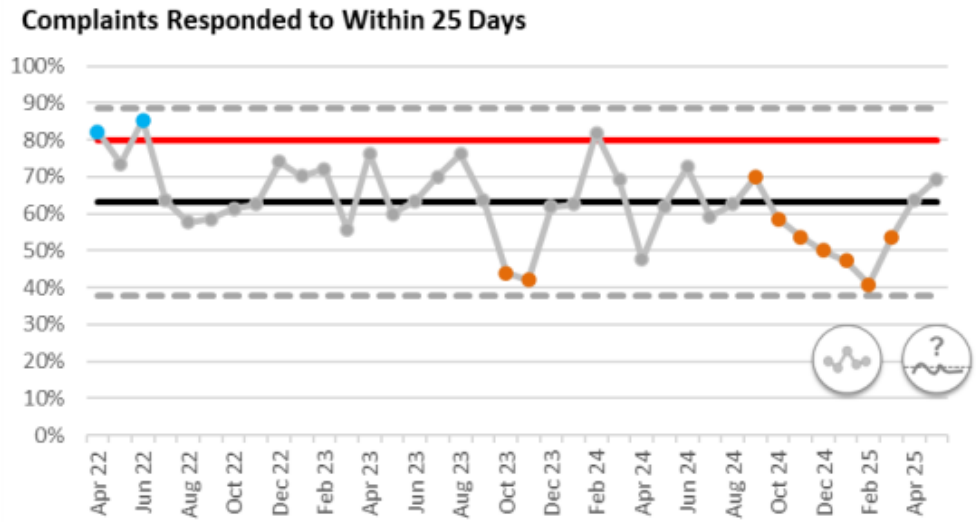
OUR QUALITY AND SAFETY - COMPLAINTS

We are driving this measure because

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



Understanding the performance

- Compliance with complaints closed within 25 days increased for the 3rd consecutive month to 69.35% in May-25 but did not meet the target.
- This metric is showing common cause variation.
- In total there were 83 new formal complaints received within May-25 with 16 (26.23%[1]) called within 5 days to discuss the complaint.
- The Trust had 116 complaints still open at the end of May-25, of which 11 have been reopened.
- Of these 116 complaints, 24 have breached 25 days (4 of which have been reopened).
- Surgery Division accounts for 46 (39.7%) and Urgent Care Division accounts for 29 (25.0%), of the open complaints.

[1] *The Denominator used when calculating the "% New Formal Complaints Telephoned in 5 Days" excludes those New Complaints received in the last 5 working days of the month*

Actions (SMART)

- Trust complaints are being closely monitored by both the Complaints team and Divisional Governance teams.
- An active initiative by way of Responding to Complaints training and monthly Complaints Review Meetings are in place to promote and monitor the benefits of a Lead Investigator call within 5 working days, focusing on:
  - Specific: Establish the lead investigator and provide a clearly defined point of contact for the complainant within 5 working days.
  - Measurable: Ensure a full understanding of the complaint by documenting key issues and concerns discussed during the Lead Investigator call.
  - Achievable: Draft Terms of Reference (ToR) during the Lead Investigator call to support a comprehensive response and streamline the complaints resolution process.
  - Relevant: Address complainant concerns effectively to reduce the need to raise additional issues, aligning efforts with Trust priorities for timely resolution.
  - Time-bound: Collaborate with divisional governance teams to consistently meet Trust timeframes for complaints resolution.
- The complaints team continue to work closely with Divisions/Divisional Management Teams to offer support to meet the Trust timeframes

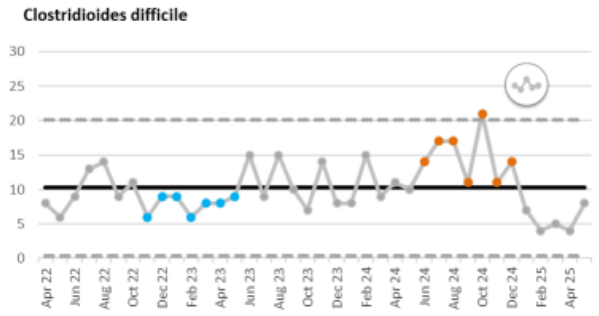
Risks

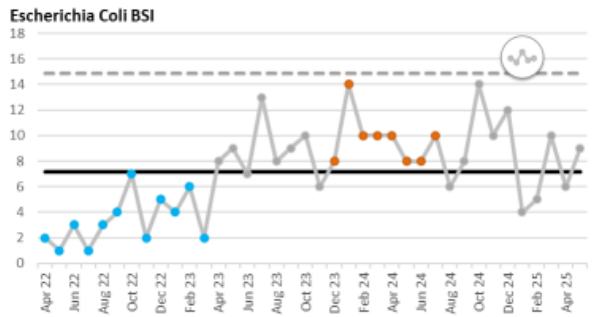
- Reputational Damage, further resource depletion due to ongoing correspondence with extended open cases, distress to patients and relatives

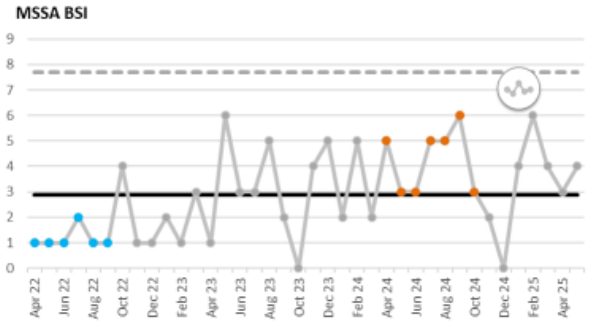
OUR QUALITY AND SAFETY – INFECTION PREVENTION & CONTROL (IPC)

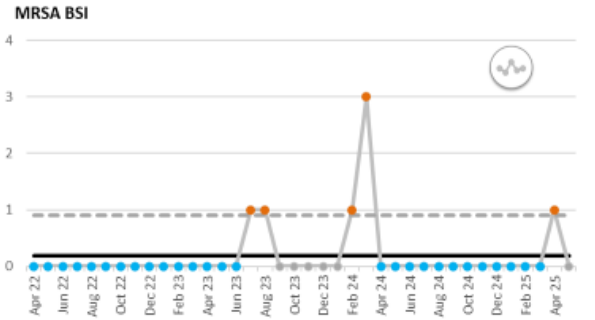
We are driving this measure because

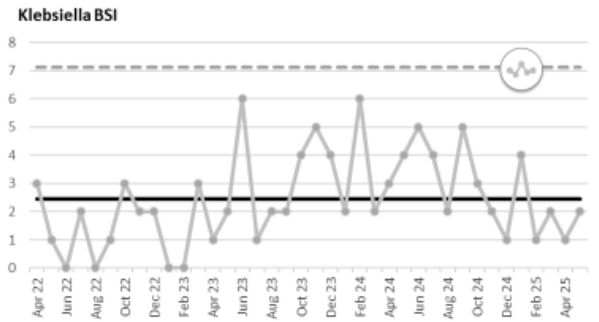
There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.

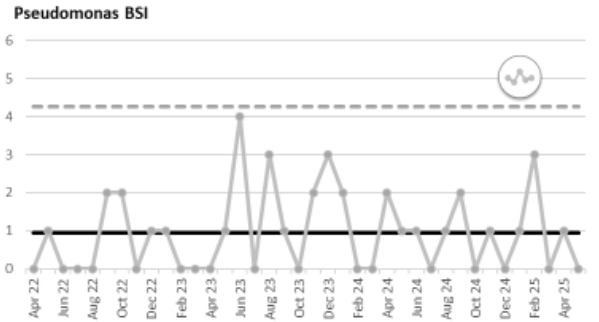


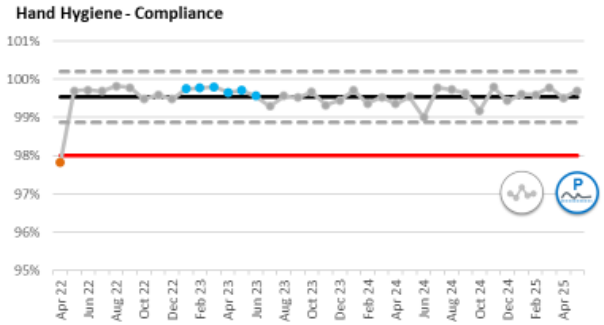


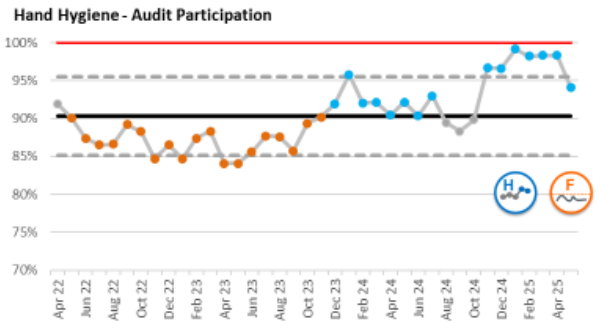












Understanding the performance

- *Clostridiodes difficile* (C.diff) **increased** in May-25 (8 c.f. 4 in Apr-25) but is showing common cause variation.
- E-Coli BSI **increased** in Jun-25 (9 c.f. 6 in Apr-25) but is showing common cause variation.
- Internal ambition: MSSA BSI **increased** in May-25 (4 c.f. 3 in Apr-25) but is showing common cause variation.
- MRSA BSI **dropped** in May-25 (0 c.f. 1 in Apr-25) and is showing common cause variation.
- Klebsiella species BSI **increased** in May-25 (2 c.f. 1 in Apr-25), but is showing common cause variation
- *Pseudomonas aeruginosa* BSI **dropped** in Jun-25 (0 c.f. 1 in Apr-25) , and is showing common cause variation
- Hand Hygiene Compliance (99.7%) has met the target (98%) every month since Apr-22 and is showing common cause variation.
- Hand Hygiene Audit participation **dropped** slightly in May-25 (94.1%) but is still showing special cause variation of improvement.
- All 11 of the High Impact Intervention (HII) audits were compliant (95%) in May-25

