 5 women (rolling 6 month)	Chief Medical Officer	**TBC**	81.4%	81.3%	81.8%	82.9%	82.3%	83.3%	84.6%	88.6%	87.0%	87.2%	87.8%	86.9%	-					84.1%						
	Maternity Activity (Deliveries)	Chief Nursing Officer		396	372	413	380	418	371	387	416	409	410	349	361	353			3,854								
Outpatient transformation	Missed outpatient appointments (DNAs) rate	Chief Operating Officer	**<4%**	5.5%	4.8%	5.0%	4.8%	5.2%	5.3%	5.0%	5.2%	5.3%	5.1%	5.2%	5.3%	4.8%	3,120	64,870	5%		7.1%	Dec-24					
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	90%	91%	91%	89%	90%	89%	88%	89%	89%	89%	89%	88%	89%	38515	43397	89%								
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Chief Operating Officer	**v 2019/20**	101%	114%	118%	110%	106%	106%	109%	113%	113%	126%	108%	110%	106%	41,737	39,419	111%								
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	114%	114%	110%	126%	105%	97%	118%	102%	112%	111%	98%	106%	104%	41,737	40,325	107%								
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	18%	18%	17%	16%	17%	15%	16%	15%	16%	16%	17%	17%	17%	10,610	62,756	17%		18%	Feb to Jan					
Prevention long term conditions	Maternity - Women who were current smokers at 36 weeks (or last smoking status)	Chief Nursing Officer	-	3.4%	2.0%	3.4%	1.9%	2.1%	3.1%	2.6%	3.5%	4.3%	5.6%	4.0%	4.8%	4.3%	8	349	2.8%								

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	97%	96%	96%	96%	96%	95%	96%	95%	95%	94%	94%	93%	95%	810	856	95%		90%	Jan-25				
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	75	102	82	69	67	59	56	48	60	65	56	55	50			535		4,549	Dec-24				
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	8.1	8.2	8.1	7.8	7.9	7.7	7.5	7.2	7.7	8.1	8.2	8.2	8.3	22937	2740	7.9		4.4	Feb to Jan				
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	3.0	3.7	3.2	3.3	3.1	3.3	2.8	3.1	3.0	3.6	3.4	3.3	3.1	1189	388	3.2		3.1					
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	14%	14%	12%	12%	13%	14%	12%	12%	15%	15%	13%	9%	15%	115	779	13.0%		23.1%	Dec				
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	7.1%	7.9%	8.5%	7.5%	8.2%	7.2%	6.9%	6.9%	5.1%	4.8%	4.5%	4.5%	4.3%	11939	507	5.2%		7.5%	Jan to Dec				
	Mortality SHMI - Rolling 12 months (new methodology introduced Dec-23 onwards)	Chief Medical Officer	**100**	104.0	103.0	103.5	102.8	103.43	103.17	104.10	103.70	103.76	-	-	-					As expected					
	Never Events	Chief Nursing Officer	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0			0							
	MRSA Bacteraemia	Chief Nursing Officer	**0**	0	1	1	0	0	0	0	0	0	0	0	0	0			0							
	MSSA Bacteraemia	Chief Nursing Officer	**17**	2	4	2	3	3	3	5	5	6	7	8	11	11			62							
	Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	**78**	8	15	9	11	10	14	17	16	11	13	11	9	11			123							
	Number of falls with moderate harm and above	Chief Nursing Officer		4	2	5	3	6	5	13	10	2	6	3	7	6			61							
	Serious Incidents	Chief Nursing Officer	**Actual**	2	1	0	1	1	1	0	0	2	0	1	0	0			6							
	VTE Risk Assessments	Chief Medical Officer	**95%**	93.3%	93.0%	92.2%	96.3%	96.0%	97.0%	96.9%	97.0%	96%	97%	96%	95%	95%	268	3,361	96%							
	WHO Checklist	Chief Medical Officer	**100%**	98%	97%	98%	98%	98%	99%	98%	98%	99%	98%	98%	97%	97%	1,475	1,515	97%							
	Stroke: % of high risk TIA patients seen within 24 hours	Chief Medical Officer	**60%**	83%	61%	66%	45%	62%	69%	83%	84%	75%	85%	62%	73%	89%	109	123	71%							
	Stroke: % of patients meeting thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	50%	75%	75%	33%	57%	57%	43%	55%	67%	63%	43%	33%	-	-	-	52%							
	Stroke: 80% of patients spend 90% of time on the Stroke ward	Chief Medical Officer	**80%**	77%	75%	82%	78%	68%	74%	75%	59%	64%	70%	59%	61%	-	-	-	70%							
	Number of complaints	Chief Nursing Officer	**2022/23 (747)**	88	77	75	80	66	73	72	70	58	70	60	61	118			728							
	Number of complaints referred to, and investigated by, Ombudsman	Chief Nursing Officer	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0			0							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**85%**	63%	82%	69%	48%	62%	73%	61%	62%	70%	59%	54%	50%	71%	57	80	64%							
	Friends and Family Test Score: Recommended/Experience by Patients (A&E)	Chief Nursing Officer	**95%**	74%	71%	77%	76%	75%	75%	78%	82%	79%	75%	71%	61%	80%	153	181	79%		77%					
	Friends and Family Test Score: Recommended/Experience by Patients (Acute Inpatients)	Chief Nursing Officer	**95%**	94%	93%	94%	94%	94%	94%	95%	96%	95%	94%	95%	94%	97%	2909	2983	95%		95%	Nov-24				
	Friends and Family Test Score: Recommended/Experience by Patients (Maternity)	Chief Nursing Officer	**95%**	33%	94%	100%	100%	88%	92%	86%	78%	85%	85%	85%	92%	96%	163	169	87%		92%					
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**20%**	23%	23%	23%	22%	23%	21%	22%	24%	22%	21%	4%	0%	4%	366	8377	17%							
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	35%	37%	37%	35%	37%	38%	39%	44%	40%	36%	40%	35%	25%	2983	11703	37%							
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	1%	9%	1%	4%	9%	8%	20%	10%	26%	19%	32%	28%	22%	169	762	17.9%							

People		Responsible Director	Standard	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6%**	9.6%	8.4%	8.8%	8.6%	9.0%	7.9%	8.6%	7.9%	8.3%	5.3%	6.9%	7.7%	6.9%			7.7%						
	Appraisals - Non-medical	Chief People Officer	**90%**	79.0%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	82.0%	82.0%	83.0%	84.0%	84.0%	5,003	5,982	81.5%						
	Appraisals - Medical	Chief People Officer	**90%**	93.0%	93.0%	93.0%	94.0%	96.0%	94.0%	93.0%	94.0%	93.0%	94.0%	94.0%	95.0%	96.0%	546	570	94.3%						
	Mandatory Training	Chief People Officer	**90%**	90%	90%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	78,569	87,394	90.5%						
	Overall Sickness	Chief People Officer	**4$%**	6.3%	5.9%	5.8%	5.9%	5.6%	5.3%	5.5%	5.0%	5.1%	5.5%	5.6%	5.9%	6.1%	13,025	215,028	5.5%						
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**11.5%**	11%	11%	11%	11%	11%	10%	10%	10%	10%	10%	10%	10%	10%	597	6,130	10.3%						
	Vacancy Rate	Chief People Officer	**7.5%**	8%	7%	7%	10%	9%	9%	9%	8%	7%	6%	6%	5%	6%	455	6,952	7.6%						

Finance and Use of Resources		Responsible Director	Standard	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Latest Available Monthly Position: Latest month v benchmark	Latest Available Monthly Position: National or Regional		SPCs: Pass/ Fail	SPCs: Trend Variation	DQ Mark
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	-£5,562	-£4,361	-£3,361	-£7,799	-£4,672	-£5,283	-£5,507	-£5,253	£24,901	£6	-£433	-£880	£1			-£4,919						
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-9.8%	-7.5%	-4.7%	-14.0%	-7.8%	-9.1%	-9.8%	-9.0%	28.2%	18.7%	-4.9%	-7.5%	12.2%			-0.8%						
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£7,277	-£6,677	-£4,954	£971	-£836	-£635	£7	-£75	£190	£355	-£143	-£289	£457			-£24						
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	-31.0%	-53.0%	-47.0%	-11.0%	22.0%	14.0%	0.0%	1.0%	1.0%	-102.0%	50.0%	49.0%	-100.0%			1.0%						
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£2,510	-£2,741	-£1,323	-£669	-£223	-£240	£251	£194	£368	£456	-£439	£94	-£403			-£612						
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	-£3,505	-£3,098	-£3,158	£3,186	£3,406	£2,965	£3,121	£2,961	£3,113	£2,375	£2,700	£3,143	£2,756			£29,727						
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	9.6%	8.4%	8.0%	8.6%	9.0%	8%	9%	8%	8%	5%	7%	8%	7%			7.6%						
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£401	-£925	£25,631	£0	£0	-£2,314	-£832	-£118	-£1,592	£934	£564	£464	£2,580			-£314						
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£7.862m	£20.333m	£11.384m	£1.125m	£1.712m	£1.182m	£1.617m	£6.732m	£13.291m	£24.208m	£16.708m	£16.428m	£14.106m			-						
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	83.1%	88.5%	95.6%	95.1%	87.9%	83%	64%	70%	55%	70%	76%	75%	74%			-						
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	85.9%	89.8%	93.3%	87.4%	89.3%	71.5%	41.1%	54.2%	55.0%	56.3%	62.9%	64.4%	65.0%			-						

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**03/03/25**
Title of Report:	Perinatal Safety Report January 2025
Status of report:	☐**Approval** ☐**Position statement** ☒ **Assurance** ☒**Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Lara Greenway – Matron Neonatal Services Justine Jeffery – Director of Midwifery Amrat Mahal – Director of Nursing – Women & Children's Division Susie Smith – Maternity & Neonatal Governance Lead
Documents covered by this report:	• NHSE (2020) Perinatal Surveillance Model • NHSR Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme

1. Purpose of the report

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

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

This month's report presents the final evidence against each of the safety actions within the Maternity Incentive Scheme (MIS).

2. Recommendation(s)

Trust Board is invited to:

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

3. Chief Officer/Executive Director Opinion[1]

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

The CNO offers assurance that our maternity and neonatal service are meeting the national requirements outlined in the documents covered by this report.

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

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

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

CQC Maternity Ratings 2020	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Worcester Acute Hospitals NHS Trust	Requires improvement	Requires Improvement	Good	Good	Requires improvement	Good
Maternity Safety Support Programme	No					

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

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

1. Introduction/Background

The purpose of the report is to inform the WAHT Trust Board and the LMNS Board of present or emerging safety concerns or activity being undertaken to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety and will provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the LMNS Board. The key performance indicators for this month are presented below and RAG rated as appropriate:

Summary of Key Safety Indicators

Metrics	Target	Current position	Previous month
Booking completed by 12+6	90%	88.9%	89.9%
Term admissions	6%	2.84%	1.38%
PMR (MBRRACE 2022)	<5.04 per 1000 births (rolling)	3.21	3.39
Stillbirth rate (MBRRACE 2022)	<3.35 per 1000 births (rolling)	2.14	2.12
NND rate (MBRRACE 2022)	<1.69 per 1000 births (rolling)	1.07	1.27
Maternity and Neonatal Moderate or above incidents	-	2	2
Maternity PALS	-	13	8
Neonatal PALS	-	0	0
Maternity Complaints	-	5	5
Neonatal Complaints	-	0	1

Summary of Key Workforce Performance Indicators

Metrics	Target	Current position	Previous month
Sickness rate (MWs)	4%	8%	8%
Turnover rate (rolling) (MWs)	11.5%	7.5%	8%
Vacancy rate (MW)	7%	5%	7%
Sickness rate (MSWs)	5.5%	14.8%	15%
Turnover rate (rolling) (MSWs)	11.5%	21.4%	19.9%
Vacancy rate (MSW)	7%	13%*	13%
Sickness rate (RNs)	4%	9.58%	8.6%
Sickness rate (NNs)	4%	12.21%	4.5%
Turnover rate (rolling) (RNs)	11.5%	7.56%	7.49%
Turnover rate (rolling) (NNs)	11.5%	5.28%	5.26%
Vacancy rate (RN)	7%	0%	0%
Vacancy rate (NN)	7%	1.06%	0.16%
Shifts staffed to BAPM	100%	76.19%	91.94%
Supernumerary shift leader (NNU)	100%	100%	98.39%
QIS trained	70%	67.7%	67.7%

Summary of Key Training Performance Indicators

Metrics	Target	Current position	Previous month
PROMPT – Human Factors & Maternity Emergencies	90%	89%	89%
PROMPT – Neonatal Basic Life Support	90% (including Doctors and Neonatal Nurses)	95%	tbc
Fetal monitoring	90%	96%	96%
Maternity Trust Mandatory training (non-medical)	90%	84.8%	89%

Maternity Trust Mandatory training (Obstetricians)	90%	77%	76%
Maternity PDR rate	90%	78.5%	75%
Neonatal PDR rate	90%	93.94%	83.58%
Neonatal Trust Mandatory Training (non-medical)	90%	92.69%	93.93%
Neonatal Trust Mandatory Training (medical)	90%	87.01%	84.16%

2. KPI Booking by 12+6 weeks' gestation

The KPI for booking by 12+6 weeks' gestation has not been met this month. Work continues to move to the new target of 10 weeks.

3. Perinatal Mortality Rate (PMR)

The national average rates for stillbirth and neonatal rates are based on MBRRACE data from 2022. The link to the online report is https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/.

The national extended perinatal mortality rate is 5.04 per 1000 births based on 2022 data. Rates are adjusted for a variety of characteristics such as socio-economic deprivation, maternal age, ethnicity etc, which the figures below are not; these are the crude figures. It is important to note that neonatal deaths (up to 28 days' post birth) are counted at place of birth, rather than place of death. This includes for those babies diagnosed with congenital anomalies and complex cases requiring surgery at tertiary centres.

3.1 Local Rates

The rates for the Trust for the last 12 months are below, and can be compared to the updated national and group rates (all per 1000 live births):

	National rate	Group rate (other Trusts with 4000+ births)	Trust 2022 MBRRACE rate	Crude Trust rolling rate (from 01.02.24 – 31.01.25)
Stillbirths	3.35	3.18	3.21	2.14
Neonatal deaths	1.69	1.08	1.12	1.07
Extended perinatal mortality	5.04	4.25	4.32	3.21

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

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

The graph below shows an increasing trajectory in our perinatal mortality rates currently. As always, it is important to note that these figures will change when they are reviewed and adjusted by MBRRACE. Small in month variations (including an increase or decrease in the number of live births) can have a significant impact on the overall numbers and rate/trajectory.

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

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

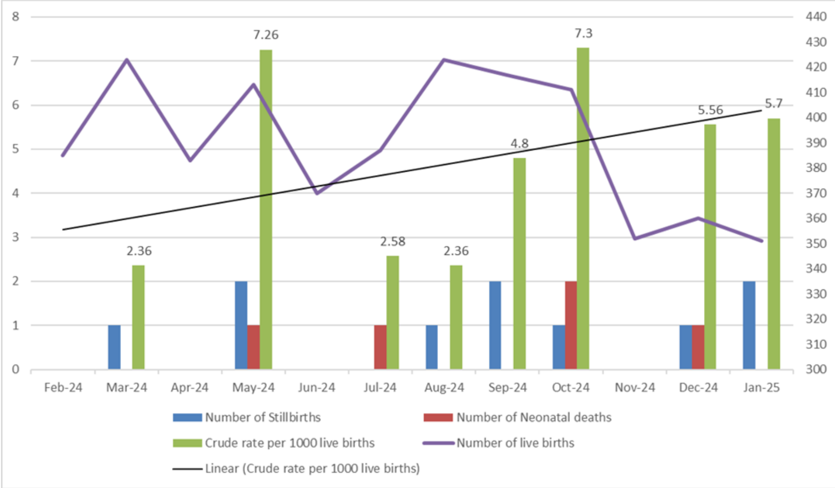


Figure 1. WAHT Perinatal Mortality Rates

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

The table below presents the annual local data for stillbirths, neonatal deaths, maternal deaths and babies transferred for therapeutic hypothermia from 2018 and demonstrates that the PMR is consistently within the national average for the last 4 years; 2023 and 2024 figures are crude data. This table also reports term babies transferred for therapeutic hypothermia; it must be noted that not all referrals result in a diagnosis of Hypoxic-Ischaemic Encephalopathy (HIE).