Actions (SMART)

- Focus during May has needed to be on respiratory infections and diarrhoea and vomiting to support capacity and flow, given very high numbers of patients with influenza, as well as COVID, and Norovirus infections.
- Divisions have reviewed patients with C.diff from April and May and presented to the TIPCC HCIA Scrutiny and Learning Group. Two CDI hotspots were identified and CDI audits completed. Action plans are in place to address learning which will be fed into TIPCC in May. Actions included completing D and v risk assessments, ensuring C.diff is discussed at huddles, completing antibiotics audits, increase commode audits.
- The team participated in the system meetings led by NHSE to review C.diff and continue to attend the weekly NHSE briefings. A new task and finish group is being established for 2025/26 by NHSE to focus solely on C.diff and the Trust will participate in this. The Trust is also attending the CDI review meetings instigated by the ICB focusing on the identification and treatment of C.diff relapses.
- Our internal ambition for no more than 40 cases of MSSA per year will remain in place for the new financial year.
- A meeting was held in May to review the MRSA bacteraemia to determine in there are any lessons to be learned. Information sharing between organisations was highlighted, UHB are developing a document to ensure patient treatment plan and care is shared.
- The team promoted hand hygiene and scrub the hub for clean your hands day in May.
- IPC link worker days have been held at both sites with the emphasis on hand hygiene, HCAIs and cleaning going back to basics.
- New NHSE thresholds have been released in June 2025 with our C.diff and klebsiella thresholds remaining unchanged. Our E.coli and pseudomonas aeruginosa thresholds have been reduced.

Risks

- Capacity: Level 4 actions impact on IPC actions as planned meetings involving clinical staff have been cancelled.
- The level of activity and high level of bed occupancy limits the ability to isolate patients in a timely manner, increasing risk of infection spread. This has been particularly challenging during this winter period due to high number of respiratory symptomatic patients including COVID-19, flu and RSV and patients presenting with diarrhoea, vomiting and Norovirus. The impact is mitigated where possible, but a number of patients with infections have been unable to be isolated. This has impacted on the cleaning and deep cleaning of areas. Continuing bedpan washer issues impact the ability to undertake high level disinfection of bedpans and other items. Work on a solution is in progress with trials of equipment taking place.

OUR OPERATIONAL PERFORMANCE

Chris Douglas

Chief Operating Officer

Throughout May we have continued to see high demand in our Emergency Department for both patients arriving by ambulance and those self-presenting with over 8,000 patients attending our Emergency Department on the Worcestershire Royal site. Despite these high attendances we have seen increases in the number of patients who leave our department within four hours and fewer patients are in our departments for more than 12 hours. There is still a significant challenge for us to improve over the coming weeks and months, ahead of what is expected to be another challenging winter period. We're increasingly focussed on a small number of priorities for improvement across the Urgent Care pathway and are working with system partners, with support from the Emergency Care Improvement Support Team (ECIST) to work on how we ensure that patients who really need the clinical expertise in our Emergency Department are able to access it quickly and effectively, and patients whose care needs can be more appropriately met by other services are directed to these alternatives including the county's Minor Injury Units, primary care and our community teams.

We have yet to find a solution to our high bed occupancy, and this continues to be the biggest focus – looking both at our internal approach to enable patients to leave our hospitals as soon as possible once they are 'discharge ready' so that we can mee the needs of those patients with the most acute care needs. We have continued to occupy additional ward spaces at additional cost and reliance on support from nursing teams through our bank or via agency.

We know that every move between wards may cause a delay in a patient being able to leave our hospitals, so we have taken the decision to reconfigure some of our wards to increase the number of beds available to patients under the care of both our Stroke and Trauma teams.

After a period of improvement, the timeliness of our care to patients with cancer has deteriorated for the second month in row. Colleagues are working hard to recover our performance but the significant decrease in our compliance with Faster Diagnosis standards means we are taking too long to make a diagnosis for those patients with suspected cancer. Working differently within and across teams is the priority to make further improvements to respond to what is now a more sustained increase in referrals. The focus on delivery for our patients remains the key focus of our teams and every specialty is monitoring and managing the situation closely, but there is clearly more to do, and we have increased the oversight in this area as a result. We do need to resolve some significant capacity challenges in oncology and are working with commissioners to enable us to do this in the best interests of our patients – this is taking too long. We are also challenged in some specialties where we are reliant on partner organisations for elements of the pathway and we are working with the Cancer Alliance and commissioners to seek solutions. There will always be more we can do make improvements internally and every tumour site has refreshed its improvement plans as we continue performance recovery journey.

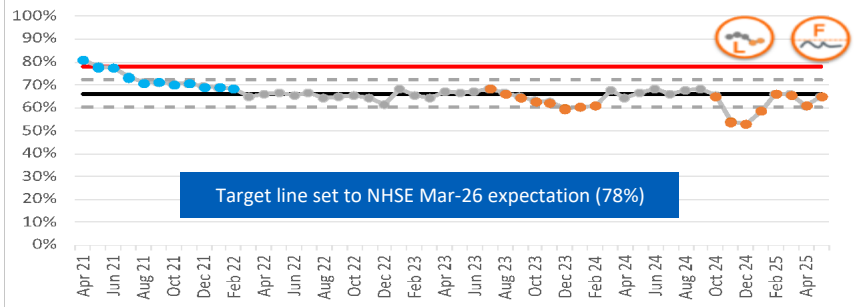
We're continuing to sustain our elective performance position and now need to step up the improvements to eliminate waits over 65 weeks and increase the number and percentage of patients waiting more than 18 weeks. We are broadly in line with our annual plan submissions but that does not mean we are not striving to go further as we know that longer waits have a detrimental impact on every patient. We start to look more to the future and development of challenge yet deliverable plans to return to an 18-week standard.

OUR OPERATIONAL PERFORMANCE – URGENT & EMERGENCY CARE

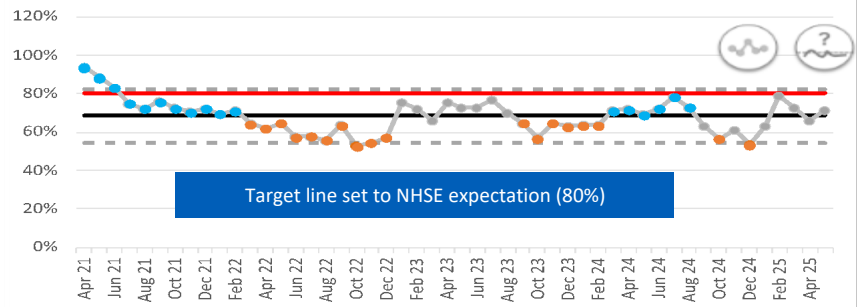
We are driving this measure because

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

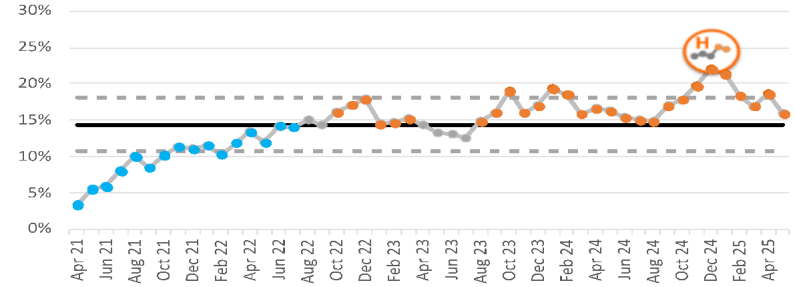
% within 4 hours (EAS All)



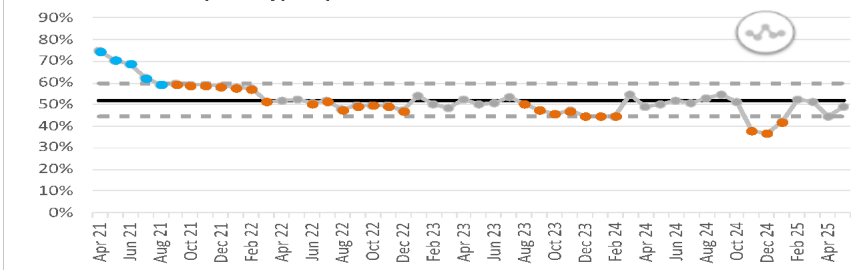
% Ambulance Handover < 45mins



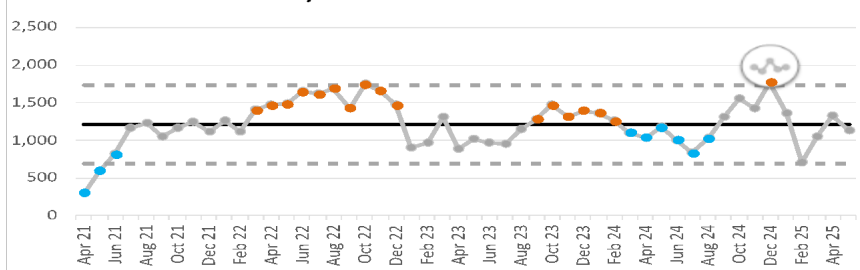
% patients spending 12+ hours in ED



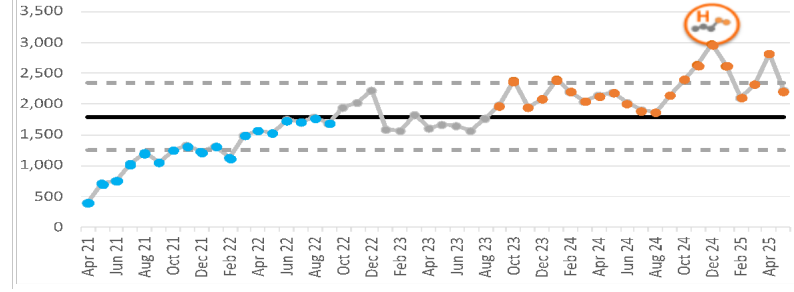
% within 4 hours (EAS Type 1)



45 Minute Handover Delays



Patients spending 12+ hours in ED



Understanding the performance

- Although not showing change in statistical significance across the metrics in this report, the improvements are nevertheless noteworthy in context of the following.
- 13,949 patients attended our type 1 sites in May at an average of 450 per day. That many attendances is a 3.7% increase compared to May 24 and was our highest number of attendances on record. This was also the third month in a row where WRH had more than 8,000 attendances.

Actions (SMART)

- Unplanned Care Operational Management Steering Group now established, incorporating 3P actions. Action Plan developed and 30, 60, 90-day deliverables in population. Each Division currently working on project – GP Navigator pilot to aid streaming, Fracture Clinic support in ED and review of SDEC SOP's to ensure smooth onward referral of Gynae.
- DTA amendment approved at TMB. DTA will now commence from referral. IPS to be agreed to ensure successful launch. This is currently with Medical Division.
- Working Groups in development focussing on streaming flow/bed configuration and IPS – governance discussions taking place, however, to feed into UEC Op's group.
- Triage improvement plan developed and actions being implemented to improve performance - monitored via weekly EAS and Non-Admitted Non-Referred divisional meeting. Impact being seen in June. Action undertaken includes:
- Triage surge plan under review
- Proposal for waiting room PODS to be re-explored.
- Plan agreed to increase number of Trauma beds within surgical bed base WRH target date June. Paper to be presented at TMB on 19th June.
- Reduction in number of face-to-face appointments in fracture clinic - referral criteria under review , training /education plan , plan for plaster tech to attend ED. Progress to be reporting in June.
- ED Workforce plan in draft. To be presented to TMB in June 2025, with implementation and prioritisation of recruitment plan.
- GP steaming criteria under review with Vertis and Urgent Care. System wide review of minor illness attendances/MIU in progress with input from Acute colleagues.

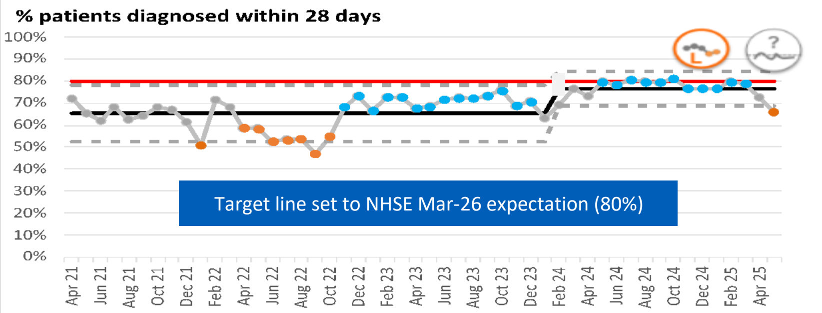
Risks

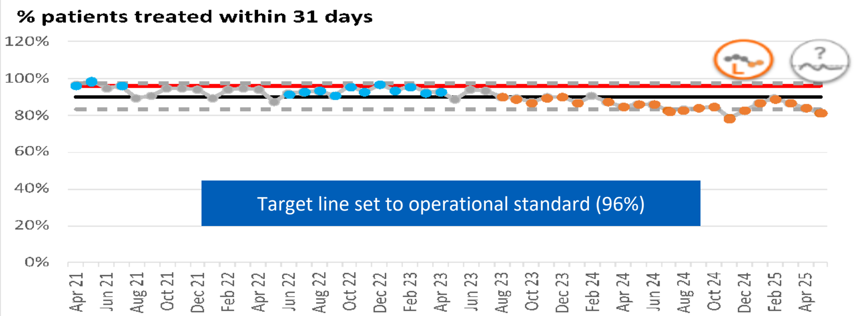
- Patient delays in waiting room and public behaviour (attending ED as opposed to accessing alternatives)
- Inconsistency in offer of alternative pathways for ED/SPOA to access
- Temporary nature of pilots such as PITSTOP, some elements of supporting functions impacting on ED attendances
- Hospital flow and late discharges
- Pathway patients and those with no reason to reside increasing
- Long delays for Ambulance Patients resulting in increased risk of harm and deteriorating patient (GRAT process in place for assessment)
- Increased in Trauma requirement with seasonal change, already seeing impact at front door
- Ability to recruit to Acute Medicine and ED – national supply/competition
- Acute Oncology capacity
- WMAS uptake of call before you convey and redirection before ED to Mental Health suite and SDEC (Pitstop mitigation supporting)
- Financial risk associated with managing safety in overcrowded department
- Additional capacity driving overspend and need to implement mitigating action to manage safety.

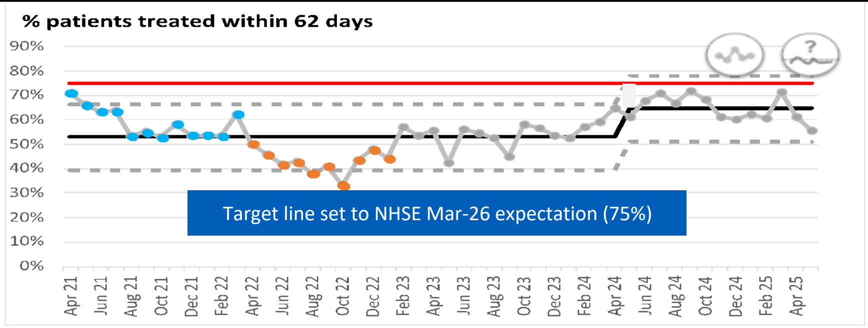
OUR OPERATIONAL PERFORMANCE - CANCER

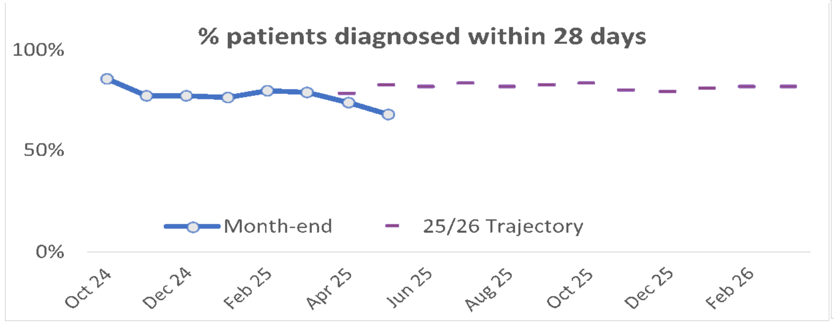
We are driving this measure because

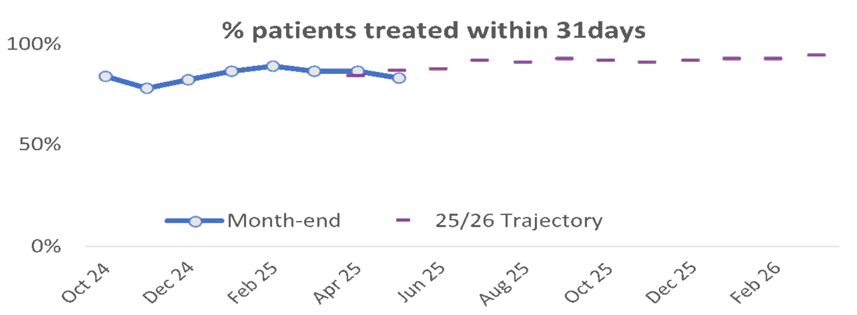
Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime.