Year	Births	Stillbirths		Neonatal deaths		Maternal deaths	Validated data by ONS & MBRRACE	Comparator group average rate	Term babies-therapeutic hypothermia/ HIE
		Count	Rate per 1000 births	Count	Rate per 1000 births				
2018	5248	17	3.40	6	1.14	0	YES – stabilised and adjusted		Not available
2019	5200	20	3.05	9	1.29	2	YES – stabilised and adjusted		6
2020	4941	17	3.25	7	1.18	2	YES – stabilised and adjusted		4
2021	4996	16	3.26	6	1.09	1	YES – stabilised and adjusted		4
2022	4843	17	3.21	5	1.12	1	YES – stabilised and adjusted		4
2023	4781	10	2.09*	10	2.09*	1	NO		3 (1 also NND)
2024	4717	10	2.12**	6	1.27**	0	NO		2
2025	351	2	5.7*	0	0	0	NO		0

*crude rate ** year to date

Key:

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

3.3 Perinatal Mortality Summary for January 2025.

In January, there were sadly two stillbirths reported; further detail will be in the Perinatal Incident report presented to Private Trust Board.

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

4.1 Background

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

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

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

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

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

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

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

4.2 Current MNSI cases: None

MNSI reference	Date of case	*DOC completed	Stage of investigation

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

4.3 MNSI Quality Review Meetings

The Trust continue to meet regularly with MNSI when there are active cases; this has been paused as there are currently no active cases. A yearly review is planned for March.

5. Incidents reported moderate or above in Maternity and Neonates in January 2025.

There were two incidents initially graded as moderate in January 2025 in maternity; further details are presented in the Perinatal Incident report.

6. Maternity and Neonatal Training Compliance

Maternity specific training:

- Training continues to maintain compliance with PROMPT and SBL is maintained – current focus on medical staff
- We remain fully compliant with our midwifery mandatory training for midwives and support staff.

Neonatal training:

- Compliance with NLS training for medical and non-medical staff remains above the 90% recommended.

- Compliance with annual neonatal resuscitation update for medical and non-medical staff remains above the 90% recommended.
- Mandatory training for neonatal nurses remains above the Trust target and medical staff compliance has increased slightly in month although remains below Trust target. Rotation of doctors is also impacting on compliance.
- PDRs for non-medical staff are above the Trust target.

Course	Staff Group	Compliance January	Previous month December
Maternity Mandatory Training – (3 yearly)	Midwives	91%	91%
Maternity Mandatory Training – (3 yearly)	MSW/MCA	90%	90%
Annual Saving Babies Lives training	Midwives	95%	92%
Annual Saving Babies Lives training	MCA/MSW	91%	93%
Annual Saving Babies Lives training	Obstetricians	68%	68%
Annual fetal monitoring training	Midwives	95%	96%
Annual fetal monitoring training	Consultant Obstetricians	93%	100%
Annual fetal monitoring training	Obstetricians (all on rota)	98%	97%
PROMPT training (Human Factors/MDT Obstetric Emergency	Midwives	97%	98%
PROMPT training (Human Factors/MDT Obstetric Emergency	MSW's	86%	90%
PROMPT training (Human Factors/MDT Obstetric Emergency	Obstetricians (all on rota per/post 1.7.24)	86%	84%
PROMPT training (Human Factors/MDT Obstetric Emergency	Anaesthetists (all on rota per/post 1.7.24)	87%	84%
Neonatal Life Support	Midwives	97%	98%
Neonatal Life Support (NLS 4yearly)	Neonatal Nurses	100%	100%
Neonatal Life Support (NLS 4yearly)	Neonatal Drs	91%	94.4%
Neonatal Resuscitation Update (annual)	Neonatal Nurses	96%	95.65%
Neonatal Resuscitation Update (annual)	Neonatal Drs	93%	94.4%
Trust Mandatory Training	Obstetricians	77%	76%
Trust Mandatory Training	Midwifery Staff	84.8%	89%
Trust Mandatory Training	Neonatal Nurses	92.69%	93.93%
Trust Mandatory Training	Neonatal Drs	87.01%	84.16%

Figure 2. Training Compliance

7. Safe staffing

7.1 Midwifery

Safe midwifery staffing is monitored monthly by the following actions:

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

- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board (Appendix 1)

There were 353 births in January. The escalation policy was enacted on 23 occasions to reallocate internal staff which is an increase on the previous month. The community and continuity teams were required to support the inpatient areas on one occasion.

The vacancy rate has reduced for midwives – there are 12WTE in the pipeline and plan to start in February/March. The rolling turnover rate for midwives remains below Trust target further however for non-registered staff remains high. Sickness absence rates for midwives and non-registered staff are also above the Trust target

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

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service. Again, the rates reported demonstrate some improvement in fill rates.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	78%	n/a	100%	n/a
Antenatal Ward/Triage	93%	93%	81%	85%
Delivery Suite	98%	100%	37%	89%
Postnatal Ward	95%	92%	72%	82%
Meadow Birth Centre	81%	839&	51%	74%

7.2 Obstetric Medical Staffing including Consultant attendance

Consultants

We have 23.5 WTE Consultants in post. The consultants at WRH previously worked 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.

The on call frequency has reduced slightly in 2025 and will reduce further if we appoint, in February, to the maternal medicine post.

There is an obstetrician off sick following elective surgery in November who is planning to return to work on the 3rd February.

Due to the return of the 2 Gynaecology Consultants we have not required locum Consultant cover during January.

Registrars

The registrars work a 1:9 on call rota. We currently have 23 WTE in post (funded for 19.6 WTE), with 14.6 WTE on the on-call rota.

Of these Registrars 11 WTE are Trainees. One Trainee is currently on a phased return to work following a prolonged episode of sickness and six are on Maternity Leave. We also have a Registrar who one has gone 'Out of Program' working with us one day a week.

We have 12 WTE CF/SAS Doctors of which 9 WTE are on the on-call rota.

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

We have 1 clinical fellow (planned to go up to the middle tier rota in January) currently working on the SHO rota and a Urogynaecology Clinical Fellow working in clinics and shadowing on calls who commenced on the SHO on-call rota in December.

We are out to advert for a Post CCT Clinical Fellow and a Clinical Fellow post and have 3 ATRs approved to backfill the vacancies.

Medical staffing at both Consultant and middle grade level is on our risk register due to the risk of 'burn out' and loss of capacity we have due to the vacancies.

Junior Grades

The junior tier works a 1:9 on call rota. We currently have 15.6 WTE with 14.6 on the on call rota, giving us a vacancy of 0.4 WTE.

We also have a CSRH trainee working with us 2.5 days per week.

Consultant Attendance

In January Consultant presence was achieved in 8 of the 8 cases (100%) mandated by the RCOG and Action 4 of CNST.

Compensatory Rest

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

7.3 Neonatal Staffing

7.3.1 Neonatal Nursing

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

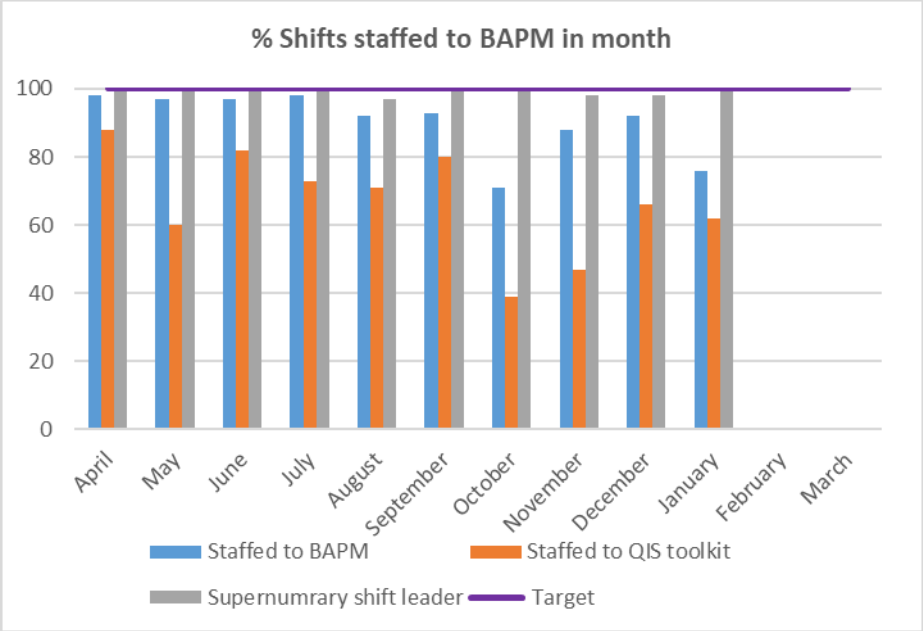
- Completion of safe staffing on Badgernet – three times day
- Monitoring nurse patient ratios as per BAPM
- Monitoring staffing red flags as recommended by NICE guidance
- Daily safety huddles
- SitRep report and bed meetings three times a day
- Monitoring sickness/absence and turnover rates
- Monitoring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

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

- 1:1 Intensive Care (IC)
- 1:2 High Dependency (HD)

- 1:4 Special Care (SC)
- Supernumerary shift leader

In January 76.19% of shifts were staffed to BAPM (shortfall of 9 shifts) due to sustained high acuity and overall activity which has been the highest for over 13 months. The supernumerary status of the shift leader was achieved, and all shifts remained safe. Escalation plans are in place and during the month there were no safe staffing red flags or staffing incidents reported.



% shifts to BAPM recommendation

It is important to note whilst the number of qualified in specialty (QIS) is below the BAPM recommended, with on-going nurse recruitment and training the percentage of compliance will fluctuate. The number of nurses qualified in specialty increased very slightly to 67.7% against the 70% recommended. Following completion of current/planned training 70% compliance should be achieved by the end of March 2025.

Sickness absence rates increased for registered and non –registered nurses and is above the Trust target. Staff continue to be directed to health and well-being support.

7.3.2 Neonatal medical staff

Consultants

The consultant attends all preterm deliveries <30 weeks of gestation and supports the neonatal team. We currently have 7wte consultants in post but require 8wte to cover the neonatal rota. We have advertised to recruit an additional NNU consultant.

Middle Grade

The middle grade clinicians currently work across paediatrics and neonates. We currently have 10.3wte in post (funded for 12 WTE) across both paediatrics and neonates. To achieve BAPM compliance and enable us to have a dedicated Tier 2 Rota we require a total of 8wte. We are looking at solutions to achieve this. Funding has been applied for using CNST.

Resident doctors

The junior tier works a 1:14 on call rota. We currently have 19.6 WTE (4 WTE are Clinical Fellows). We budgeted for 17.66 WTE. This is because of variable allocation of GPVTS doctors each four months and taking on additional FY1 as per the Trust request.

Compensatory Rest

We have identified that currently we are not collecting data for 11hrs compensatory rest. We currently do not have any mechanism in place to achieve this as often the on-call consultant is either working on the NNU or OPD following their on-call. We have started to collate this data and will be able to report on the outcome from this in Sep 2025.

7.3.3 Neonatal AHPs

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

8. Service User Feedback

8.1 Maternity& Neonatal Voice Partnership

Work continues on the he birth preference card and BRAINS tool. A new work stream commenced in January to review the current 'debrief service'. A new service specification will be agreed in February.

8.2 Baby Friendly and BLISS Accreditation

The neonatal unit was awarded BFI stage 1 accreditation in 2024 and is now submitting action plans for a stage 2 assessment in July 2025. The maternity unit continues to work towards 'GOLD'.

The neonatal unit is also now working towards Gold BLISS accreditation, having achieved Silver accreditation in January 2025.

8.3 Complaints and PALS feedback – Maternity and Neonates

Complaints received on a weekly basis at the QRSM. PALS are handled by the clinical team and Matrons and themes noted and discussed as required. There are no themes/trends identified.

Neonatal: No complaints or PALS received.

Maternity: In January 2025, 5 formal complaints were received:

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
95175	02/01/2025	Maternity (formerly Obstetrics)	Patient Care	Cannula management
95537	13/01/2025	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives
96018	20/01/2025	Maternity (formerly Obstetrics)	Communications	Communication with patient
95271	03/01/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Mismanagement of labour
96286	24/01/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure to diagnose (inc e.g. missed fracture)

In addition, there were 13 Maternity PALS query received as below.

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
96351	29/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - TELEPHONE
95333	07/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
95433	09/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - TELEPHONE
95266	06/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - TELEPHONE
96517	31/01/2025	Maternity (formerly Obstetrics)	Clinical Treatment	PALS – Delay or Failure in Treatment/Procedure
96226	24/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Incorrect Entry on Medical Records
95997	23/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
96368	28/01/2025	Maternity (formerly Obstetrics)	Trust Admin Policies & Procedures (Incl. Patient Records Management)	Other (Trust administration)
96471	31/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - EMAIL
96328	28/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
96345	28/01/2025	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	PALS – Attitude of Medical Staff
95252	06/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON
96228	27/01/2025	Maternity (formerly Obstetrics)	Communications	PALS – Communication with patient - IN PERSON

9. Safety Champion escalations

The Safety Champions meetings took place on 16th January 2025. Meeting notes are presented in the CNST table safety action 9.

In summary, the Neonatal Unit and Meadow were visited by Safety Champions. The neonatal unit raised a concern regarding parents exiting the unit via tailgating and not using the buzzer provided, Poster has been created to cover the 'press to exit' sign. Alternative long-term options are for the buzzer to be relocated to behind the ward clerk's desk. In addition, a water leak was noted but solutions have been found and a specific nasal cannulas had been discontinued - an emergency meeting took place, mitigations were agreed and the issue was recorded on the risk register. No issues were raised on Meadow Birth Centre.

Review of previous actions this month noted that there is a plan to replace the windows on delivery suite to address the temperature control of the rooms.

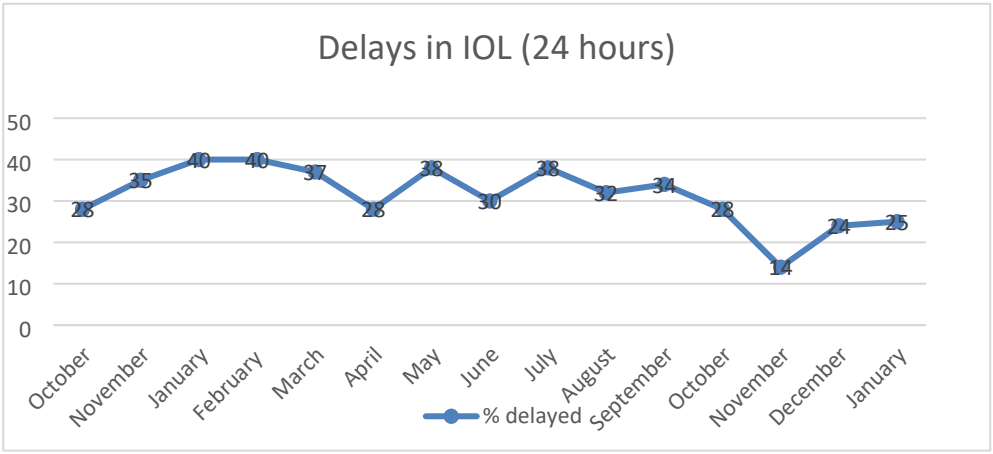
New actions to note: TOR for the group to be updated once new Perinatal Surveillance Model published and monitoring of the neonatal exit buzzer.

9.1 Delays in care

Induction of labour

Delay in induction of labour is recorded via the acuity tool but this is not reliable and does not reflect the

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



Induction of labour pathway remains a focus as delays in care is a significant red flag - a QI project continues to reduce delays in this pathway. The new electronic booking system has supported a significant improvement in the delays in the pathway coupled with the increase in midwifery staffing.

9.2 Claims scorecard review in conjunction with incidents and complaints

The Q3 maternity and neonatal claims and learning review will be included in the March 2025 report.

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

The maternity service was rated as good overall. The safe domain remains at 'requires improvement. All actions are monitored via the COSMOS platform and are discussed at ISAG.

The most recent CQC maternity survey was received by the Trust in December and there is an overall improvement in performance. The survey results are presented in a separate report and the coproduced action plan (appendix 2) is now completed to reflect the recent findings.

10.1 CQC Rait Tool

Below is a summary of 'Must' and 'Should' Do's by Level of Assurance from the Regulatory Activity Tool (RAIT) produced from the published report 29.11.23. There have been no changes since the previous report.

The only outstanding 'must do' that has not yet been achieved is safeguarding training being above 90% - all others have been achieved with an assurance level of 7.