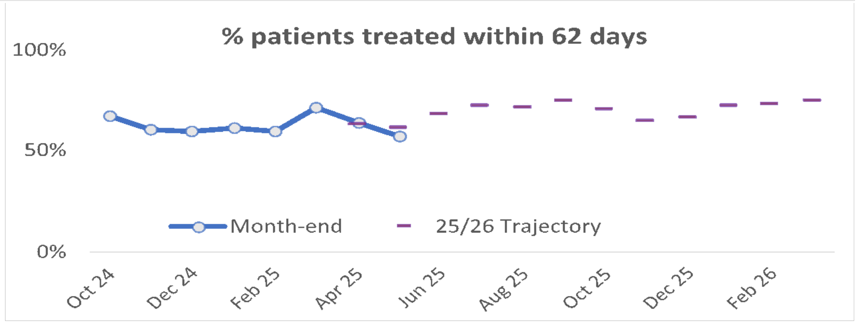












Understanding the performance

- In-month cancer referrals continue the recent trend of over 2,850 a month.
- The decrease in 28-day performance (68%) is below our annual plan target. Eight specialties saw a decrease in performance between April and May. 346 fewer breaches would have resulted in achieving the April target.
- The 31-day performance (83%) is below our annual plan target. Although 4 specialties did achieve the 96% operational standard, they contribute low numbers of patients to the numerator and denominator. Skin is our most challenged specialty for this metric, followed by Breast and Urology.
- The 62-day performance (57%) is below our annual plan target. Although the interim target of 75% isn't to be achieved until Mar-26, no specialty achieved the standard in May.
- Breast, Skin, Upper GI and Urology are the specialties that are contributing the most breaches to our month end position.

Actions (SMART)

- Ongoing fortnightly oversight, monitoring and support from ICB and NHSE.
- Additional remedial action plans sought due to performance trend, with refreshed FDS stories per cancer specialty produced and re-issued to operational teams to support this.
- Breast – action plan in place including continued use of 'Mega Wednesday' clinics to target first seen delays, risk stratification of referrals to ensure high risk seen first, development of new low risk pathway to manage demand and Radiologist insourcing to maximise one-stop clinic capacity. Anticipated recovery September 2025.
- Gynaecology – short term plan to use WLI's for diagnostic stage of pathways with implementation of new PMB pathway expected commencing late June 2025.
- Head & Neck – process mapping complete and awaiting results of clinic audit to help inform of any changes required to front end of BPTP pathways.
- Lung – Continued micro-management of the PTL amid ongoing workforce shortfall challenges.
- Skin – Projects underway to implement both teledermatology which should aid demand management and re-introduction of one-stop / see and treat clinics to include Max Fax provision. Additionally, advertising for both Locum Dermatology Consultants and substantive Max Fax Consultant to address capacity and demand imbalance.
- Urology – Appointed to WMCA funded Consultant to increase outpatient appointment post MDT with expected start of July 2025. Close monitoring of steps within the LATP process with support being sought from SCSD their reporting and additionally in respect to MRI capacity and reporting.
- Development of a business case to extend operating capacity to support delivery of the 31 day and 62 cancer standards for both Urology and Colorectal.

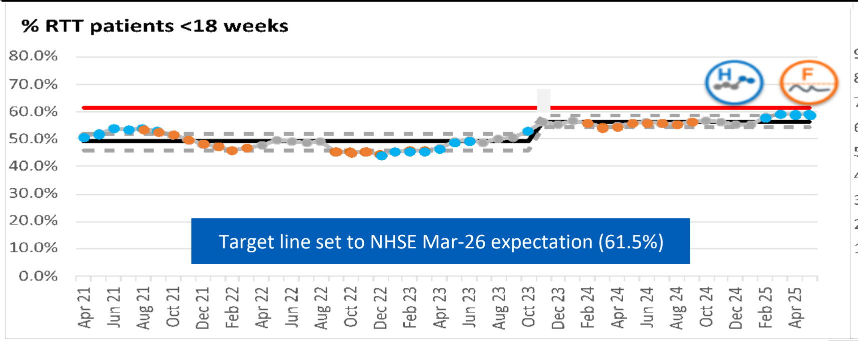
Risks

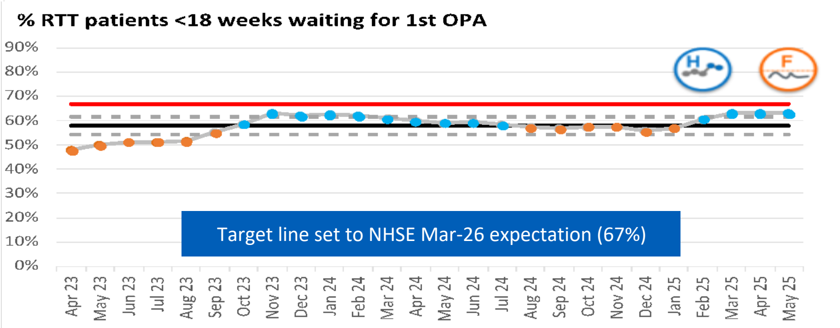
- Impact to achieving delivery of 31 and 62 days resulting from insufficient Oncology and radiotherapy capacity
- Ongoing financial impacts associated with the use of high-cost diagnostic outsourcing solutions in histology and radiology.
- Risk to delivery of FDS, 31- and 62-day targets due to service model fragility particularly for skin (which also relates to fragile max fax service) which does not have a permanent solution for service delivery.
- Delays in pathology turnaround times impacting on all tumour site pathways.
- Delays in imaging, particularly MRI, impacting on all tumour site pathways.
- Financial impact due to use of agency locum Consultants in Urology.

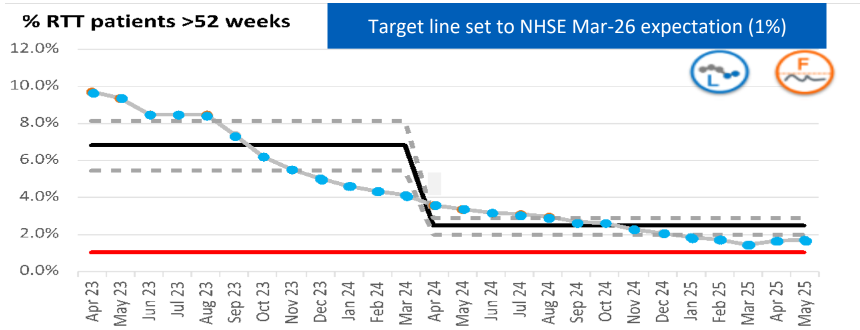
OUR OPERATIONAL PERFORMANCE – REFERRAL TO TREATMENT

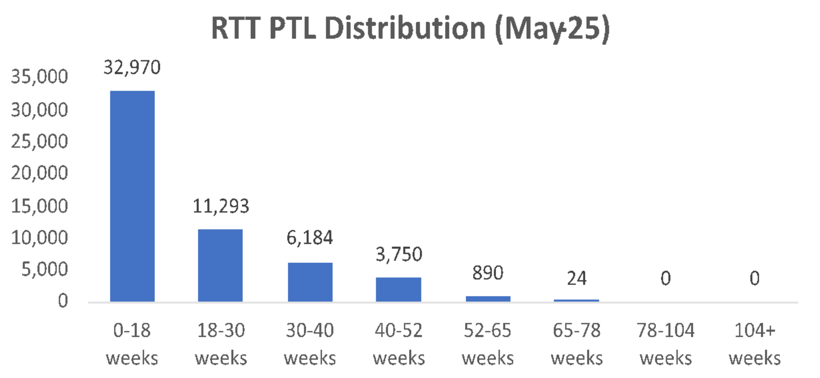
We are driving this measure because

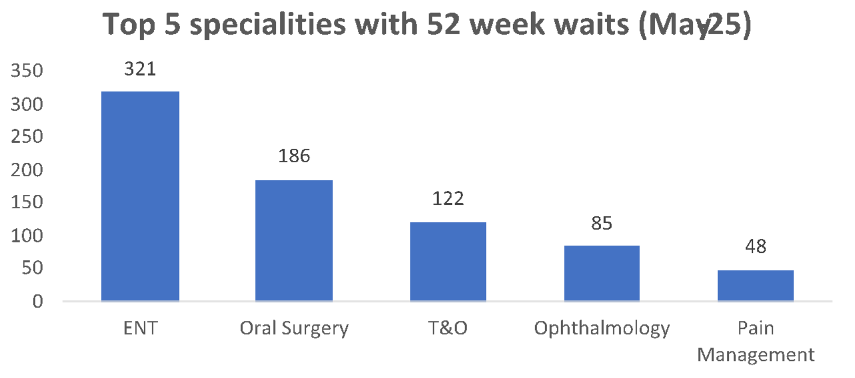
It is a key priority to ensure that patients can access the elective treatment they need in as timely a manner as possible and to continue to recover to the 18-week Referral to Treatment standard as set out in the NHS constitution.

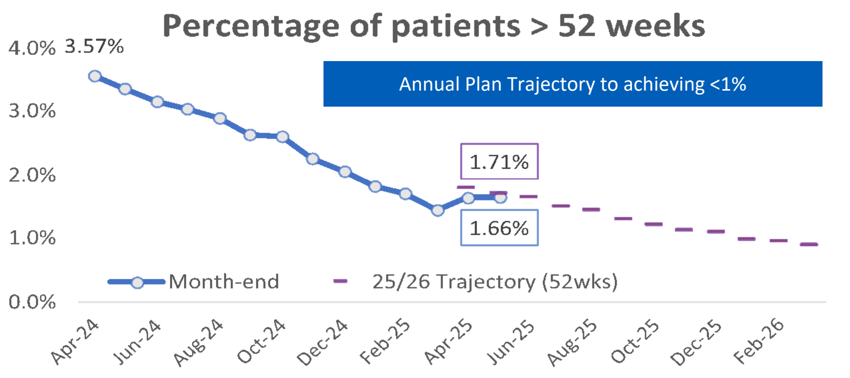












Understanding the performance

- At the end of May-25, 59.8% of patients, of a waiting list of 55,115, were waiting less than 18 weeks for their first definitive treatment. This continues the recent trend of significant improvement.
- For those patients waiting for their first appointment, the proportion waiting less than 18 weeks remains the same as the previous month at 63.1%.
- In line with our annual plan forecast, the number of patients waiting over 52 weeks has increased to 914 patients (1.66% of the total waiting), however this was better than plan.
- The top 5 specialties with 52-week waiters contributed 83% to the Trust overall position.

Actions (SMART)

- Fortnightly oversight, monitoring and support from ICB and NHSE
- Weekly COO oversight and monitoring of our longest wait patients
- Focus in general surgery to bring all new OPAs to under 30 weeks and reduce risk of late referrals to externally sourced diagnostics, therefore reduce risk to patients breaching 65 weeks.
- Additional supplier of corneal transplant tissue sourced to help reduce long waits.
- Divisional oversight and micro-management of patients on admitted pathways requiring surgical treatments which exceed 52 weeks
- All divisions reviewed at risk specialties and confirmed plans to achieve elimination of 52 week waits by March 2025. – May 2025

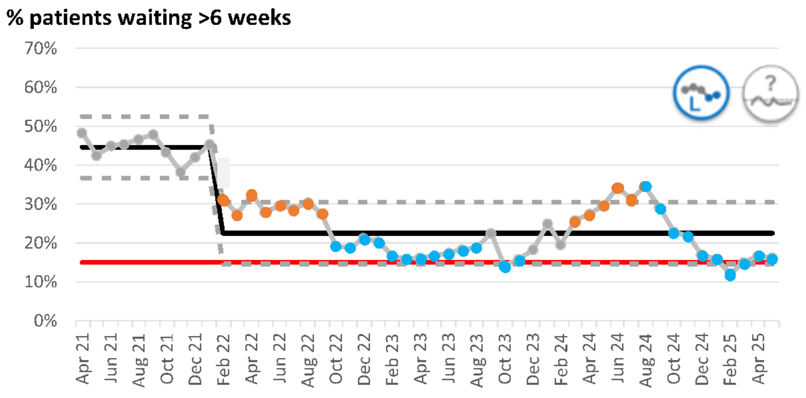
Risks

- Risk to elimination of 65+ week waiters due to late onward referral to external diagnostic services with limited capacity i.e. manometry, HIDA scans, impacts gastro and general surgery pathways
- Risk to delivery of eliminating all waits over 52 weeks by Mar 2026 particularly for ENT, T&O and pain services, without in year process change/ services transformation
- Financial impacts of ongoing use of insourcing and outsourcing solutions particularly in dermatology
- Availability of corneal transplant tissue impacting on long waiters in ophthalmology
- Delivery of 52 weeks target for OMFS due to fragility service resulting from medium to long term absence of Consultants.

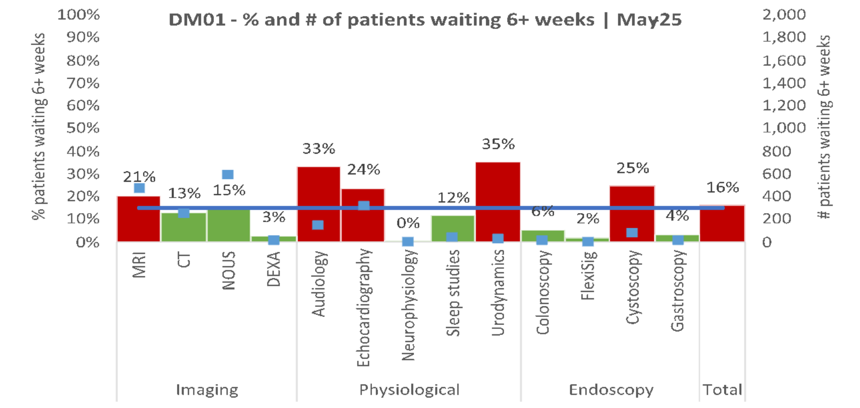
OUR OPERATIONAL PERFORMANCE – DIAGNOSTICS

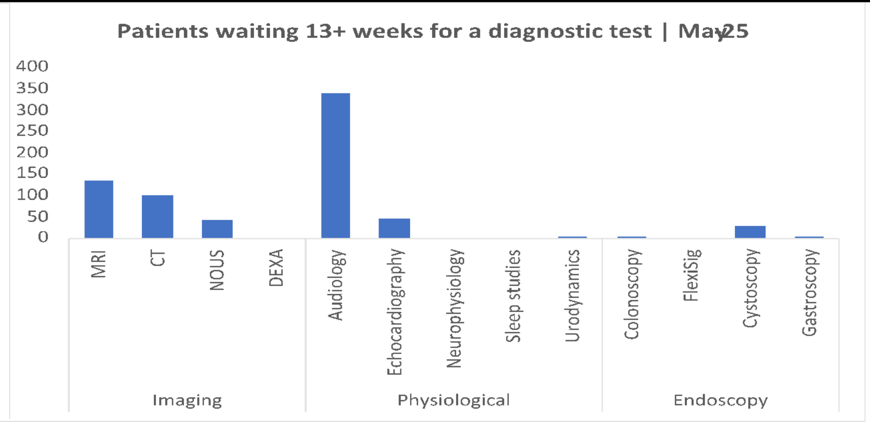
We are driving this measure because

Early diagnosis is important to patients and central to improving outcomes, for example early diagnosis of cancer improves survival rates. Bottlenecks in diagnostic services can significantly lengthen patient waiting times to start treatment.



Target line set to NHSE expectation (no more than 15%)





Understanding the performance

- 2,023 (16.2%) patients were waiting over 6 weeks at the end of May-25.
- The target is achievable, although not consistently.
- 5 modalities are above the 15% threshold. They account for 52% of all patients breaching 6 weeks at the end of May.
- Following an extensive review of Audiology, which resulted in patients no longer needing to be tested, MRI has the most patients over 13 weeks followed by CT and Echocardiography. These three modalities account for 65% of patients breaching 13 weeks.

Actions (SMART)

- **MRI –** Insufficient capacity to meet demand. Service reviewing options to increase capacity to include mobile and WLIs both of which are not funded.
- **Audiology** action plan in place. Breaches relate to paediatric waiting list, specifically under 4 years of age. Plan in place to resolve paediatrics by end of August. Plan includes modifying the referral pathway and waiting list validation to reduce overall numbers in line with new pathway criteria.
- **Echocardiography –** New starter commencing end of June provided 40 scans per month. Conversion of facilities to create a dedicated echo room comes online July 25 resulting in 70 per month. Further recruitment to vacancies for physiologists.
- **Urodynamics** – plan in place to resolve breaches, expected improvement in performance in July 25.
- **Cystoscopy** – Equipment fixed and plan for waiting list initiatives to reduce backlog. Performance improvement expected June 25

Risks

- Risk to delivery of DM01 performance resulting from carve out of capacity to support cancer pathways e.g. urology prostate MRI
- Risk to permanent recruitment to audiology vacancies could impact on delivery.

OUR WORKFORCE

Ali Koeltgen

Chief People Officer

Recruitment

Establishment increased at budget setting by 193.76 wte mainly in Medicine. Funded establishment has increased by a further 3 wte this month and is 295.19 wte higher than M2 last year due to agreed business cases. We have recruited 63 new staff but have only 4 more starters than leavers due to a planned slowing down on recruitment to align with the annual plan. There has been a reduction of 8.68 wte in staff in post in Corporate, Digital and Estates Services (non-clinical).

Vacancy Rate

Our vacancy rate has increased slightly to 7.39% (562.27 wte vacancies) mainly due to the growth in establishment. This is above the Trust revised target of 6.5% but compares favourably to a vacancy rate of 9.32% in May last year.

Our Non Clinical vacancies are low which will cause us some challenges with the requirement to reduce these posts as turnover is low in these groups. We have 79.09 wte Admin and Estates vacancies (6.59%), 18.16 wte Managers vacancies, and 10.30 wte Other infrastructure support (3.93%).

Monthly Agency Spend

Agency spend remains our biggest challenge. There has been an 18.48 wte reduction in agency worked in May which translated to a reduction in the % of gross spend to 4.81%. Surgery and Medicine are outliers with 7.86% and 7.34% of gross spend. The Target of agency costs as a % of gross spend has been reduced to 4.7% to align with Annual Planning submission.

Annual Staff Turnover

Our annual staff turnover has reduced again to 8.92%, which continues to meet our target of 11.5% and is improving compared to rates of 10.86% last year. We benchmark well against other Trusts at Quartile 1 (best) on Model Hospital (February 2025 rates). All divisions meet the target.

Sickness Absence

Monthly sickness absence has reduced by 0.30% from last month to 4.75%. This is 0.82% better than the same month last year demonstrating efforts to work towards achieving the 4% Group target. The % of absence attributed to stress has increased slightly to 30.49% with Women and Children's as an outlier with 41.08%. The highest Long term sickness levels are in Digital (4.04% but skewed by size of the department and low overall sickness), and Medicine (2.77%).