No of Must Do's by LOA		No of Should Do's by LOA		RAIT Tool Attachment
7	3	7	3	WAHT_RAIT Maternity 31.12.24.x
6		6		
5	1	5		
4		4		
3		3		
2		2		
1		1		

11. Coroner Regulation 28 made directly to Trust

No regulation 28 regarding maternity or neonatal care was made to the Trust in January 2025.

12. In-utero and ex–utero activity

The table below summaries the in-utero and ex-utero transfers as per network pathway:

Type of Transfer	January		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	1	2	1 in from Hereford as per LMNS pathway. 1 out to Heartlands & 1 out to Coventry as per <27 week pathway.
IUT Transfers for non-clinical reasons	0	2	1 out to Stoke & 1 out to New Cross due to acuity & capacity at WRH
IUT Transfers outside of the network	0	0	
Ex-utero Transfers for clinical reasons as per network pathway	0	1	1 out to BWH as per <27 week pathway
Ex-utero Transfers for non-clinical reasons	1	0	1 in from BWH – repatriation
Ex-Utero Transfers out of network	0	0	
Delays in transfer in/out	0	0	
IUT or Ex-utero Exceptions	1		<27 week born outside of a NICU

13. MSSP Report

Formal confirmation of our exit from the MSSP was received in June 2024. A sustainability plan

has been agreed and shared at Trust Board. Progress with the plan will be monitored by the ICB and a quarterly update will be provided via this report.

Focus continues on the following actions:

- PDR compliance rates – rates have improved as per trajectory.
- Increasing Consultant led theatre lists – recruitment of the maternal medicine consultant post will improve the consultant led lists
- Enact findings of administrative review – a formal management of change process is currently underway to enact the proposed changes
- Review GTT service efficiencies – this service is now being reviewed as part of a wider review of antenatal outpatient services.
- Exploration of service improvements at AGH – this will require capital funding to make improvements to the environment

There are no further updates for this month.

14. Evidence of NHSR CNST 10 – Maternity Incentive Scheme

All of the evidence has now been submitted to Board and the ICB for the year 6 MIS; it has been agreed that the Trust will declare 9/10 this year and will submit additional information for safety action 1. It is hoped that following review of the additional evidence the Trust will be awarded full compliance. The declaration form has been prepared for sign off by the Trust CEO and the Accountable Officer (AO) of the Integrated Care Board. Once completed it will be sent to nhsr.mis@nhs.net by midday on 3rd March

2025. Whilst we await the publication of the Year 7 scheme the following table will continue to be presented monthly to ensure that we sustain our current compliance.

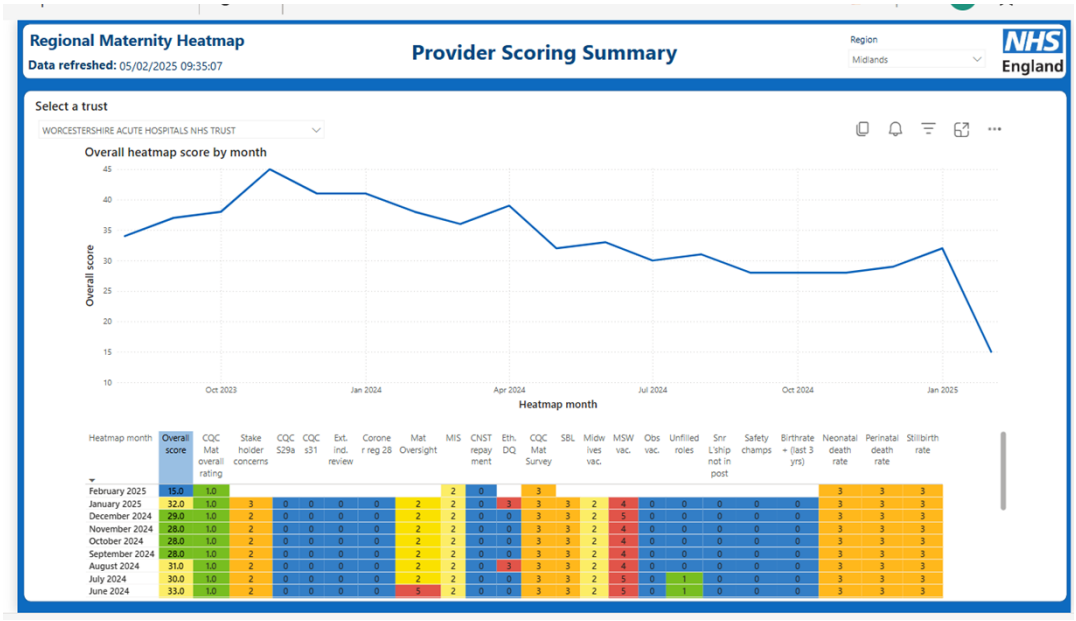
Safety Action & Current status		Actions	Evidence for Trust board prescribed in CNST year 6	Document to follow in 24-25
1	PMRT	• Quarterly reporting in place • Evidence collation discussed with NHSR and MBRACE compliance is subject to external validation	*All documents submitted to Trust board and LMNS for CNST year 6*	Q3 24-25 in March 2025 report
2	MSDS	• Submission and criteria met July 24	*All documents submitted to Trust board and LMNS for CNST year 6*	
3	ATAIN/ TCU	• Quarterly reporting in place • QI project completed (thermoregulation) to be presented in full to LMNS and Perinatal Governance in Q4 24-25	*All documents submitted to Trust board and LMNS for CNST year 6* ATAIN Report Q3 24-25.docx	Q4 24-25
4	Clinical Workforce	• Medical and Midwife Safe Staffing reports in place • NCCR implementation plan embedded 4.11.24 • Audits for Obstetric Medical staff complete • Consultant attendance item 7.2 within report • Clinical Supervision of Locum and Temporary Medical staff in place • Compensatory rest monitoring	*All documents submitted to Trust board and LMNS for CNST year 6*	
5	Midwifery Workforce	• Monthly Safe staffing report in place. • Item 7 within report • BR+ tabletop due Jan and July • BR+ Audit May 22 • BR+ Audit currently underway	*All documents submitted to Trust board and LMNS for CNST year 6*	
6	Saving Babies Lives	• Quarterly reports in place • NHS Futures Implementation Toolkit continues • Validation with LMNS quarterly next due 19.3.25 • Current level of Compliance 94% Validated by LMNS 11.12.24 (evidence embedded)	*All documents submitted to Trust board and LMNS for CNST year 6*	Q3, 4 24-25
7	MNVP	• Additional funding from LMNS agreed • Strategic lead for MNVP (appointed) • CQC action plan (Picker survey) agreed at Safety champions and trust board received plan in Septembers PSR. • MNVP highlights reports embedded (Oct PSR) • MNVP included in Terms of reference as members for, Guidelines, Perinatal Governance, Labour Ward Forum and Patient experience meetings	*All documents submitted to Trust board and LMNS for CNST year 6*	
8	MDT Training	• CNST compliance across all training met. • Item 6 within this report • Action plan submitted in Octobers PSR now complete. One rotational Obs doctor did not meet 90% training for EFM – Doctor attended Training in January.	*All documents submitted to Trust board and LMNS for CNST year 6*	
9	Safety Champions/ Perinatal Safety	• Reporting process in place. • Roles embedded and SC meetings working well. • Perinatal Surveillance guideline updated in line with yr 6 – awaiting new Perinatal Model • Claims scorecard Quarterly reporting next due Feb 25 • DMT present at every Safety Champions meeting embedded • Regular Safety champions meeting with Quad quarterly (next Feb 25) • Summary of Perinatal Culture SCORE survey results	Notes- 16.01.2025 MNSChampions (1).c Notes from Meeting 16.1.25 *All documents submitted to Trust board and LMNS for CNST year 6*	Q3 24-25 in March 2025 report
10	NHSR EN Scheme	• Reporting process in place – externally validated. • See monthly table in item 4.2	*All documents submitted to Trust board and LMNS for CNST year 6*	

15. Regional Heatmap

The Regional Perinatal Heat map was introduced in October 2023 and tracks 22 quality and safety indicators. This will read the signs of trusts that require additional early intervention and support. It scores systems and providers to ensure the right level of support is in place to enable focussed quality improvement to address key challenges.

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

The Trust position for January is as follows:



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Corone r reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
February 2025	15.0	1.0							2	0		3									3	3	3
January 2025	32.0	1.0	3	0	0	0	0	2	2	0	3	3	3	2	4	0	0	0	0	0	3	3	3
December 2024	29.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	5	0	0	0	0	0	3	3	3
November 2024	28.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	4	0	0	0	0	0	3	3	3
October 2024	28.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	4	0	0	0	0	0	3	3	3
September 2024	28.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	4	0	0	0	0	0	3	3	3
August 2024	31.0	1.0	2	0	0	0	0	2	2	0	3	3	3	2	4	0	0	0	0	0	3	3	3
July 2024	30.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	5	0	1	0	0	0	3	3	3
June 2024	33.0	1.0	2	0	0	0	0	5	2	0	0	3	3	2	5	0	1	0	0	0	3	3	3

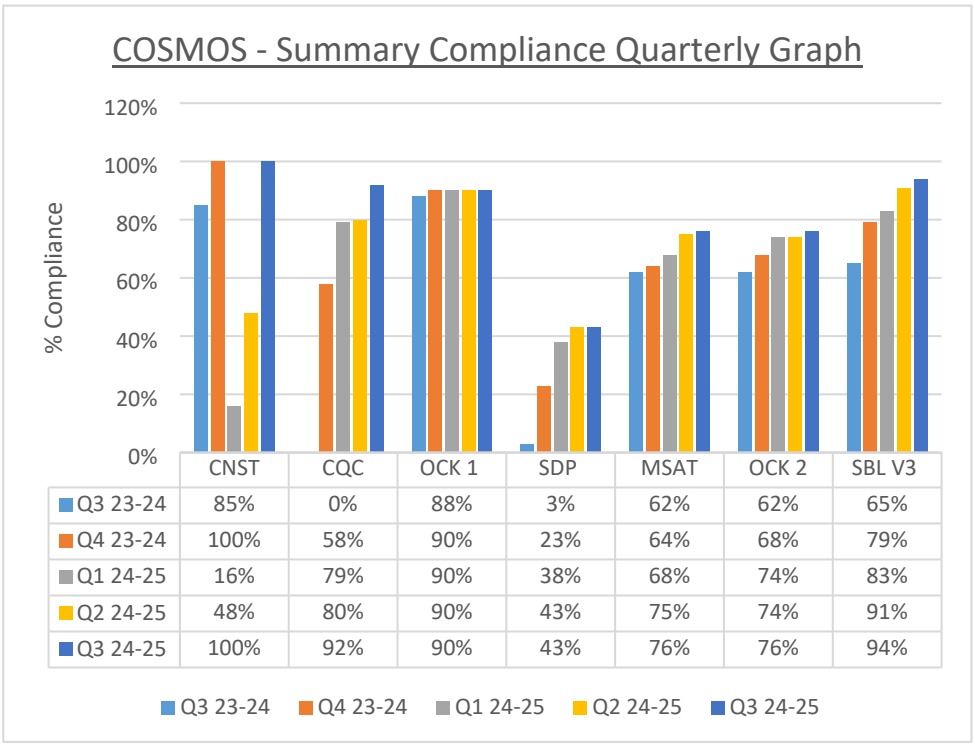
The score has increased in month due to not achieving 90% for the submission of the ethnicity data – this will improve again next month. There is an outstanding query with the regional team as there is also an increase in the number of stakeholder concerns – this has not been shared with the Trust and is likely a data entry error.

The score will reduce by a further 5 points across the next quarter as vacancies are filled. Further score reductions will be achieved if we can evidence compliance against the 10 CNST standards and the local perinatal death rate continues to reduce.

16. CCOSMOSS

CCOSMOS is a local acronym for Clinical Negligence Scheme for Trusts (CNST), CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2, Saving Babies Lives (SBL) and Safety Champions. The recommendations/actions (n=505) from all these national documents have been captured within a TEAMs platform to ensure that the directorate can track the progress of actions completed, communicate with leads and demonstrate monthly position/compliance.

The directorates quarterly progress is presented below:



	CNST	CQC	OCK 1	SDP	MSAT	OCK 2	SBL V3
Q3 23-24	85%	0%	88%	3%	62%	62%	65%
Q4 23-24	100%	58%	90%	23%	64%	68%	79%
Q1 24-25	16%	79%	90%	38%	68%	74%	83%
Q2 24-25	48%	80%	90%	43%	75%	74%	91%
Q3 24-25	100%	92%	90%	43%	76%	76%	94%

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**03/03/2025**
Title of Report:	**Midwifery Safe Staffing Report January 2025**
Status of report:	**☐Approval ☐Position statement ☒Information ☒Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Justine Jeffery Director of Midwifery
Documents covered by this report:	• NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • NHSR Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme • NHSE (2020) Perinatal Surveillance Model

1. Purpose of the report

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

2. Recommendation(s)

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

3. Chief Officer/Executive Director Opinion[1]

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

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

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

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

Introduction/Background

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

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- Sickness absence, vacancy and turnover rates
- Recruitment & retention rates
- Monthly report to Board

In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits.

The summary of the workforce KPIs are as follows:

Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	8%	14.8%
Turnover rate (rolling)	11.5%	7.5%	21.4%
Vacancy rate (MW)	7%	5%	13%*
Maternity Leave	-	3.13%	1.44%
Midwife to birth ratio (in post)	1:24	1:18	
1:1 care in labour	100%	Achieved	
Shift leader SN	-	Achieved	

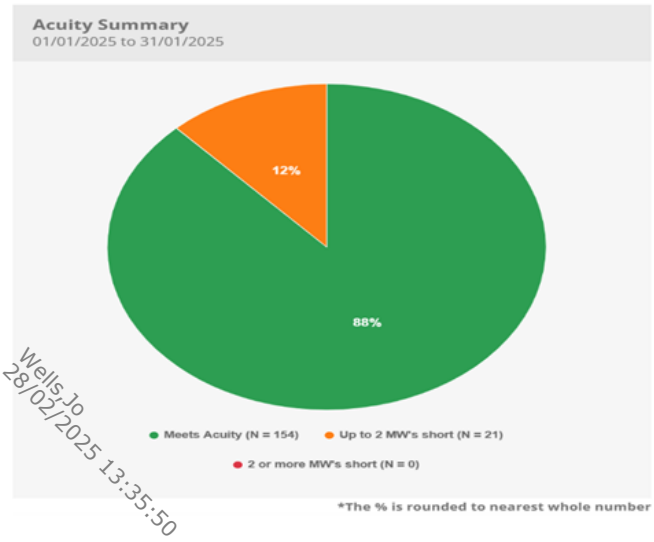
*Following change in establishment

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 81% of the expected intervals therefore the data presented is reliable. The diagram above presents when staffing met or did not meet the acuity.



From the information available the acuity was met in 88% of the time and recorded at 12% when the acuity was not met prior to any actions taken. This has increased in month and again no red shifts were reported. This indicator is recorded prior to any action taken. Safe staffing levels were maintained on all shifts in January following mitigation.

The mitigations taken are presented in the diagram below and demonstrate the frequency of (n= 23) when staff are reallocated from other areas of the inpatient service. There was one reported occasion when the community/continuity teams were deployed to supported the inpatient area. There were two reports of staff not being able to take breaks and no reports of staff staying late.

Number of Management Actions
01/01/2025 to 31/01/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	23	88%
MA2	Redeploy staff from community	1	4%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	8%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call midwife	0	0%
MA10	Escalate to Manager on call	0	0%
MA11	Maternity Unit on Divert	0	0%
TOTAL		26	

*The % is rounded to nearest whole number

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

All of the NICE recommended red flags can be reported within the acuity app and are presented below. There were two reported delays in time critical activity, no other red flags were reported.

Number of Red Flags recorded
01/01/2025 to 31/01/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	0	0%
TOTAL		2	

*The % is rounded to nearest whole number

Birth Centre

In January the completion rate for the acuity app for the birth centre was at 81%. The acuity was reported as being met 100% of the time. The number of women accessing the birth centre continues to steadily rise.