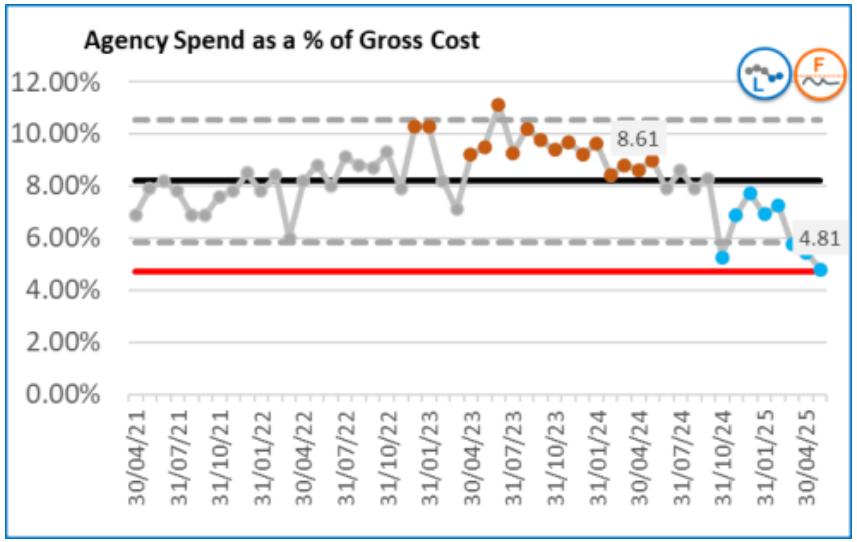
Job Planning

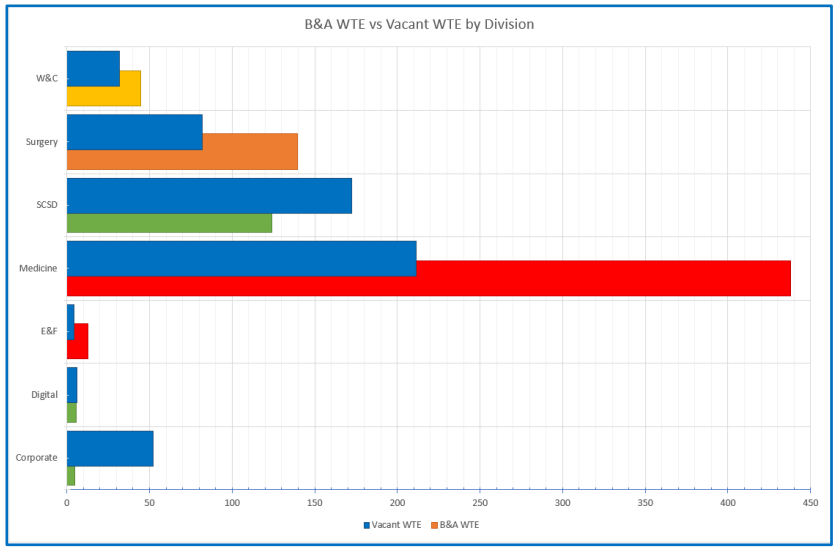
Consultant Job Planning has improved by 2% to 73% against target of 95%. Women and Children's are the only division to meet target. Surgery are significant outliers at 54% but have improved by 7% this month. Medicine have the highest improvement of 11% but remain low at 67%.

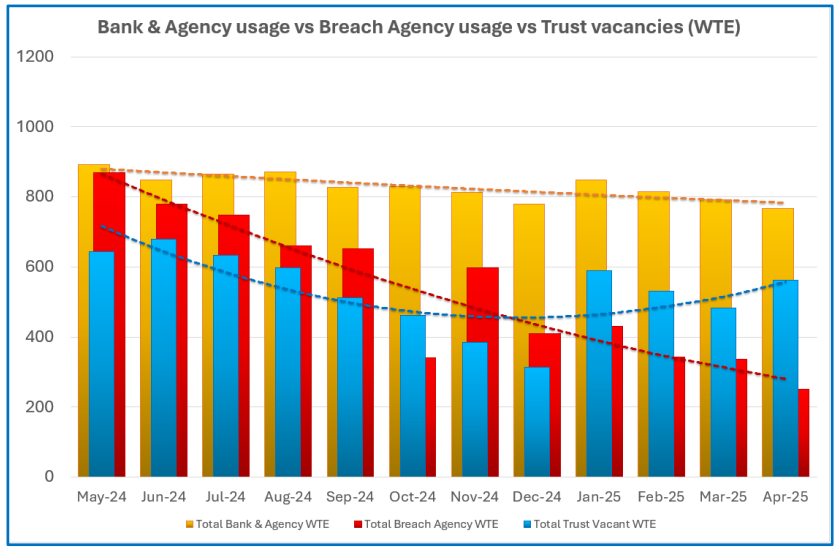
OUR WORKFORCE PERFORMANCE – REDUCTION OF AGENCY SPEND

We are driving this measure because

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







Understanding the performance

The updated target % of agency spend for 2025-26 is 4.7%. There has been a reduction in % spend in May to 4.81% compared to 5.75% in April. This spend is 4.18% lower than M2 2024.

Agency spend has increased in Surgery and W&C, with Surgery being an outlier at 7.86% of gross cost.

Agency AHP migration to bank is showing positive progress in Pharmacy, Radiology, and Pathology.

Non-DE usage is reducing significantly in A&E, T&O, and Rheumatology, with several agency medics in A&E ALX also moving to bank.

N&M are exceeding the agency Price Cap Compliance target of 70% with a compliance rate of 94% across the Trust, with projects now underway within AHPs and Medics.

Actions

All divisions to continuously review their vacancy position and recruitment pipeline to reduce gaps.

Monitoring of booking behaviours against published SOP has begun, including framework compliance, price cap compliance, and retrospective bookings. Improvements to be made to empower booking staff to follow the SOP.

Updated Trust Temporary Staffing Policy has been approved and published to the Staff Intranet.

Continue to confirm & challenge temporary workforce usage through the Medical Agency Reduction Panel.

Develop new methods to streamline current authorisation processes.

Risks

Retrospective agency bookings leading to inaccurate ADI reporting on agency usage.

Potential reduction of agency worker pool due to continued pressure to reduce rates to price cap in line with NHSE Price Cap Compliance project.

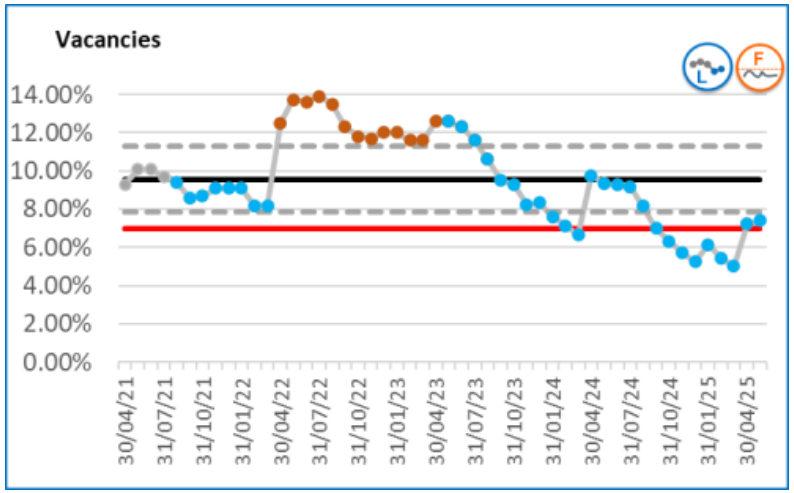
Inappropriate booking behaviours leading to unnecessarily increased spend on temporary workforce.

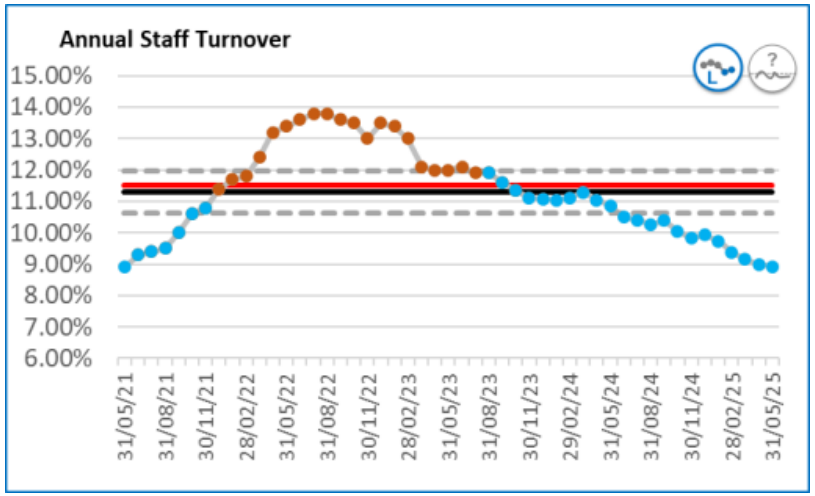
Government directive to reduce bank spend may impact work being undertaken to reduce agency spend or may lead to increases in agency spend.