Intrapartum & Non-Birthing Categories
01/01/2025 to 31/01/2025

Categories	Number in Categories	Percentage
Cat I	32	64%
Cat II	2	4%
Cat PN	15	30%
Cat X	1	2%
TOTAL	50	

*The % is rounded to nearest whole number

Staffing incidents

There were two no harm staffing incidents:

1. Medical rota error- no second doctor for ANC
2. No support staff available to chaperone USS List

Medication Incidents

There were seven no harm medication incidents:

1. Patient self-administered paracetamol 4 hourly prior to admission – exceeded daily dose
2. FP10 missing
3. Incorrect prescription (3)
4. Incorrect dose of oral medication
5. Incorrect frequency of TTO prescription noted on follow up appointment

Monitoring the midwife to birth ratio

The ratio in January was 1:18 (in post) and 1:17 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the unit bleep holder, midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Deputy Director of Midwifery with an escalation to the Director of Midwifery as required. No additional huddles were held in January to maintain safe staffing and manage flow. Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

Maternity SitRep

The maternity SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional SitRep is submitted daily.

Unify Data

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Continuity of Carer	100%	100%	n/a	n/a
Community Midwifery	78%	n/a	100%	n/a
Antenatal Ward/Triage	93%	93%	81%	85%
Delivery Suite	98%	100%	37%	89%
Postnatal Ward	95%	92%	72%	82%
Meadow Birth Centre	81%	839&	51%	74%

National Maternity SitRep

The national COVID SitRep was stood down in October 2023. A revise national maternity submission is now available and is completed each fortnight; it is expected that the regional SitRep will be rolled out across England – this is still awaited.

Vacancy

There remains 12WTE unfilled clinical midwifery posts and no unfilled specialist roles – vacancy rate now at 6%. The remaining 12 WTE posts have been offered and they are expected to start in February/March 2025. There are 7 WTE MCA posts vacant with plans to recruit.

Sickness

Sickness absence rates for midwives were reported at 8% and 14.8% for non-registered staff – this has decreased in month for non-registered staff.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Focus review of sickness management in areas with high levels of absence
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Regular walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.

In addition to the above actions the Director of Midwifery will be meeting with all maternity matrons and the HR business partner each quarter to review all sickness plans across the service.

Turnover

The rolling turnover rate is at 7.5% for midwives and at 21.4 % for non-registered staff – this is a slight increase for non-registered staff. The PDM for MSW/MCA is currently working with HR to ensure that this group are aware of the Trust offer around Health and Wellbeing and also the development opportunities.

Risk Register –staffing

Risk ID	Narrative	Risk Rating
4208	If maternity safe staffing levels are not maintained this may impact on safety and outcomes for mothers and babies	**5**

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day
- Monthly 'drop - in' sessions led by the DoM.
- Safety Champion walkabouts
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

Conclusion

To maintain safety staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. The escalation policy was utilised on 24 occasions to maintain safety. The community and continuity of carer midwives were required on one occasion to support the inpatient team.

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

Sickness absence rates for midwives and non-registered staff remains high in month. Additional divisional support is planned for Q4.

The vacancy rate is at 5% for MWs and 13% for MCA's. There are 12WTE midwives in the pipeline and further recruitment is planned for the MCAs.

Any reduction in available staff on duty will impact on the health and wellbeing of the team; support is available from the visible leadership team, PMAs and local line managers.

Recommendations

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COMMITTEE REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**03/03/2025**
Title of Report:	Nurse safer staffing report
Status of report:	☐**Approval** ☐**Position statement** ☒**Assurance** ☐**Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Sue Smith, Deputy Chief Nursing Officer
Documents covered by this report:	

1. Purpose of the report.

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

2. Recommendation(s)

Committee members are invited to:

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

3. Chief Officer/Executive Director Opinion[1]

Staffing on Paediatrics, Neonates and all Adult in patient areas has been maintained at safe levels throughout January 2024 despite high turnover of patients and fluctuating acuity levels on Riverbank and in paediatric A&E.

Caring for patients who are not always in designated bed spaces continues on wards on the WRH site and both Emergency departments on daily basis.

Due to increased pressures additional capacity continued to be utilised with PDU being open throughout January. Avon 1 winter pressure ward remains open with substantive recruitment continuing in order to offset temporary staffing usage. Temporary Escalation Spaces were in full use during January 2024.

The space in Medical Same Day Emergency Care (MSDEC) was risk assessed to be used for next day discharges overnight and was staffed accordingly. This was in use from end of December 2024 and continued throughout January

The associated increased costs (bank and agency) for these areas / departments can be seen in the attached staffing paper.

In January the 'PIT STOP' pilot commenced with ACP usage from both agency (off framework) and bank suppliers. Financial implications of this will be included in the February staffing paper.

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

4. Executive Summary

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

- The safe staffing position across these staff groups
- The reduction in overall pay costs and bank and agency spend, with a stable agency spend.
- The maintenance of safe fill rates for registered and unregistered nursing which has been achieved whilst maintaining a downward trajectory in bank and agency spend.

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

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

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

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

Overall Level of Assurance for this Report

Tick ✓ the level of assurance for this report

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

7. Supplementary/Supporting Information

N/A

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Meeting	Public Board
Date of meeting	3 March 2025
Paper number	

1. Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for January 2025 with financial figures for December 2024.

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

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

2. Content of report

Harms

In January 2025 there were 25 insignificant or minor incidents reported. The insignificant and minor harms reported relating to nursing / midwifery staffing and were largely reported as near misses due to staff absence, rather than patient harm. All incidents were included in NWAG Divisional reports and assurance of mitigation where appropriate has been given.

Safe Staffing

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

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

Current Trust Position December 2024 data			What needs to happen to get us there	Current level of assurance
	Day % fill	Night % fill	This month fill rates remain stable, with registered and non-registered meeting national targets of 95%. Last dip below 95% for RN October 2023. HCSW night fill at 114% is reduced slightly as a result of some template changes and this is a trajectory we anticipate continuing as further template amendments following the A&D reviews come into place.	6
RN	98%	102%		
HCSW	100%	114%		

Care hours per patient day (CHPPD)

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

The Trust average for CHPPD for December 2024 was **9.1 (increased from 9.0 in November).** There has been a slow but incremental rise on CHPPD over the last quarter. This is reflective of the work completed by all divisions in both staffing escalation meetings and through Acuity and Dependency reviews led by the CNO. The average national range for CHPPD is 9.1 with a variation of **6.33 to 15.48**, which the Trust sits comfortably within.

In December no area's fell below the minimum of 6.30.

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

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

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

Nurse to bed ratio

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

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

Vacancy (Trust target 6%)

December 2024 data

Current Trust Position **WTE** **December 2024 data**	**Previous month** **November 2024**	**Model Hospital data Sep 2024 Benchmarking**	**Current level of Assurance**
RN 1.09% (23.65 WTE) HCSW 7.19% (75.77 WTE)	RN 2.6% (56.63 WTE) HCSW 9.04% (96.74 WTE)	RN 8.1% HCSW 10.4%	6

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

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

- employing use of bank and agency workers.

To note, there are 16.6 confirmed HCA starters in January, with a further 73 in the pipeline due to start Feb / March / April 25. The monthly generic assessment centres for HCA's led by Workforce are now established with good involvement from ward managers and are proving an effective approach to the scale of recruitment required.

International nurse (IN) recruitment pipeline

The initial target for the year 25/26 was initially 50-60 nurses supported by an internal business case, in the absence of assured external funding from NHSE. This number is under ongoing review however, and our current predicted requirement for 25/26 is 24-30 RN's given positive local recruitment. Data regarding the international pipeline has been circulated to all divisions to allow for the development of CPIP's.

Domestic and international nursing recruitment

The current 12-month trajectory looks positive, the initial prediction of the month 12 position in terms of vacancy rate was 31 WTE RN, given current trajectory it is likely this will be exceeded. This will put us in a positive position in terms of any additional business cases / expansions in the new financial year. This is based on active recruitment drives for both autumn and spring qualifying cohorts and a moderate international pipeline of 50. This is in combination with baseline local recruitment and RNA to RN top ups of existing staff.

The Trust held a face-to-face recruitment event on the 21st of September at CHEC, with exceptionally good attendance, predominantly from the cohort qualifying in Feb 2025 at University of Worcester, with 37 offers of employment being made on the day. 31 have been made formal offers and are either in post or due to commence in Feb / March and the remaining 6 are awaiting offers of placement. A further event aimed at the September 25 qualifying cohort is booked for the 5th and 6th of April 2025 and interest in this event is strong.

A recruitment event for HCA's was held on the 17th of January at KTC with 7 offers being made at Worcester, (these are included in the pipeline previously mentioned). Further face-to-face recruitment events are planned through to April 2025.

Bank and Agency Usage
December 2024 data

Bank and agency usage, total combined RN & HCSW was 562.4 WTE.

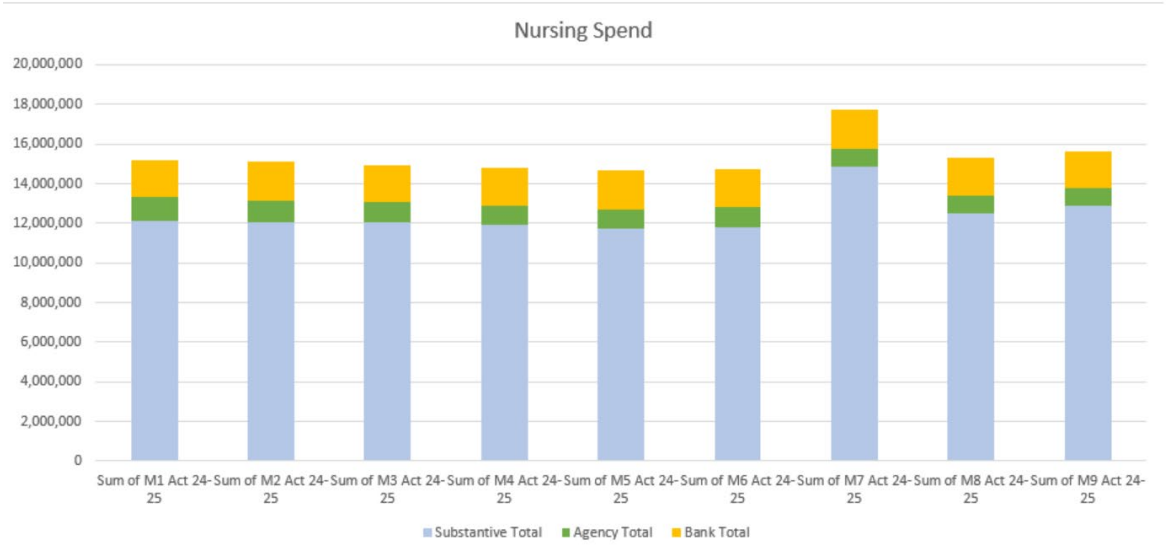
Triangulated data for sickness / vacancy and maternity leave gives an overall absence of 250.65 WTE for registered (not including midwifery) and 178.41 for un-registered nursing.

Overall nursing pay costs in month 9 are £15.6m – of which £0.3m is costs associated with Winter
Substantive nursing pay spend of £12.9m in December 24 is an increase of £0.4m compared with spend in November. The adverse movement is largely due to the Bank Holidays in December and an increase in Winter costs in month.
Bank spend of £1.8m in December is a decrease of £0.1m compared with last month. This is mainly with Speciality Medicine and relates to the temporary closure of PDU.

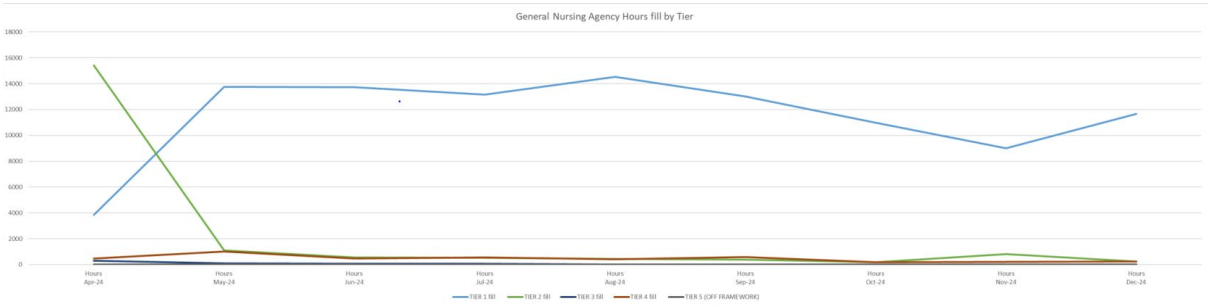
Agency spend of £0.9m in December is consistent with spend in November.

Tier 1 agency for general and critical nursing continues to be strong at 96% for RN00 (up from 90%) and 83 % for RN04 (down slightly from 87% last month). We would anticipate that the RN04 agency usage will decrease overall in coming months as bank to agency bumping was turned on in both A&Es with Divisional support in January with early changes looking positive for increased bank fill in these areas.

Graph showing trend of substantive / bank and agency spend



Reduction of agency spend & average hourly rate, remains a focus. The graph below illustrates the consistent reduction of Tiers 3 & 4 and removal of off framework agencies. Whilst usage remains relatively consistent the increase on both bank and Tier 1 fill provide assurance that ongoing actions are achieving the aim of off setting more expensive providers whilst not impacting fill rates.



Sickness

December 2024 data (% reflects updated headcount)

Current Trust Position December 24	**Previous Month Position** **November 24**	**Model Health System data Feb 2024 Benchmarking**	**Current Level of Assurance**
RN 6.49% (138.75 WTE) HCSW 7.53 % (73.64 WTE)	RN 6.36% (135.15 WTE) HCSW 7.46 % (72.65 WTE)	RN 5.4% HCA 7.5 %	**5**

Absence (December 2024 data)

- 250.65 WTE RN total absence due to vacancy, sickness and maternity leave (down from 285.78 in November,) versus bank and agency use of 296.26 WTE (down from 311.4 WTE in November).
- 178.41 WTE HCSW total absence due to vacancy, sickness and maternity leave (decreased from 201.4 in November) versus bank and agency usage of 266.14 WTE (decreased from 275.65 in November),

The Trust currently has 89 RNs and 29 HCSWs on maternity leave (slightly reduced from November 24). The options paper continues to be developed, the CNO has requested that this is completed by end of February.

Additional Capacity Usage / Costing

Avon 1 remains open as winter funded additional capacity with a mixture of substantive and temporary staffing – acknowledgement of the impact of winter funded capacity on overall spend has already been noted.

Other focuses of additional capacity are MSDEC / Discharge lounges and the reopened PDU. Details for financial implications are below for the month of December:

Ward	Month	Registered		Unregistered		Total	
		Hours	Cost	Hours	Cost	Hours	Cost
Medical SDEC WRH	Dec	564	£18,988.35	35	£880.72	599	£19.869.07
Discharge Lounge AGH	Dec	130	£3.836.34	96	226	226	£6,263.94

Discharge lounge WRH	Dec	138	£4,348.05	108	£2,611.42	246	£6,959.47
PDU	Dec	999	£30,535	541	£12,172	999	£42,707
Grand Total	Dec						£75,799.48

Current cover arrangements.
Currently budgets do not contain uplift for maternity leave cover and sickness. Whilst budgeted for, this sits within the bank / agency line so hence is reliant on temporary staffing solutions.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**03/03/2025**
Title of Report:	Patient and Public Forum (PPF) Bi-Annual Board Update
Status of report:	☐**Approval** ☐**Position statement** ☒**Assurance** ☒**Discussion**
Report Approval Route:	Other
If Other, provide details:	Patient and Public Forum
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Patient and Public Forum Chair
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The purpose of the report is to inform the board of the activities of the PPF, achievements, frustrations, risks and to provide assurance to the Board that the PPF is a strong forum where the views and experiences of patients and carers are influencing the way that services are delivered to improve the quality of care provided to our patients.

2. Recommendation(s)

The Board is invited to receive the report for assurance and note the positive contributions that the PPF are making to ensure the patient voice is heard.

3. Chief Officer/Executive Director Opinion[1]

The PPF Terms of Reference were reviewed in 2024 and part of this review was to consider how the patient voice could be strengthened in board sub committees, Trust business meetings and at Trust Board. An outcome of the review was that the PPF Chair would present Bi-Annual update directly to the Board, this is the first report that is being presented.

The CNO offers assurance that the changes which have been made strengthen the Trust's compliance with the Health and Care Act 2012 in relation to putting the patient first – and making this a reality. We have started the journey in moving towards shared decision making becoming the norm.

4. Executive Summary

The Patient and Public Forum is an autonomous diverse group representing our patients and the people of Worcestershire.

Our purpose is to act as a critical friend to the Trust with a view to improving patient experience and supporting our staff. This is achieved in many ways. Committee representation, supporting the Trust with the ward accreditation programme, clinical and estate audits are some of our many activities listed in the report.

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

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

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

PPF report for Trust Board for the year 2024

1 Executive summary

The Patient and Public Forum is an autonomous diverse group representing our patients and the people of Worcestershire.

Our purpose is to act as a critical friend to the Trust with a view to improving patient experience and supporting our staff. This is achieved in many ways. Committee representation, supporting the Trust with the ward accreditation programme, clinical and estate audits are some of our many activities listed in the report.

The purpose of the report is to inform the board of the activities of the PPF, achievements, frustrations and risks.

2 Report

We end the year with 11 active members and 2 further members on sabbatical for health reasons.

All members are volunteers who are fully vetted and do mandatory training before being accredited.

Members meet bimonthly with the Trust and have member interim meetings to plan and monitor their work schedule. A work plan was developed at the beginning of the year.

3 2024 Activities

- Developed a work plan
- Approved revised terms of reference
- Supporting the Trust with Quality Review Visits as part of the Care Excellence Accreditation process
- Support the Improvement Programme
- Audits within ED (care in the corridor)
- Cleanliness walk arounds
- Hygiene audits
- PLACE and efficacy audits
- Big Quality Conversation
- Attendance at Trust committees
- Deep dive into outpatient cancellations
- Deep dive into stroke services including liaison with HealthWatch
- Support for the appointment of an ECLO (eye clinic liaison officer)
- Support for Patient Voice with the voluntary sector and Health and Care Trust
- Attendance at interviews for key staff members
- Quality Account – proof read as well as comment on it
- Suggested various changes within the estate e.g. better signage for people with a visual impairment
- Monthly meetings with the Foundation Group Chair and six weekly with the Chief Nurse
- Vet patient leaflets

4 Committee attendance

This year with the considerable help of our Chief Nursing Officer, we are now represented on some new committees for us e.g. Strategic Programme Group. We find these meetings very informative and endeavour to highlight any patient issues. Below is a list of the attendance at Trust committees/meetings together with the membership (only one person to attend even if there are two people identified)

- **Strategic Programme Group -** Stuart Larnder and Simon Marriott
- **Single Point of Access Steering Group – Simon Marriott**
- **Fundamentals of Care** - Simon Barugh
- **Trust Infection, Prevention and Control Committee - Sheila Try**
- **DREAMS – Rosemary Smart and Kimara Sharpe**
- **Executive Risk Management Committee - Julia Rhodes**
- **Dementia and Falls – Simon Barugh**
- **Learning Disability – Simon Barugh**
- **Patient, Carer and Public Engagement -** Kimara Sharpe and Sheila Try
- **Patient Safety Incident Response Group - Julia Rhodes (patient safety partner)** ***Not directly a PPF role***
- **Quality Governance Committee – Rosemary Smart (deputy Julia Rhodes)**
- **People and Culture – member on sabbatical**
- **Divisional Board meetings:**
    - SCSD – John Hill
    - Women and Children – Sheila Try
    - Surgery – Kimara Sharpe
- **Gynae – member on sabbatical**
- **Infection, Prevention and Control Group – Sheila Try**
- **Nutrition and hydration – Rosemary Smart & Paul Crouch**
- **Digital Strategy Group – Paul Crouch**
- **Transition steering group – Rosemary**

5 Achievements

- Review of response letters to complaints and recommendations: This was a follow up to a review we did just before Covid.
- Raising awareness about Veterans, services for people who are hard of hearing and communication problems between Evesham and our Trust in relation to stroke services.
- Ensuring healthy options are available in vending machines at the Alex
- Extensive input into various estate issues [e.g. signage and disability friendly issues]

6 Frustrations

- Lack of speed in responding and actioning issues raised
    - Nearly 2 years ago we raised the issue of a yellow line on the floor at Kidderminster for those who are have sight problems. This has only just been put into place
- We struggle to receive timely feedback from areas visited and the development of an action plan. Outstanding actions are reducing now, with the introduction of a more robust mechanism for monitoring.

We are hopeful now that due to recent changes within the Estates and Facilities Department that a more proactive approach will be evident.

7 Risks

- We constantly have issues of attendance and ability to undertake some tasks due to other priorities that members have outside the PPF
- One member resigned as a direct result of lack of perceived action by the Trust (within the last 12 months)
- Recruitment of members who are able to contribute to the wide range of activities the PPF undertakes

8 Issues for consideration in 2025

- Nutrition & hydration in the Worcester Royal ED, both through the vending machines and meal service
- Stroke services – continuing to review, particularly the liaison between the Acute service and the Community beds at Evesham

9 Thanks

On behalf of all members, I would like to thank the following personnel for their support during the past year

- Sarah Shingler – Chief Nursing Officer
- Amy Gray/Rachael Beasley Suffolk and the Health Care Standards staff
- Anna Sterckx – Head of Patient and Public Involvement
- Janet Neate – Head of Volunteering
- Julie Webber and Patience Ngumbo
- And all the other staff who have been so accommodating and supportive when members are visiting their areas

Rosemary Smart
Chair, PPF

Authors - Kimara Sharpe (PPF vice-chair) and Rosemary Smart

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Worcestershire Acute Hospitals NHS Trust

Minutes for Quality Governance Committee

Thursday 28th November 2024 at 10.00 am
Via MS Teams

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

Item	Title
QGC/24/1	**Welcome and Apologies for Absence**
	Dame Julie welcomed all present at the meeting.
QGC/24/2	**Declarations of Interest**
	There were no new declarations of interest raised.
QGC/24/3	**Minutes of the last meeting**

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	The minutes of the meeting held on the 31st of October 2024 were confirmed as a factual representation of the meeting and approved.
QGC/24/4	**Action Schedule**
	Progress on the outstanding actions was reviewed, and updates were provided. The topic of Medical Devices will be discussed at the January meeting, with a paper to be presented.
QGC/24/5	**Escalations from Chief Medical Officer and Nursing Officer for items outside of standard report / not on the agenda**
	Ms. Shingler highlighted increased regional concern regarding the harm caused by long ambulance handovers, particularly for patients waiting 8 hours or more. She assured the committee that a harm review process has been implemented, which will focus on cases involving ambulance offloads exceeding 8 hours, patients remaining on ambulances for over 4 hours awaiting admission, and patients in the Emergency Department (ED) for more than 48 or 72 hours. This process is now underway, and a monthly report will be provided through QGC. In response, Ms. Moore asked whether the region had offered any further advice, guidance, or additional support on these issues. Ms. Shingler also raised a further regional concern regarding ambulances being used as makeshift cubicle spaces, highlighting the strain on resources. However, she confirmed that safety in the ED is being carefully managed, and that high-quality care is being delivered both in the ED and on the back of ambulances, ensuring patient safety during transfers. She clarified that harm reviews are being conducted by the patient safety team and site matrons, as the ED team is required for direct patient care. Ms. Moore emphasised the importance of the trust clearly outlining the strain being placed on the entire system. She instructed the group to ensure that it is communicated what actions are being taken to address these challenges, and how the trust is doing its utmost in what is an extremely difficult situation. There are no updates on the Mandolite issues at present. Ms. Shingler will follow up for an update
QGC/24/6	**Best Services for Local People**
QGC/24/6.1	**Perinatal Safety Report**
	Ms Jeffery presented report. Ms. Jeffery explained that this month's report is slightly different, as it marks the end of the reporting period for our MIS submission, with a primary focus on CNST evidence. The KPI for 12+6 bookings has been met for the first time in a long while, which is excellent news. The perinatal mortality rate remains lower than the national average, driven by a reduction in stillbirth rates. The maternity self-referral service was launched on 1st November, which has led to an increase in the national target by 10 weeks. Training is on track to meet CNST requirements. However, challenges with medical staffing, particularly around consultant sickness, continue. Mitigation measures are in place, and this issue is included on the risk register. The heatmap now shows the trust ranked 8th out of 21. Ms. Jeffery presented CNST Update.

	One case was graded as C. However, it was not felt that the care provided contributed to the outcome. There is currently a vulnerability in Element 1 due to some reporting requirements not being fully met in the way NHSR expects. Additional evidence can be presented to NHSR to show that reviews were completed within the suggested timeframes. Ms. Jeffery will discuss this with NHSR next week. The report outlined training compliance requirements for Junior Doctors. NHSR recognises that it is challenging to keep everyone up-to-date due to frequent rotations every four to six months. An action plan is in place to identify groups of individuals and the dates by which they must complete training, with six months allocated to complete these actions. The Q2 claims card, included in the appendices, triangulates claims, complaints, and incidents, and identifies recurring themes. Moving forward, there needs to be a greater focus on triage and how women are managed through this pathway. Ms. Jeffery discussed the shift from standardized CTG (cardiotocography) interpretation to physiological CTG interpretation, which is the newer recommended approach. Although this has not yet been fully implemented, the shift is underway. Foetal monitoring and escalation concerns remain a focus, with the trust currently participating in Royal College Escalation Toolkit training across the region. Much of this work is being discussed with safety champions to embed these practices into the teams. Ms. Jeffery acknowledged the receipt of the Safety Champion meeting minutes, which include discussions with both non-executive and executive directors about their development and how they can support the team. Evidence of this engagement is included in the document pack. The development of the quadrants for safety champions and the engagement with both executive and non-executive safety champions is ongoing, with quarterly meetings planned to ensure continued support. Ms. Jeffery noted that work is underway to address concerns regarding the cold room windows. There have also been some concerns about signage on the labour ward, specifically regarding room identification. These issues are being addressed, and improvements have been made. Ms. Jeffery acknowledged the receipt of the score survey, noting that, not surprisingly, consultant staff are feeling burnt out. The main areas identified for improvement are line management and staffing levels. Ms. Jeffery explained that the trust is a positive outlier, being open and honest in the way reports are submitted and committed to providing feedback and learning from mistakes. An update on developments from the survey will be included in the next perinatal report. Ms. Moore asked Ms. Jeffery about actions taken regarding room temperatures. Ms. Jeffery confirmed that cold rooms have been identified, and another round of temperature checks is scheduled soon. Ms. Shingler noted that the delivery rooms are warm enough due to measures in place. Ms. Moore & Ms Lynch expressed concerns regarding the PFI company not meeting its obligations, particularly around secondary glazing. Initially, secondary glazing was agreed upon, but it has since been deemed unnecessary, as the rooms are sufficiently warm due to the current measures in place to regulate room temperatures. **Action:** Ms. Shingler to discuss with Ms. King the possibility of producing a paper to take to the Trust Board regarding room temperatures and the concerns around the PFI company's obligations.
	Resolved that: The report was noted for assurance.
QGC/24/6.2	**Perinatal Incident Report**
	Ms Jeffery presented report. Ms. Jeffery sadly discussed three unfortunate cases:

	One case involved a stillbirth, where a rapid review was conducted. No immediate concerns were identified following the review. A baby died on-site following a road traffic collision at 27 days old. Full support has been provided to the family, including maternity and bereavement services. A baby deceased at 29 weeks despite all appropriate care being provided. A review of this case will be completed in collaboration with the tertiary centre. Moderate Harm Cases: A lady was diagnosed with a severe infection, suspected to be necrotising fasciitis. The family has submitted questions, and a meeting is planned for next week to address these questions and provide a debrief on the case. In a case of an unplanned home birth, the cord snapped during delivery, although the birth appeared to be progressing well. This case will be discussed at the PSIRG (Patient Safety Incident Review Group). Ms. Jeffery reported a slight increase in open actions, but the team continues to focus on addressing these. No new MNSI (Maternity and Neonatal Safety Investigation) cases have been reported. Ms. Moore queried whether the case of a baby who had been dropped on the head had been referred to the relevant departments. Ms. Jeffery confirmed that this has been done.
	Resolved that: The report was noted for assurance.
QGC/24/6.3	**Midwifery Safe Staffing Report**
	Ms. Jeffery presented the staffing update: The trust continues to maintain safety across all shifts. There has been a reduction in the time that acuity was met, primarily due to ongoing challenges with sickness. There has been a sustained peak in activity during August, September, and October. The number of vacancies in the midwifery group has decreased. A further 6 midwives have joined the team, and all other vacant posts have been filled, with new staff set to arrive in February 2025. Turnover rates are down in both midwifery and nursing groups. Ms. Moore queried where the trust stands in terms of staffing profiles. Ms. Jeffery reported that the regional staffing situation is quite similar, and international recruitment has significantly contributed to reducing staffing gaps.
	Resolved that: The report was noted for assurance.
QGC/24/6.4	**Nurse Staffing Report**
	Ms Shingler presented report. Paediatric neonates and all adult areas maintained safe staffing levels throughout October, despite a significant rise in activity. The care hours per patient did decrease to 8.7 hours, due to two specific wards. This has been addressed through the acuity review, with additional staffing allocated to those areas. Overall pay costs for Month 6 amounted to £14.76 million. There was an increase in substantive nursing pay in September, primarily linked to the August bank holiday. There was a decrease in bank spend for the period. The registered nurse vacancy rate is **3.6%**, which remains low. Following the closure of the PDU, the 21-nursing staff affected are being reabsorbed into current vacancies. The Healthcare Assistant vacancy rate is 9%, which is improving, though it remains a challenge. Work on maternity leave funding is in progress, with data from finance now received and being incorporated into the plan.

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	Resolved that: The report was noted for assurance.
QGC/24/6.5	**Fundamentals of Care**
	Ms Shingler presented report. Ms. Shingler highlighted ongoing concerns around respect, privacy, and dignity, particularly regarding boarding patients on wards. This continues to be a significant issue. Monthly audits are being carried out in collaboration with PPF colleagues to monitor and address this. A key concern identified is the noise levels made by staff during the night, particularly in the ward setting. Ms. Shingler explained that while noise from nursing staff in ED may be somewhat different, the focus needs to be on where changes can be effectively implemented to reduce disturbances on wards. Absconding patients remain a key focus for the committee, with ongoing work being done to address this issue. Compliance for dementia training has risen to 95%, which is a positive development. Delirium Screening: Unfortunately, the delirium screening standard has not been met. There are ongoing challenges with the EPR team, particularly around the transition from paper-based to digital systems. The increased length of stay for dementia patients continues to be a focus, with particular concerns around ward transfers after 8:00 PM. This is being actively monitored and addressed. Readmission rates have increased by 3% since Q4. There is ongoing work to understand the reasons behind this rise. Ms. Shingler noted that earlier discharges could be contributing to this issue, suggesting that there may be concerns at the front door regarding patient flow and discharge processes.
	Resolved that: The report was noted.
QGC/24/6.1.6	**Blood Transfusion**
	Ms Walton presented the report. Ms. Walton presented the report, noting that the Blood Track implementation is progressing well and is currently at the midway point of Phase 2. This phase includes the roll-out at the ward level, as well as in EDS and ITU So far this year, the trust has recorded 16 sharp reportable transfusions, marking a significant decrease compared to the 45 transfusions reported in total for 2023. This reflects a positive improvement in transfusion management. Ms. Walton confirmed that the trust is on track to further reduce the number of sharp reportable incidents moving forward. Ms. Smart raised a query about lymphoma patients needing radiated blood and mentioned that there were two incidents earlier in the year where these patients did not receive it. She asked what systems are now in place to prevent this from happening again. Ms. Walton explained that these incidents were reviewed by PSRIG and reported to National Blood and Transfusion Services to highlight the issue. Locally, she confirmed that all necessary systems and safeguards are now in place to ensure this does not happen again.
	Resolved that: The report was noted.
QGC/24/6.1.7	**HSE Safer Sharps Updates**
	Ms Shingler report.