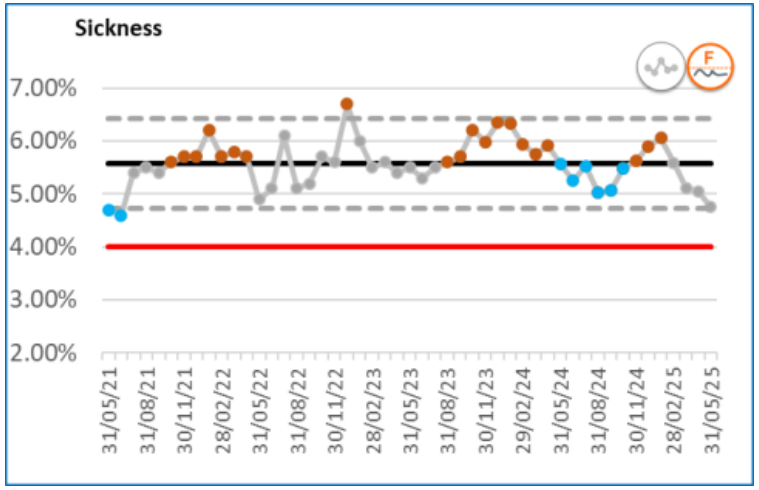
OUR WORKFORCE PERFORMANCE – VACANCIES, TURNOVER AND SICKNESS

We are driving this measure because

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







Understanding the performance

- **Trust-wide Vacancies** Staff in Post has grown by 0.55 wte this month. An increase in establishment at budget setting has increased our vacancy rate to 7.39% against a revised target of 6.5%. Medicine have the highest vacancy rate at 8.85% which is partly due to a 108.14 wte increase in funded establishment at budget setting. We have 119.43 wte less vacancies overall than last year due to successful recruitment campaigns and reduced turnover.
- **Starters and Leavers** - We have just 4 more starters than leavers this month due to slowing down of recruitment to align with our annual plan as our vacancies are low. We have processed 63 new starters in month (headcount). Leavers increased slightly to 59.
- **Annual Staff Turnover** continues to meet our 11.5% target at 8.92% (improved) which is 1.94% better than the same period last year and back to pre-pandemic levels.
- **Monthly sickness absence** has reduced by 0.30% to 4.75% which is 0.82% better than last year.
- There have been sickness absence reductions in all divisions except SCSD. Estates and Facilities are outliers with 5.82% although improved significantly this month.

Actions (SMART)

- **Continued Support** is being offered to staff through Occupational Health, Staff Support, Employee Assistance Programme (EAP) and Wellbeing interventions.
- **Targeted intervention meetings** implemented with managers in areas of highest sickness absence levels, with support from the HR Advisory team. Identifying hotspot areas and getting back to basics to ensure processes are in place to manage absence effectively within a timely manner as well as providing drop in sessions for managers.
- **Trigger reports** have been discussed at divisional meetings to drive compliance with policy and ensure sickness is appropriately addressed
- Work is being undertaken to identify non-clinical posts that can be reviewed as part of Annual Planning targets.

Risks

Performance to Plan Our 2025/26 workforce plan includes challenging bank, agency and infrastructure workforce reductions. At present the divisions are using Bank and Agency that is taking them over establishment.

Healthcare Support Workers Vacancy rate has improved from 13.45% (155.62 wte vacancies) to 12.81% (148.54 wte vacancies). This high rate is directly due to an increase in funded establishment Medicine and SCSD at budget setting.

Sickness for Estates and Facilities continues to be high at 5.82% (despite a significant improvement) and is in the 4th Quartile (worst) on Model Hospital.

Absence due to stress remains higher than pre-pandemic levels. Women and Children's are significant outliers with more than 41% of their sickness due to S10 (Stress and Anxiety).

OUR FINANCIAL PERFORMANCE

Neil Cook

Chief Finance Officer

Financial Plan 2025/26

A balanced plan was submitted for 2025/26, this included Non-Recurrent System Deficit Support funding of £47.3m. Deficit support funding will be approved quarterly in advance based on the Trusts financial performance and a credible Cost & Productivity Improvement Plan (CPIP) being in place to support achievement of our overall financial plan.

Income & Expenditure Performance

At the end of Month 2 we report a year to date (YTD) £0.3m adverse position against plan. Adverse variances are primarily driven by under-delivery against CPIP and additional resources supporting flow. This position has been supported by non recurrent benefits.

Income is £0.1m favourable YTD – favourable variances offset costs. Elective activity is slightly ahead of the phased plan, income over performance has been supressed recognising phasing of overall activity plan and contractual agreement. Contracts and pricing rules for 2025/26 remain under discussion with a view to signing in July.

Employee expenses are £0.8m adverse YTD – adverse variances include CPIP under delivery of £0.2m and additional resources supporting flow £0.6m.

Operating expenses excluding Employee Expenses are £0.1m favourable YTD – this includes favourable non recurrent variances of £1.1m including balance sheet releases which are offset by £0.4m adverse on Non PbR Drugs and Devices which are offset by income, under delivery of CPIP of £0.2m, £0.3m of insourcing in Surgery partially offset by Dermatology vacancies, and £0.1m of mobile scanner hire spend in SCSD during capital works. The position continues to be supported by other budget underspends largely in Corporate.

Financial Risk - An early financial forecast enables us to proactively anticipate trends, allocate resources efficiently, and improve decision-making. Our initial assessment indicates that without mitigation the value of CPIP reported as opportunity and pre pipeline represents our most significant financial risk. This could lead to a substantial shortfall against our financial plan and impact our ability to access Deficit Support Funding if these plans do not progress to delivery. Divisions are currently assessing the balance of risk across quality, performance and Finance and are developing mitigation plans.

Capital – The MOU for external PDC for the Linac has been approved @ £2.354m. The Trust has received notification of approval of £3m for Critical Infrastructure PDC funding.

Month 2 YTD capital actual expenditure is £2.946m, the majority of which is spend on the strategic schemes (£2.2m spend on ALX fire scheme and £0.2m on RAAC). This is £778k lower than the expected YTD Internal Plan. Variance is due to the delay in the procurement of the 2 Radiology US leases that will be later in the year than expected. A short-term extension has been arranged in the interim.

Cash – The Trust cash position at the end of Month 2 was £21.473m. The Trust has received the notified deficit support of £3.942m in May (£7.884m to-date, £47.3m for 2025/26).

Clinical Coding – May coding is at 100%, as at day 10 (13/5/2025), coding 15,207 FCE's. The coding team continue to supporting the Trust CPIP with all specialities.

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	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Operating income from patient care activities	122,027	122,202	175
Other operating income	6,157	6,111	(46)
Employee expenses	(82,453)	(83,272)	(819)
Operating expenses excluding employee expenses	(48,097)	(48,008)	89
OPERATING SURPLUS / (DEFICIT)	**(2,366)**	**(2,967)**	**(601)**
FINANCE COSTS			
Finance income	246	465	219
Finance expense	(1,775)	(1,733)	42
PDC dividends payable/refundable	(841)	(841)	0
NET FINANCE COSTS	**(2,370)**	**(2,109)**	**261**
Other gains/(losses) including disposal of assets	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(4,736)**	**(5,076)**	**(340)**
Remove capital donations/grants/peppercorn lease I&E impact	30	30	0
Remove PFI revenue costs on an IFRS 16 basis	6,226	6,924	698
Add back PFI revenue costs on a UK GAAP basis	(7,924)	(8,575)	(651)
Adjusted financial performance surplus/(deficit)	**(6,404)**	**(6,697)**	**(293)**

Understanding the performance

At the end of Month 2 we report a year to date (YTD) £0.3m adverse position against plan. Adverse variances are primarily driven by under-delivery against CPIP and additional resources supporting flow.

Income is £0.1m favourable YTD – Patient Care Income is £0.2m favourable to plan. Elective activity is slightly ahead of the phased plan, income over performance has been supressed recognising phasing of overall activity plan and contractual agreement.

Employee expenses are £0.8m adverse YTD – of which £0.6m is additional resources supporting flow in Medicine and £0.2m under delivery of CPIP.

Operating expenses excluding Employee Expenses are £0.1m favourable YTD – this includes favourable non recurrent variances of £1.1m including balance sheet releases which are offset by £0.4m adverse on Non PbR Drugs and Devices which are offset by income, under delivery of CPIP of £0.2m, £0.3m of insourcing in Surgery partially offset by Dermatology vacancies, and £0.1m of mobile scanner hire spend in SCSD during capital works. The position continues to be supported by other budget underspends largely in Corporate.

Finance Costs are £0.2m favourable YTD – this is due to higher interest received on cash balances.