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	This is an interim report, with the final report to be presented to the QGC for final sign-off. The HSE has enforced the trust with two improvement notices following their review of an inoculation injury in July. The HSE noted weaknesses in compliance with the Health and Safety Regulations 2013, as well as with elements of the Management of Health and Safety at Work Regulations 1999. A working group, led by the Health and Safety Manager, has been set up to address all the issues raised in the HSE's report. This group is actively working through the findings to ensure compliance and implement corrective actions. Although the HSE has not issued any enforcement actions or fines, the trust is required to cover the inspector's time. Ms. Shingler will arrange an urgent meeting with the Health and Safety Inspector to discuss the possibility of developing an action plan to address the outstanding issues.
	Resolved that: The report was noted.
	Resolved that: The report was noted for assurance.
QGC/24/7.	**Best Experience of Care and Best Outcomes for Patients**
	Resolved that: The report was noted for assurance.
QGC/24/7.1	**Integrated Performance Report**
	Mr. Douglas presented report. Mr. Douglas reported that the trust has been stood down from National Cancer Tiers, after an 18-month process. This is a positive development, particularly in relation to the faster diagnosis standard, which has been maintained at over 80% across all tumour sites. The trust is consistently meeting either the national target of 77% or the local target, with some areas slightly lower due to service demands. The trust has sustained its position for the 62-day cancer pathway, continuing to meet targets despite challenges. There are ongoing concerns around respiratory medicine capacity and tertiary providers, but the trust is working with NHSE and the Western Council Alliance to support improvements in these areas. A business case is being developed within oncology to increase overall capacity, ensuring more timely access to treatment for patients. The published data for the 62-day cancer pathway is positive, with the trust ranking in the top 20 for the highest volume of patients treated within this timeframe. The trust is third highest in performance for this pathway overall. The 31-day cancer pathway remains a concern, particularly due to delays in dermatology. However, this is expected to improve and return to performance by Q4. Ms. Moore queried whether the trust is still dealing with the backlog caused by Covid-19. Mr. Douglas confirmed that while the backlog is being addressed, there is still insufficient capacity in certain specialties to meet ongoing demand. Mr. Douglas discussed the insourcing plan for ENT and Maxfax services, noting that continued work through the annual planning process is needed to address these challenges. The trust is focusing on a target of 65 weeks for the elective pathway, ensuring no patients wait beyond this time frame. An insourcing process is currently underway through the governance process to secure the necessary sign-off. However, there is concern over the high number of same-day cancellations of procedures. In October, the trust recorded: • 97 cancellations at ALEX • 58 cancellations at KTC • 26 cancellations at WRH Mr. Douglas stated that further work is needed to reduce this number. Mr. Douglas expressed concern regarding audiology, with 73% of patients currently waiting over 6 weeks. A meeting has been scheduled with the service following concerns raised the previous day. Urgent emergency care continues to be a significant operational challenge, particularly with ambulance handover delays. In October, the trust recorded 1,268 patients who

	waited over 1 hour for handover, with 37 patients waiting more than 8 hours. These delays remain a key area of focus for the trust. The Emergency Department has faced challenges in recent weeks due to the department being spread across two floors. However, the department is now back in its core footprint, which should help alleviate some of the operational difficulties. The launch of the EPR system went live in November. While the implementation is progressing, Mr. Douglas noted that there have been delays in discharge letters being produced due to the new system. He assured the committee that a recovery plan is in place to address these delays and improve the discharge process moving forward. Ms. Moore raised concerns about the high number of same-day cancellations of procedures which are cancelled by the patients themselves. Mr. Douglas confirmed that automated text messages are now being sent to patients to confirm their intention to remain on the waiting list. This process has been validated, and the trust is monitoring its effectiveness in reducing cancellations. Ms Lynch queried if a standby list in the event that people cancel on the day surgery, Mr Douglas did explain that this is something that has recently been introduced but isn't comprehensive. Ms. Shingler raised concerns about the number of overdue complaints in the surgical division, currently standing at 12. However, this is a significant improvement from 56 in mid-October, demonstrating sustained progress. Ms. Shingler reported an increase in C. diff cases. The action plan to address this is being reviewed, and updates will be provided at the next committee meeting. There has been an increase in falls, although there has been a reduction in hospital-acquired pressure ulcers. Ms. Smart inquired whether disposable bedpans are used for patients at risk of C. diff, particularly in light of ongoing issues with bedpan washers. Ms. Shingler highlighted improvements in antimicrobial stewardship compliance and ward cleanliness. Additionally, the department is piloting bedpan macerators, though concerns about drainage capacity need to be addressed. Ms. Dunne noted that, as a system, the trust is performing well on four out of five national targets. However, C. diff remains an outlier, and there is a need to investigate community-level factors contributing to the rise in cases.
	Resolved that: The report was noted for assurance.
QGC/24/7.2.	**End of Life Care**
	Ms Heron presented report. Ms Heron highlighting the ongoing success within the EOLC department. She shared that the national audit results are proving to be quite positive, with key areas of strength identified. For areas where improvements are needed, action plans have already been put in place to address these gaps. Ms. Walton acknowledged the team's efforts, confirming the EOLC team's excellent performance and expressing her gratitude to Ms. Heron for her valuable contributions to the presentation.
	Resolved that: The report was noted for assurance.
QGC/24/7.3	**Cancer Patient Experience Survey 2023**
	Ms Stratford presented report. Ms. Stratford provided an update on the 2023 patient survey, which includes patients aged 18 and above who have received treatment as inpatients or day cases within the

	trust's services. This encompasses patients undergoing immunotherapy, chemotherapy, and radiotherapy.
	Resolved that: The report was noted for assurance.
QGC/24/8	**Governance**
QGC/24/8.1	**Improvement Safety Action Group Escalation Annual Report**
	Ms Shingler presented report. Ms Shingler stated that a decision has been made to change the ISAG agenda, this will look at reviewing themes to make improvements to address ongoing concerns. No new escalations from the last quarter. Ms. Stratford reported that three questions in the survey were ranked above the expected range of the national averages. Several questions scored below the expected range, though the results were not significantly deviating from the national average. Ms. Stratford outlined the key actions being implemented to improve patient experience within Cancer Services: Ensuring all cancer patients have a designated main point of contact or keyworker. Conducting walk-arounds in clinical areas to ensure information posters are clearly displayed for patients. Providing information to patients on their entitlements to benefits and financial support. Establishing a new Cancer Patient Forum to gather feedback and improve services. Targeting low-scoring areas with visits from the Macmillan Information Hub to provide additional support and information. Ms. Stratford highlighted that Cancer Services have made significant positive developments based on survey feedback and ongoing improvements.
	Resolved that: The report was noted for assurance.
QGC/24/8.2	**Risks**
	Ms Shingler presented report. Ms. Shingler reported that there are nine risks rated at 15 or above. Of these, three risks have been scored at level 20: 1. Cath lab equipment failure 2. Medical staffing shortages at the Alex 3. Overcrowding in the Emergency Department There are three risks with current scores of 60: 1. Pharmacy-related concerns 2. Nutrition-related concerns – Ms. Shingler was pleased to inform the committee that she has received the nutrition business case, which will be reviewed and put through the approval process. 3. Urgent care delays – Risks related to harm caused by delays in the department and ambulance handovers. Ms. Shingler asked the committee for approval regarding the escalated risk of C. diff. Ms Moore approved.
	Resolved that: The report was noted.

QGC/24/8.2.1	**Patient Safety Incident Investigation**
	Ms Jeffery reported report. The MNSI was discussed at the PSIRG and an action plan was agreed upon by the division. It was noted that although the baby was born in poor condition, the baby remained unharmed. Ms. Jeffrey confirmed that all actions outlined in the plan have shown progress, with some actions already being completed.
	Resolved that: The report was noted.
QGC/24/8.2.2	**Regulation 28 November Report**
	Ms Shingler presented report. The Trust has received three regulations since July 2024, with one significant case from September involving a patient who was referred after a fall at home, later suffering three additional falls during admission and passing away following surgery. The coroner raised concerns over the lack of a fall prevention plan, and the fall processes are currently being reviewed. These will form part of the dashboard for QGC starting in January 2025. A 41-year-old nonverbal gentleman with learning disabilities is part of the ongoing discussions in the Improvement Action Group, due to multiple issues arising from his care. The Regulation 28 responses were submitted within the required timeframe. A review of the process around Regulation 28 and coordination with ICB, CQC, and the Board has been completed and documented in Datix. Ms. Lynch inquired about ways to be more proactive rather than reactive. Ms. Shingler reassured that falls are decreasing, and work is ongoing to address overcrowding in the ED. Fall prevention processes are under review and will be incorporated into the QGC dashboard from January 2025. Ms. Walton emphasised that Regulation 28 responses offer an opportunity to actively learn and improve practices. Concerns Raised by the Coroner: • A Coroner's letter was sent to the Chief Executives regarding the fundamental care of patients in ambulances. • Another case involved a patient with multiple comorbidities who missed a sepsis diagnosis after being in an ambulance for 12 hours. The patient later died from an infected pressure ulcer. Continued work within the Improvement Action Group to address the ongoing care issues, particularly around learning disabilities. • A third case involved a patient absconding from AMU, falling, and being found deceased the next morning. This is under investigation, with the Health and Safety Executive now involved.
	Resolved that: The report was noted for assurance.
QGC/24/8.3	**QGC Terms of Reference**
	Ms Shingler shared the annual review ToRs. Ms. Shingler expressed her interest in involving the Director of Estates. This suggests a focus on addressing infrastructure or environmental factors in relation to patient care and safety, potentially linking back to issues such as falls prevention or patient safety in ambulances.
	Resolved that: The report was noted.
QGC/24/8.4	**Professional Bodies Update**

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	Ms Shingler presented reported. There are currently 11 open cases at the Nursing and Midwifery Council (NMC). Of these: • 5 cases involve Human Resources (HR). • 6 cases relate to former employees who have already left the Trust Ms. Shingler assured the committee that there has been progress in terms of oversight of agency staff referred to the NMC. The report also includes data on protected characteristics, showing that 15 of the cases involved white employees, with one individual having a registered disability on the Electronic Staff Record. Ms Dunne asked Ms Walton if we have a similar report with medics. The Trust is making progress with better oversight and reporting, particularly concerning agency staff and their referral to the NMC. Ms. Dunne asked whether there is a similar report regarding medics, comparable to the one on nurses. **Action**: Ms. Walton and Ms. Shingler will investigate the possibility of creating a combined update that includes healthcare professionals across different professional bodies.
	Resolved that: The report was noted.
QGC/24/8.5	**CQC Urgent Care Final Report and Ratings**
	Ms Shingler presented report. Ms. Shingler informed the committee that the CQC is due to publish its electronic report on 29th November 2024. The Trust's rating remains "Requires Improvement" across all areas. Ms. Shingler emphasized that the Trust's rating is unlikely to improve to "Good" until issues like overcrowding and AMS offload delays are addressed, as these are critical factors in the CQC's evaluation. Despite the challenges, Dame Julie Moore acknowledged that staff have worked extremely hard during exceptional times. She commended the staff's exceptional efforts under the current circumstances, noting that their hard work is evident even if the rating remains as "Requires Improvement. "Ms Jeffery confirmed the CQC survey has shown improvements.
	Resolved that: The report was noted.
QGC/24/9	**Committee Escalations**
	• The coroner raised concerns over the lack of a fall prevention plan, and the fall processes are currently being reviewed. These will form part of the dashboard for QGC starting in January 2025. • Ms. Shingler reported an increase in C. diff cases. The action plan to address this is being reviewed, and updates will be provided at the next committee meeting. • Ms Walton to investigate Medical Professional Bodies report.
QGC/24/9.1	**Trust Board**
	• Ms. Shingler to discuss with Ms. King the possibility of producing a paper to take to the Trust Board regarding room temperatures and the concerns around the PFI company's obligations.
QGC/24/9.2	**Other Committees**
	Nothing to note

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QGC/24/10	**Any Other Business**
	Next meeting date - 30th January 2025
QGC/24/11	**Reflections on the meeting** Thanked all for their attendance.
QGC/24/12	**Closed at 11:55**
QGC/24/13	**Acronyms**

AUDIT AND ASSURANCE COMMITTEE

Minutes of the Meeting held on Thursday 14 November 2024 at 09.00am held via MS Teams

PRESENT:

CHAIR:	Colin Horwath	Non-Executive Director
MEMBERS:	Simon Murphy	Non-Executive Director
	Karen Martin	Non-Executive Director
	Tony Bramley	Non-Executive Director
IN ATTENDANCE:	Neil Cook	Chief Finance Officer
	Emma Masters	Internal Audit
	Lynne Walden	Associate Director of Finance (Financial Services & Coding)
	Paul Westwood	Counter Fraud
	Kristina Woodward	Internal Audit
	Gwenny Scott	Company Secretary
	Leanne Hawkes	Internal Audit
	Stephen Collman	Managing Director
	Rebecca Brown	Chief Digital Information Officer
	Nicola O'Brien	Deputy Chief Information & Performance Officer (Item 006/24)
	Tom Brown	Chief Technology Officer (Item 006/24)
	Hugh Morrow	Lead Pharmacist (Item 012/24)
	Sue Smith	Deputy Chief Nursing Officer (Item 005/24)
	Sanjeev Narwal	Director of Procurement (Item 018/24)

APOLOGIES:

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

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

002/24 **DECLARATIONS OF INTEREST**

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

003/24 **MINUTES OF MEETING HELD ON 12 SEPTEMBER 2024**

The minutes of the meeting held on 12th September 2024 were approved.

RESOLVED THAT: The minutes of the meeting held on 12th September 2024 were approved.

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

The action schedule was reviewed and updates were noted.

Internal Audit

005/24 **Progress Report**

2 reports had been finalised.

2 new Terms of Reference for Internal Audit had been issued.
A review of Finance and Payroll has commenced.
The BAF review had also commenced. A new format and process was being developed. The timeframe has been adjusted slightly to incorporate the new process.
All audits had now been scoped or scoping meetings arranged.

Appendix A detailed the audit plan.
Appendix B included the 2 ToRs issued.
Appendix C outlined the Key Performance Indicators.
Appendix D was the recommendation tracker. 7 were overdue. The level of risks were included.
A meeting had taken place to review Consultant Job Plans and it was suggested that update in regard to management response in line with the action plan was reviewed at the Financial Recovery Board and the People & Culture Committee.

Ms Martin queried how false assurance could be avoided in the future in regard to actions that were not achievable. Mr Cook replied that engagement at the time was required in order to collectively agree the actions.
There needed to be clear engagement and discussion to ensure that actions are smart.

It was highlighted that there was a number of unexpected and difficult challenges which were uncovered.

Mr Horwath encouraged sight of the revised targets and asked that the People & Culture Committee had overview of progress.

CPIP QIA Report
Moderate assurance was reported for CPIP QIA. The policy was out of date and screening tools which were not fully completed. Actions had been implemented and the issues now rectified. The QIA policy had been re-written and published on the Trust Intranet.

Mr Horwath was pleased to gear of the progress made.
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Data Quality DM01
Moderate assurance was reported for Data Quality. Reporting to Trust Board had not occurred for a period due to changes in reporting metrics, a lack of a Standard Operating Procedure in place, reporting process and lack of an audit trial of checks completed. Actions had been agreed and some were due to be implemented over the coming months. 6 control areas had been reviewed but as work was ongoing, moderate assurance was provided. It was anticipated that the majority of work should be complete by December.

The confidence about the validity of our data was questioned. Ms O'Brien informed that the data submitted reflects what is in the system.

Mr Collman encouraged the triangulation of reports. Ms Masters added that the Executives were met with upon the issue of the report, however the lead Executive had now left the Trust.

The reports were noted.

006/24 **DATA QUALITY & CYBER SECURITY UPDATE**

An update was provided against national compliance, including the latest scores which were published in June. The data quality matrix is changing to a set of data fields. There is an internal target of 95% and the Trust was performing reasonably well. Maternity was reporting 86%, which relates to a data field issue on Badgernet. Only 5 fields had failed and would be reporting 99%+ once the fields were rectified. ED EPR will give opportunity for the use of SNOMED and improvements should be seen in the next submission.

Elective recovery has seen improvements along with robotic processing. There were issues with patients on duplicate pathways and a significant volume of patients going onto an elective pathway from ED attendance.

2 dedicated data quality analysis were in post and focus is on waiting lists. There is a large volume of patients that are not scrutinised externally.
Model hospital identifies opportunities and adjustments have been made within theatres and lunch breaks.
A further area of focus is ensuring that robotic automation and AI tools are securely managed. Policies and procedures are under review due to vulnerabilities.
Malware protection compliance has improved and multi-factor identification has been rolled out. Perimeter security (firewalls) had been reviewed along with back up policies. Wi-fi security had been improved and a cyber awareness campaign was run during October.

<u>Next Steps</u>
Lifecycle decommissioning of legacy operating systems continued.
Deployment of password self-reset.
Migration off the malware platform onto Microsoft defender endpoint is a CPIP planned for next year.
Cyber security dashboard has been built.
A cyber security consultant has been bought in.

Areas of concern were phishing, ransomware attacks and defence evasion.

There is an everchanging nature of everchanging risks and the need to react quickly, continuously review and improve. Centralised funding was being sought to conduct BCP tests and undertake tabletop exercises.

Risk scores have improved month on month and there is close control on monitoring. Within plans for 2025, there were DSPT submissions, a new ICS cyber strategy and a robust plan to remove end of life strategies.

Continued support was welcomed. The BAF risk remains high as it continues to require investment to provide protection.

Ms Martin acknowledged the huge amount of work that is ongoing but the recommendations are asking to support the request for a substantive position and the Committee cannot provide that approval. The risk score was also one of the highest in the organisation and the threshold for risk was queried. Mr Brown replied that there are some legacy infrastructure and estates risks. There are old

applications on unsupported systems which are unable to be patched, therefore are open to attack. Upgrades are being accelerated but work was planned over 2 years. Much of the nature is unknown. There is a Risk Management Group that meet every 6 weeks and review the risks regularly. The Trust is consistent with others reporting a level 20 risk. From a DSPT perspective, the standards are being met.

Mr Collman suggested rewording the recommendation to request open ended support. The nature of the risk will always be high. There are big consequences but a degree of it is out of our control.

Mr Horwath advised that the Committee were mindful of the everchanging nature of those wanting to do harm and assurance was provided that as a Trust, we are doing the best we can under the circumstances.

The report was noted for assurance and Committee supported the increased awareness.

007/24 **NEW INTERNAL AUDIT CODE OF PRACTICE**

There is an external code of practice and it was presented for awareness, particularly in regard to the role of the internal audit service.

Ms Hawkes added that it was not aimed at the public sector, therefore there were no actions undertaken. The global internal audit standards will be issued in January and will apply to NHS Trusts from March.

The Internal Audit Code of Practice was noted for information.

008/24 **CONFLICT OF INTEREST POLICY REVIEW**

New guidance was released in September to align with the code of governance. A review of the policy was underway to incorporate changes. Support was sought to improve the compliance position and to change the definition of decision-making staff. It was recommended that declarations are requested from band 8D up. A new system using ESR will be implemented.

The proposed changes to the Conflict of Interest Policy were approved.

Counter Fraud

009/24 **Counter Fraud Progress Report**

Mr Westwood informed that an in-year review had been completed.
Awareness work was underway. Fraud Awareness Week is taking place next week and information had been shared with the Communications team to advertise to staff.
A procurement review national exercise had taken place and a submission made.

3 alerts were reported and no risks to the Trust were identified.
Details of the open and closed investigations were included within the report.
There had been 2 referrals made which have been closed and no evidence of fraud found.

The compliance actions were reviewed. One key issue is that testing did not take place to ensure that awareness has increased or embedded with staff.

The report was noted for assurance.

External Audit

010/24 **External Audit Progress Report**

Ms Walden informed that the planning stage had commenced. It was likely that the team would remain the same as the previous year.

The report was noted.

011/24 **TRUST RESPONSE TO GOVERNANCE RECOMMENDATIONS – INTERNAL & EXTERNAL AUDIT**

Ms Scott presented the report which was linked to the Head of Internal Audit Opinion. Work was underway with Ms Walden regarding the remaining VFM recommendations.

The majority of governance recommendations had been implemented. Further work was taking place around the BAF and overview of assurance by the Board.

There were no elements of the BAF that were unusual or unexpected but it was being strengthened and would have greater oversight at the Committee and its effectiveness.

The report was noted.

012/24 **MANAGING MEDICINES WASTE**

Mr Morrow informed that the Trust was achieving 0.2% based on the first 6 months of the year. An issue was reported last year due to the failure of a cold store fridge at the Alex. The team were working with estates to resolve factors that resulted in the loss last year.

Key drivers haven't changed such as the influenza vaccine: order values had been lowered gradually due to staff uptake. Crest Pharmacy were involved with vaccines this year. Other drivers are antidotes which have to be kept in stock, however lower wastage has been reported this year. TPN work continues to be steady.

A business case for pharmacy robotics in both departments was being drafted. There would be the advantage of freeing up physical space. The Trust was one of few nationally that were yet to implement robotics. A single site aseptic unit would be beneficial from a drugs management perspective.

It was queried whether the team were working with colleagues in the Foundation Group. Mr Morrow informed that there is liaison between Chief Pharmacists regarding consolidation of single sites.

Investment, risk and timescales were queried. From a robotics perspective, there is building work related to designing for the robot which was an issue and would not be timely.

The report was noted for assurance.

013/24 **DEBT WRITE OFF**

Approval was sought to write off £51k of debts which were unable to be collected. Detail of the debts were included within the report. 12 invoices related to salaries and overseas debts.

It was queried what percentage of the overall costs overseas debts accounted for. Ms Walden replied that the total income can included within the next report. There were a number of debt write offs with overseas visitors. Unless the patient is on site, there were often issues to obtain payments and there had been a number of patients who are deceased. There was a team of 3 members of staff who provided support.

Mr Cook agreed that metrics and benchmarking including in future reports would be beneficial. Salary overpayments are comparable across the Group. Assistance had been sought from internal audit.

The Debt Write Offs were approved and Committee noted the ongoing debt recovery work.

014/24 **DEBTORS & CREDITORS £5k AND 6 MONTHS**

The report was presented in line with SFIs and internal controls are in place.
The overall total is £1.5m.

The controls in place for monitoring were noted.

015/24 **STAFF SALARY OVERPAYMENTS**

Much work was underway with assistance from Deloites. KPIs were making continued improvements.
Deloites had highlighted 2 recommendations: Enhanced communication and additional training.
The biggest issue is medical staffing, but the same processes will be utilised.
The Trust is one of the lowest in terms of overpayments, following a recent review.

The report was noted.

016/24 **SFI & SOD BREACHES**

Assurance was provided that all breaches are recorded once known. Details of where and how they occurred was included within the report.
There were a number of breaches within one division. A training session was being held to drive improvement.
Mr Cook added that the team meet with individuals concerned to improve engagement.

Mr Horwath informed that the Committee had been concerned about consequences previously and welcomed the improvement.

The report was noted for assurance.

017/24 **LOSSES AND SPECIAL PAYMENTS REPORT**

The report covered the period of October 2023 to September 2024.
Expired stock related to pharmacy stock.
2 bad debts were detailed in the report. The biggest loss related to patient property at £16k.

The report was noted.

018/24 **TENDER WAIVER REPORT**

Mr Narwal informed that the number of waivers are reducing. The volume is higher than the last period but the value is less.
There were a number of large waivers, particularly relating to fire training, repairs of fire doors and inspections. A contract manager was now working with the estates team.
A contract was now in place for taxis.

Waivers across divisions have reduced.
Corporate is an area to be reviewed going forward. Waivers were often generated as there is no alternative such as training and items not on frameworks.

Accountability was an area of active focus. Estates, corporate and surgery created the highest amount of waivers. A dashboard was being developed across the 4 hospitals in the Foundation Group.

Staffing and capacity had been challenged and it was asked whether it still remained an issue. Mr Narwal informed that there is an underspend of £120k which equated to 2 positions. An interim had been bought in to work on the CPIP programme. The structure was being reviewed next week with the Foundation Group. There had been difficulties with suitable candidates but the posts would be readvertised in January. Apprenticeships and developing our own staff was preferable and opportunities were in place.

Significant problems with NHS supply chain and their own capacity issues had previously been reported, impacting upon the Trust. National meetings were taking place with the Advisory Board but there were likely no quick improvements.

The report was noted.

019/24 **BOARD ASSURANCE FRAMEWORK**

The BAF was presented which now included the actions, which demonstrates there are gaps. The formal would be updated as it currently limits the detail required.

The review was welcomed.
Ms Martin highlighted the culture risk referred to the 4ward improvement system, which was in the process of re-framing. The workforce and financial planning risks lacked some actions around specific points.

The Board Assurance Framework was noted.

For Information

020/24 **Any Other Business**

There was no other business.

021/24 **Committee Escalations**

Job planning and amended targets to be reviewed by People & Culture Committee.
Cyber and backlog maintenance.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Microsoft Teams Meeting
Tuesday 3rd December 2024 at 10:00

Present		
Chair	Karen Martin (KM)	Non-Executive Director
Members	Colin Horwath (CH)	Non-Executive Director
	Jules Walton (JW)	Interim Chief Medical Officer
	Stephen Collman (SC)	Managing Director
	Sue Sinclair (SSi)	Non-Executive Director
	Sarah Shingler (SSh)	Chief Nursing Officer
	Richard Haynes (RH)	Director of Communications & Engagement
	Liz Faulkner (LF)	Deputy Chief People Officer
	Bianca Edwards (BE)	Assistant Director of People & Culture
	Rich Luckman (RL)	Assistant Director of People & Culture
	Mel Stinton (MS)	Freedom to Speak Up Guardian
	Chris Douglas (CD)	Acting Chief Operating Officer
Attendees	Tracey Baldwin (TB)	Divisional Director of Nursing (SCSD)
	Stephen Goodyear (SG)	Divisional Director (Surgery)
	Heidi Napier (HN)	Lead Consultant Psychologist
	Joanna Chant (JC)	Organisational Development Practitioner
	Mark Stanley (MSt)	Organisational Development Practitioner
Apologies	Ali Koeltgen (AK)	Chief People Officer
	Julie Moore	Non-Executive Director
	Neil Cook	Chief Finance Officer
	Julian Berlet	Interim Chief Medical Officer
	Justine Jeffery	Director of Midwifery

Ref		Action
083/24	**Chairs Welcome and Apologies for Absence**	
	KM welcomed all attendees to the meeting and the apologies received were acknowledged above.	Chair
084/24	**Quorum and Declarations of Interests**	
	There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website. KM confirmed that: a) A Quorum of the P&C was present. b) There were no declarations of interest.	Chair
085/24	**Action Log and Minutes of the previous meeting**	
	The minutes of the last meeting held on the 7th October were reviewed and agreed as a true and accurate record. The ongoing action log was reviewed and updated accordingly	Chair

086/24	**Job Planning Audit**	JW
	JW presented the papers to committee for approval to combine actions from the internal audit with existing job planning actions, to create a singular action plan. SSi noted the widespread general unrest in the medical community and added that the Trust needs to be mindful to maintain goodwill. The Medical Revalidation policy states that Doctors must have an up-to-date job plan, and the Trust has now stated in a publicly owned document that a significant number of staff do not have one. The GMC requires relevant documentation in order for staff to revalidate, and SSi noted her concern that the Trust has allowed revalidation without the policy being implemented properly. JW advised that this has not previously been stated in the Trust's documentation, and that it would therefore be unfair to implement this for Doctors currently in the revalidation cycle. Moving forward, it will be expected to have an up-to-date and compliant job plan as part of the appraisal process. The appropriate environment and processes needed to be in place to facilitate this before enforcing compliance. SSi asked whether payment will be forthcoming for consultants who have worked more than 12PAs and not been paid for this, and JW advised that this could potentially be the case. CH referred to the percentage of staff without a current job plan and asked what interim arrangements are in place to gain insight into the work that is being done. JW responded that the rotas show the work that needs to be done in order to deliver safe services, but job plans illustrate the details and create an image of the service as a whole. The long-term aim is to have job planning aligned and for it to be a prospective agreement detailing what the Trust needs the consultant body to deliver over the next 12 months, to meet its objectives and deliver the services needed. CH asked if JW has sufficient support from the Board, and she responded that she feels supported, including from HR and operational colleagues. JW asked for understanding from the Board that this issue has been escalating over several years, so will take time to resolve. KM asked if September 2025 was an achievable timescale for all colleagues who require a job plan to have one in place, and JW confirmed that the goal is to have most job plans completed by September. KM commented that there will be lessons to learn for the organisation in terms of signing off action plans that are now non-deliverable. It was agreed for the action plan to be monitored through this committee.	
087/24	**Staff Story – Sexual Safety Complaint**	MS
	MS informed the Committee that the staff member involved wished to remain anonymous but agreed for her story to be shared. The female staff member had raised a Freedom to Speak Up concern via the online portal regarding the behaviour of 2 male staff members when she visited a front facing service. Some of the behaviours involved were pointing, whispering and staring. She felt that they had disregarded what she had said and that they did not want to help her.	

	Following submission of the concern on the portal, the issue was quickly escalated to the Director overseeing the service. The manager investigated the situation and actions were agreed. The service advised that one of the individuals involved on the day was not a permanent member of staff but had been asked to cover sickness at short notice. They were informed of how their behaviour had made the member of staff feel and agreed that all staff should be made to feel welcome, respected and comfortable. A document has now been produced to remind staff in the service how to greet colleagues accessing the service. The individual who raised the concern felt reassured that the issue had been addressed quickly and thoroughly. MS noted that the experience highlights that misogyny is still present and advised that the government are considering making this a hate crime. KM appreciated that staff involved had acknowledged how their behaviour had made the individual feel and then learnt from it and KM asked for this feedback to be shared with them. SC commented that stories such as this should be communicated widely, especially as there has been positive action by the manager, including in-depth communication and prompt action to resolve the issue. LF shared that NHS England have launched a national policy framework and accompanying e-learning packages and actions will be brought back to the next Committee meeting on how the Trust can incorporate the resources available.	
088/24	**Chief People Officer Report**	
	LF summarised the report and highlighted the key workforce pay impacts from the autumn budget announcement: • The delay in having a national award agreed has the potential to impact band 2 staff, as the Trust needs to ensure they are paid above national minimum wage. The government has committed to bring forward agreements in future. • The sexual misconduct policy has been shared by NHS England and this will be brought to the next Committee meeting with plans on how the Trust will utilise the national policy framework. • Review of statutory and mandatory training by NHS England – The 11 core skills are being reviewed with the aim to streamline processes and remove repetition to make a better experience for staff.	
089/24	**People & Culture Updates**	
	Progress with Trust's Values RL advised that throughout early leadership conversations, workshops held on all sites, and conversations in team meetings, over 500 staff engaged in developing the Trust's values. Thes values were replayed and sense-checked with those same groups, and then shared at the leadership conference held in October. The values are being open and honest, ensuring people feel cared for, and showing respect to everyone. The next stage is to develop behaviours that align with the values.	RL

	Cascade packs including a video and a group activity, have been developed for people to take back into their teams to gather thoughts and feedback on behaviours. RL advised that they are anticipating being able to report on the feedback by the end of January. The new values and behaviours will be launched and begin embedding in March, however there is considerable work to do to sunset the existing materials between January and March. The values will need to be drip fed into the organisation and built into new processes and operating language. After March, the values will also be incorporated into early resolution work. KM recognised that it would take time for the values to be well embedded and commented that some departments are already aware of the new values, whereas others are not. RL confirmed that they would be looking for a January-March timescale for staff to have name recognition.	
090/24	**Medical Agency Reduction Plan (Outcomes from deep dive)** LF advised that the medical agency deep dive had been stood down due to site escalations but December FPE's will be repurposed to focus on job planning and medical agency. Key outcomes from this will be presented at the next committee meeting. There is some progress and reduction within urgent care regarding non direct engagement. Surgery division have also been working closely with NHS professionals to reduce agency rates so that the Trust is better aligned to the agency cluster rates. The Nursing and Midwifery Midlands programme to reduce all agency above price cap compliance by the end of March 2025, is seeing positive progress. A medical agency programme to mirror this will be set up and it is anticipated before the end of the financial year. This will provide an opportunity to learn from what other Trusts have done to reduce their agency spend across the Midlands. KM recognised the improvement that has been made and that the work is gaining traction and asked whether the longest serving locums are being reviewed. LF advised that this information is anonymised and included in the IPR, for increased visibility. Information on both the highest costing locums, as well as the longest serving have been shared with HRBPs so they can work with Divisions to develop swap-out plans.	LF
091/24	**Staff Survey campaign & next steps** MSt confirmed that last year the Trust achieved a response rate of 31%; the lowest in more than 5 years and around 17% below the national average. The staff survey is vital to understand what is happening on the floor and informs work happening across the board. A stakeholder event was held in the summer to understand the reasons for the low response rate, and what actions could be taken to improve it. A detailed promotional campaign was developed to keep the momentum going throughout the duration of the survey. Feedback was received that the Trust had been too reliant on digital communication in the past, so this year the team tried to create more physical	MS/RL

	resources and carry out floor-walks to promote the survey to staff in person. Staff were signposted to the new intranet site, which included a myth-busting video to tackle common misconceptions. Social media, desktops and articles on The Source were also utilised to highlight examples of "you said, we did". Feedback was also provided regarding limited access to PCs in order to complete the survey. This year, a staff survey area was created at each site with laptops setup for staff to drop in and complete. The Trust achieved a response rate of roughly 46%, which is a 15% increase on last year. Buy-in and engagement from divisions has been considerable and regular updates have been shared with them to cascade to their teams and push for more engagement. Every division has surpassed their response rate from last year and all are above 40%. Key improvements are in Urgent Care; having achieved 25% last year, and 46% this year, and Estates; which achieved 20% last year and 45% this year. Floorwalking on all 3 sites was well-received and feedback was received in real-time as to why some staff were not completing it. This provided an opportunity for the team to reassure them particularly regarding confidentiality concerns. There is a gap between the survey closing and full results being received, and the team are intending on filling this period with more information about things that have gone well. Initial results are received before the end of year, and these are mapped against the People Promise. MSt noted that a higher response rate this year may make difficult reading but will provide richer feedback to work with as being more representative of the workforce. Headline results will be received end of January with an embargo date. In spring, full results will be communicated and development will start on a simple action plan. Historically, a considerable amount of time has been spent on detailed action plans with little actual progress. the team are aiming to simplify this, to make it specific and meaningful for Divisions to take ownership of. Divisional focus groups will be held to maintain engagement. RL shared that feedback from staff has been that they don't know what happens with the results or cannot see or feel any difference that it makes. The team will be supporting Divisions to create staff forums, where staff at any level can join to understand the results with management, HRBPs, OD and the Improvement team, and work through strengths and opportunities for improvement. RL observed at the Leeds visit that the Staff Forums were utilised to push forward on the actions identified and gain traction.	
091/24	**Reciprocal Mentoring** JC explained that the programme had launched prior to the pandemic but had not been sustained. The aim now is to review and simplify the programme.	JC/RL

	Starting with Executives and senior leaders will demonstrate commitment to the programme and encourage buy-in from other staff members. The lived experiences that decision-makers will hear, regarding how existing policies, procedures and practices impact different groups of people, will be a catalyst for change. The existing coaching and mentoring platform will be used to match mentors with mentees and track progress. Training will be available for both mentor and mentee in how to support each other in managing the relationship effectively. A 45min/1hr workshop for board development in February 2025. Resources are in the process of being uploaded to the OD hub on the intranet. Feedback will be requested at the end of each relationship to understand what went well and any barriers or opportunities for improvement. SC raised that both parties need to be clear on the role of the Executive or NED involved, and that some staff may feel that they will be able to solve the problems they are being presented with, and not understand that their position is to learn about their experience. Psychological support also needs to be readily available for staff recounting difficult stories. SC commented that programme needs to be discussed with Executives and divisional leadership teams to gain buy-in. JC advised that all staff networks will be invited to participate as part of the first cohort. KM confirmed support and commitment from the committee for the proposal to be taken to TMB.	
092/24	**WRES and WDES Action Plans** RL presented the Trust's equality standards for race (WRES), disability (WDES) and sexual orientation. There have been improvements in WRES, however there has been some deterioration and stagnation in the WDES. The key indicators of concern are regarding reasonable adjustments and staff experiencing discrimination. The team have been working with Occupational Health to create a business case to provide support to managers and employees regarding reasonable adjustments. Alongside this, there needs to be better education and training for managers to make reasonable adjustments at pace. RL informed that it is being picked up through various channels including FTSU, the DAWN Network and the WDES indicators, that staff who are disabled feel their experience at work is not as good as those without protected characteristics. The launch of the new values will tie into understanding the experience of staff with a disability. Over the coming months, the resource allocated to support EDI will be reviewed, as it is prioritised in the people strategy as requiring improvement. In the Trust's latest EDI report 4% of the organisation declare a disability, however it is anticipated that when the staff survey results are received in January, more people will declare a disability. **ACTION – DAWN network to attend the next meeting, particularly to discuss WDES data.**	RL

	CH queried whether it is a training issue for managers, or whether they may feel constrained by resources. RL responded that more in depth conversations are needed with staff who have long term conditions to understand where the barriers are. RL acknowledged that managers are stretched and that where staff need additional support, they are possibly not as visible as they could be, however the Trust is slow to act on advice provided by Occupational Health. The agreed business case will provide this support to managers in arranging the reasonable adjustments more quickly. SSh emphasised the importance of the values of care and compassion, in identifying disabilities that may otherwise be hidden. Through understanding some recent disciplinary cases, early identification of a hidden disability could enable support to be put in place sooner and avoid escalating issues. RL advised that the reports have been approved by TMB and KM confirmed the committee's approval for publishing.	
093/24	**EDI Annual Report** RL presented the report and highlighted the positive steps that the Trust has made in the last year regarding EDI. Project Search has been highlighted as a key success, supporting local young people with learning disabilities in gaining work experience and progressing to achieve employment with the Trust. The EmbRACE and Faith networks have been crucial to the Trust in navigating the last 6 months, providing support during the riots and social unrest. The recent Divali celebration also brought joy and positive energy to staff. The committee approved for publication on the Trust's website.	RL
	Other Updates for Committee	
094/24	**Alex Theatres – Progress against action plan** TB advised that work is progressing well to improve the culture in the Alex Theatres. The cultural barometer survey has been revisited and the team are awaiting the results. 18 months ago, roughly 75% of senior staff were on sick leave due to experiences at work, however this figure is now 0 which reflects the improved culture. Having Stuart Coleman as Matron has been invaluable as he continues to engage with staff, have open and honest conversations, encourage reporting on Datix where there have been incidents. There have also been training days focussed on the Trust's behavioural charter and sexual orientation charter. KM raised that feedback from past walkabouts has been that further communication was not received after Datix's were submitted. TB advised that there is a better relationship and communication between SCSD and Surgery governance teams now where they are able to share learning and feedback, and teams are confident that process of providing feedback is more robust.	TB/SG

	SG agreed with TB's comments and added that this results in a quicker resolution and with greater transparency. This also means there is greater opportunity to resolve through informal methods such as mediation where appropriate. Those that need to be escalated are flagged as a concern between both governance teams. The teams are also observing fewer formal processes regarding equality and diversity being enacted due to the learning and timely informal resolution. Rainbow badge training and Civility Saves Lives have been cascaded to all Directorates and there is a frequent exchange of information between leaders. SG agreed that they are expecting to see an improvement in the results of the cultural barometer survey.	
095/24	**HEE Midwifery Students Report** Item deferred to February due to apologies.	JJ
096/24	**Freedom to Speak Up Report (quarterly)** MSt provided a summary and highlighted that there has been a significant reduction in the number of anonymous concerns being raised; from 45% to 25%. A higher percentage of staff willing to put their name to their concern means a better experience and that feedback can be provided back to them. Speak Up training compliance is above 80% in all divisions and Listen Up training has been scoped. Site walkabouts with KM have been continuing, and their recent visit to Mortuary at WRH was positive, with staff speaking about the people in their care with compassion. MSt highlighted a growing trend in concerns related to misogyny. This has been raised with AK as Chief People Officer, and agreed there needs to be further work on sexual safety across the Trust. KM asked if the Listen Up training will be mandatory for all staff, and MSt confirmed this has been worked through with Louise Pearson and approved by the Nursing & Midwifery meeting. JW confirmed that this is awaiting approval at the Chief Medical Officer meeting. **ACTION – CMOJW to confirm approval of Listen Up training at CMO meeting.**	MSt
097/24	**Staff Psychological Wellbeing Service Annual Report** Funding was approved in 2022 for 1.6 WTE clinicians for the staff psychological wellbeing service. The service has been fully staffed from May 2023, with referral rates peaking in October 2023. Issues are predominantly anxiety, work-based stress and home stress. The benefits of a system approach is recognised, including Occupational Health, HR, OD, Talking Therapies and community mental health teams. Since its launch, the need for the service has grown exponentially and the waiting list has increased to 12 weeks. The team are considering expanding the service, and this will require further investment as well as into OH and HR.	HN

	Self-referrals from staff are accepted as well as referrals by managers, but confidentiality is maintained, and the managers will not receive further updates. Referrals will be acknowledged within 24hrs, triaged and offered a crisis triage appointment in less than a week if deemed urgent. The team holds weekly service huddles to discuss the appropriateness of referrals and provide information to staff regarding how long they could be waiting for an appointment, signposting to other services for support as necessary. During an initial appointment, the staff member is seen by a Clinical Psychologist who carries out an assessment, care planning and agrees on goals. The service can also support with necessary critical incident debriefs and team referrals, in addition to 1:1 support. Feedback from staff is consistently positive and 96% would recommend the service. There is a continued focus on outcomes and experience measures, for example an indicator that a goal has been achieved. The team triangulate their data with sickness absence across the Trust in each division, ensuring referrals to the service are reflective of the greatest need. KM noted that the number of corporate referrals is significantly higher than any other division and asked if this could be due to being more aware of the service. HN agreed that awareness needs to be increased across all divisions as well as all staff groups. HN confirmed that there is an online employee assistance programme in the form of telephone counselling. KM noted that it can be stressful for staff involved in a grievance or disciplinary process and suggested a staff story at a future committee meeting on a member of staff's experience of this. KM noted it was beneficial to have the sickness absence graphs showing the impact of the service and keeping staff in work. CH asked if HN feels assured that there are effective lines of communication back into the Trust to learn from mistakes. HN advised that they can link back in with managers if there is a learning opportunity if the staff member is happy for this to happen	
098/24	**Governance**	
	People & Culture Risk Register There were no additional risks or closed risks reported. The 2 risks that are over 15 regarding the temporary workforce, and job planning compliance have already been covered within the agenda.	LF
099/24	**Any Other Business (AOB)**	
	None.	
100/24	**Date of Next Meeting**	
	The date of the next meeting is 4th February 2025, Colab, Kidderminster Treatment Centre.	

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT

Report to:	**Public Board**
Date of Meeting:	**03/03/2025**
Title of Report:	Board Assurance Framework and High Risk Report
Status of report:	☐**Approval** ☒**Assurance** ☐**Information**
Report Approval Route:	Other
If Other, provide details:	Executive Risk Management Committee
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Gwenny Scott, Company Secretary
Documents covered by this report:	Board Assurance Framework and High Risk Report

1. Purpose of the report

The Board Assurance Framework (BAF) in its current form is held on Datix, the Trust's Risk Management system, alongside the Trust's risk register. The BAF represents a report from the system, which is presented monthly to the Executive Risk Management Committee (ERMC) for review together with all the Trust's high-scored risks.

A revised BAF format is in development and the attached interim report is presented to the Trust Board to provide assurance as to the regular oversight of the individual risks within the Trust's governance structure.

2. Recommendation(s)

The Trust Board is asked to:

- Note the interim BAF report and summary high risk report.
- Take assurance from the report as to the oversight of individual risks within the Trust's governance framework.
- Note the plans to develop the BAF format and to present this to the Board in April 2025.

3. Chief Officer/Executive Director Opinion[1]

The Chief Nursing Officer is reviewing ERMC to enhance its focus on assurance and strengthen oversight and reporting to the Board.

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

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

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

Board Assurance Framework Report March 2025

The Board Assurance Framework is currently undergoing a revision with a view to providing a more digestible format, incorporating additional information and increasing the focus on assurance and actions to reduce risks in line with the target scores.

This work will be completed in tandem with planned developments of the Executive Risk Management Committee, which will increase its focus on assurance from subcommittees responsible for overseeing non-clinical risks and enhance its oversight of clinical division risk management processes and effectiveness.

The Executive Risk Management Committee will provide a regular escalation and assurance report to the Board to strengthen the Board's oversight of risk management and non-clinical regulatory compliance.

The Board Assurance Framework will also be refreshed in the new financial year to align with the updated Trust strategy.

The attached interim report sets out a summary of the current Board Assurance Framework risks and the Trust's highest scored risks (scored 15+).

The clinical divisions oversee divisional risks within their respective divisional governance arrangements and provide regular updates to the Executive Risk Management Committee.

All risks score 15+ are reviewed regularly by the Executive Risk Management Committee, with scheduled deep-dive reviews of risks within each division scored 12+.

All corporate or Trust wide risks/related assurance, are overseen by the Board committees and sub-committees within the Trust's governance structure. This structure includes committees related to quality of care, health and safety, finance, workforce digital and strategy.

Board Assurance Framework Risks

Ref	Title/summary	Current score	Target score	Committee Oversight
5475	Risk to staff health and wellbeing due to operational pressures.	12	9	People and Culture
5474	Risk of a failure to sustain a positive change in organisational culture.	12	6	People and Culture
5473	Risk of insufficient workforce capacity	16	12	People and Culture
5479	Ability of the System to manage flow across the Urgent and Emergency Care Pathway	20	8	Finance and Performance Executive
5485	Delivery of operational capacity plans	20	10	Finance and Performance Executive
5481	Cyber Security	20	10	Digital Strategy
5480	Digital infrastructure	12	12	Digital Strategy
5491	Delivery of financial plan	20	10	Financial Recovery Board
5492	Insufficient capital funds to deliver Trust's objectives	15	9	Strategic Programme Board
5483	Carbon reduction	10	6	Green Steering Group
5484	Maturity of PLACE	12	6	PLACE Board
5486	Tertiary Partnerships	12	8	Strategic Programme Board

High Risks (15+)

Ref	Risk Description	Current score
4205	Risk of not being able to manufacture SACT within the Trust as a result of existing aseptic units working at capacity.	16
3648	Risk that equipment required for sterilisation of surgical instruments will fail as a result of aged infrastructure.	15
4773	Risk of delayed implementation of the Digital Care Records Programme, resulting in failure to realise quality benefits in a timely way.	20
5744	Risk of patient harm and operational pressures related to the incidence of COVID infection.	16
3603	Risk that the Trust will be subject to a cyber-attack resulting in loss of personal data and disruption to core services	20
4084	Risk that by not replacing power a severe data centre failure will occur, leading to loss of digital services.	16
5124	Risk of breakdown of sterile services washer disinfector equipment (AGH), impacting service delivery.	15
5568	Risk of failure to comply with national digital clinical safety standards.	16
5498	Risk that without new data storage, significant failures could occur, leading to loss of clinical systems	16
5138	Risk of increased equipment downtime within Cath Lab due to issues with x-ray machines.	20
4115	Risk of fire compartments being compromised due to damaged fire doors	16
5511	Fire compartmentation is compromised due to the use of Mandolite being past its suggested life span at Alexandra Hospital	20

5820	Increased Demand for BCG Immunisations beyond clinic resources	15
5692	Job Planning Compliance	16
3643	Lack of assurance relating to sharps safety leading to avoidable staff harm	16
5576	Lack of availability/suitability of trained Estates Authorised Persons	16
5614	Risk that due to lack of capacity within theatre that women's surgical treatment for breast cancer will be delayed	16
4816	Operational pressures limiting infection prevention and control practice	16
5793	Risk that the reopening of the PDU area to admit patients due to operational pressures could impact quality of care due to suitability of the environment.	16
4964	Patients and staff will come to harm due to ED crowding.	20
3908	Patients arriving by ambulance may come to harm if they cannot be safely brought into the ED due to crowding	15
5329	Delays in specialty reviews following referral by the Emergency Department team	16
5806	Timely access to trauma beds due to high demand.	15
5260	Inadequate specialist nutritional nurse capacity	16
5575	Risk of delay to patient pathways due to typing backlog	16
4824	Re-opening beds in COVID contact bays	15
5440	Risk of mixed sex accommodation breaches for stroke patients from due to increased demand and patient flow challenges.	16
5694	Risk of delay of patient treatment on Lung Cancer Pathway	16
5675	Risk of Echocardiography data not being accessible to clinicians due to current software system not functioning correctly	20
5410	Risk of increased length of stay and service disruption if ward 12 is surged into ward 16.	16
5189	Risk of loss of acute MRI service at WRH as a result of MRI scanner being end of life	16
5592	Risk of patient harm and increased length of stay, due to decreased levels of medical staffing on general medical wards.	20
3341	Risk of patient harm due to C.difficile	15
4873	Risk of breach of best practice target of 36 hours to theatre for repair of fractured neck of femur	15
5461	Risk of patient harm if discharge lounge remains open overnight due to patient flow pressures	16
5545	Risk of unstable service delivery in Dermatology due to reliance on insourcing.	16
3761	If we do not upgrade the telephone systems, critical services will stop working.	16
5133	Risk to external telephone lines and services	20
5625	Risk of an over reliance on temporary workers leading to increased costs and potential impact on provision of patient care.	16
4875	The Ambulance Service Rapid Release Protocol may compromise safety for patients and staff in the ED	16
5807	The current wound assessment documentation in EPR risks inappropriate or inaccurate documentation.	15

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

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

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