Actions (SMART)

Weekly CPIP review meetings are taking place with Divisions and majority of Corporate teams to identify and progress CPIPs through the maturity rating to Fully Developed.
Finance and Performance Executive meetings with Divisions will focus on management of the run rate and actions to address any overspends in the months ahead

Contract negotiations are continuing with ICBs to minimise risk of income loss in line with the submitted plan

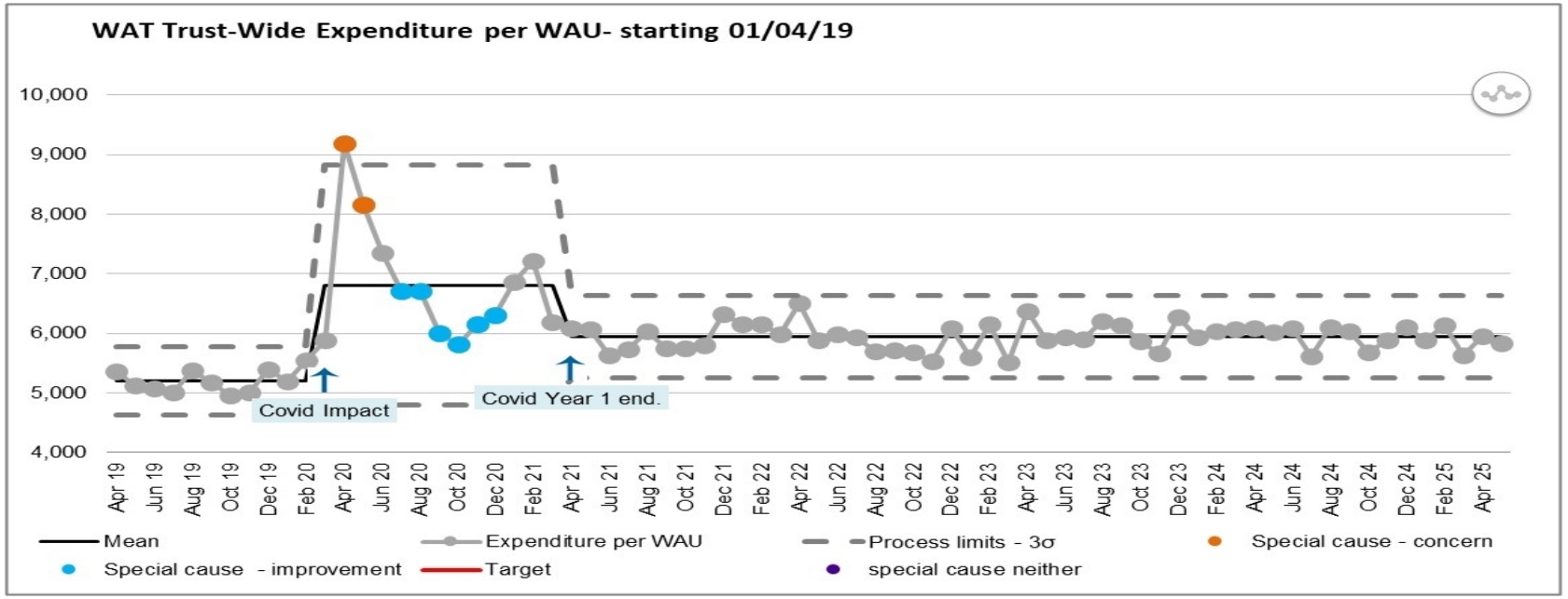
Risks

If CPIP plans do not progress through maturity to delivery in line with the plan the Trust will experience cash flow problems and be challenged by NHSE regarding release of deficit support funding.

BEST USE OF RESOURCES – ADJUSTED EXPENDITURE PRODUCTIVITY TREND

We are driving this measure because

This SPC measures expenditure against activity, allowing us to follow productivity changes. Tracking is currently available at Trust wide level only. Weighted Activity Unit (WAU) has been developed within the Foundation Group using Inpatient/Outpatient/ED/Critical Care activity, adjusted to be weighted equally. There is no adjustment for working day variations.
Previous years Expenditure is adjusted up for inflation to make them comparable with the current year. As the WAU relies on coded activity, recent months can still move until coding is complete.



Monthly Movement

	Apr-May	Adjusted for
Exp per WAU	-1.9%	-0.0%
Expenditure	-0.8%	-0.8%
WAU	1.1%	-0.8%

Costing Team Update

- Foundation Group agreed Cost visual inflates previous years expenditure to current year to make comparable. This changes the Cost per WAU to reports in previous years

Understanding the performance

In May, our Cost per WAU is **1.9% lower than April (unchanged when adjusted for working days for Elective)**. This means that we are spending less per unit of activity delivered.

(Note uncoded activity can impact this position).

Expenditure adjusted for Inflation is **0.8% lower** than April. WAU is **1.1% higher. (0.8% lower after allowance for working days for Elective) The trust is delivering the similar level per working day but spending a bit less to achievement this.**

Elective admissions and Outpatients are unchanged per working day. Emergency activity is fractionally reduced per day.

Actions (SMART)

The Costing team continue to support Divisions in identifying opportunities to improve productivity.

A Service Line Reporting dashboard is currently in test with the Surgical Division which will enable specialties to drill into the granular cost detail for each patient.

Risks

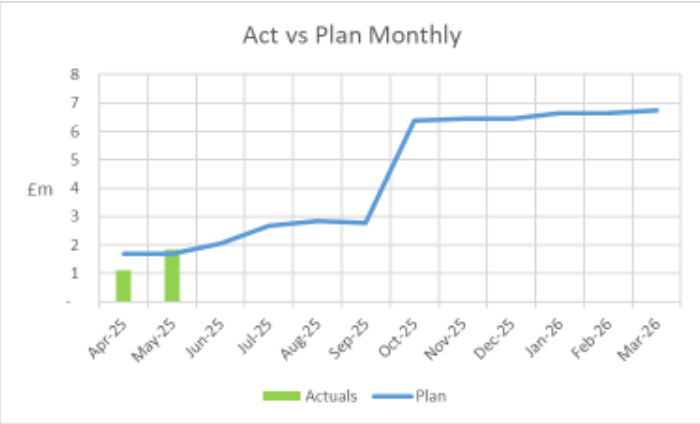
If the Trust cannot reduce expenditure whilst also increasing activity levels, then achievement of financial and performance targets are at risk.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

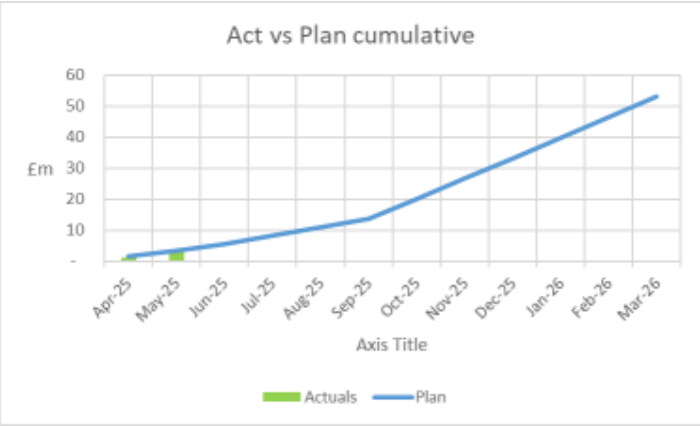
We are driving this measure because

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

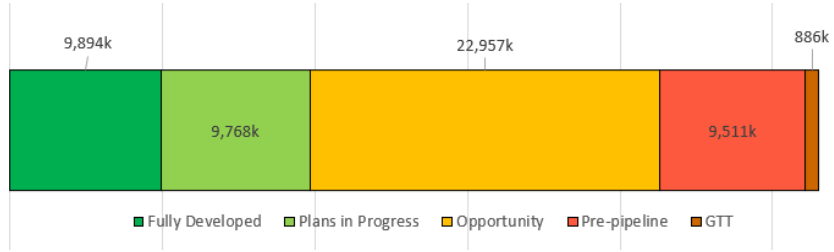
YTD CPIP achieved
vs plan target (£53.016m) month



YTD CPIP achieved
vs plan target (£53.016m) cumulative



Schemes identified (forecast) vs target (£53.016m)



Understanding the performance

The Trusts 25/26 target as submitted to NHSE is £53.016m. M2 Plan figure was £1.700m, M2 Actuals delivered £1.851m, an over delivery of £0.151m. M2 Actuals comprise £1.270m recurrent and £0.581m non-recurrent

Please note additional maturity ratings have been introduced via NHSE for 25/26;
Opportunity comprises basic outline cost (not just a number from benchmarking tool)
Pre-pipeline comprises initial idea identified with potential indicative value

For month 2 the Trust still has £9.511m in pre-pipeline and £0.886m in gap to target. There is an urgent need to progress this through to Opportunity and to Fully Developed for delivery of the programme in line with the plan.

Actions (SMART)

Work is continuing to focus on delivery of the CPIP schemes for 25/26 through the Trust maturity levels. CPIP review meetings are taking place weekly to challenge performance and improve scheme maturity. These sessions also provide a mechanism for reviewing benchmark productivity performance metrics to identify further opportunities to make savings.

Risks

The 25/26 target is c£10m higher than we delivered in 24/25 and will therefore prove challenging at the pace required to deliver the plan.

Failure as a system to demonstrate credible plans could lead to the withholding of deficit support funding.

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 backlog maintenance requirements and much needed equipment replacement.

Position v Budget

Workstream	Scheme	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Digital	Additional Digitial Schemes	£0	£0	£184,107	£184,107
Digital	CAP2425 Cardiac PACS	£300,000	£200,000	£1,143	-£198,857
Digital	LIMS Pathology	£370,000	£123,334	£15,402	-£107,932
Digital	Phase 2 - Telephony Systems Critical Upgrades	£0	£0	£8,351	£8,351
Equipment	Equipment Schemes	£0	£0	-£16,237	-£16,237
Other	2526 LSE ALX US	£74,000	£74,000	£0	-£74,000
Other	2526 LSE Fleet vehicles	£345,000	£0	£0	£0
Other	2526 LSE FNA clinic US	£102,000	£102,000	£0	-£102,000
Other	2526 LSE WRH Car park	£259,000	£0	£0	£0
Other	2526 LSE Xray dept US	£103,000	£0	£0	£0
Other	CBRN Tent	£0	£0	-£2,270	-£2,270
Other	Donated Equipment Schemes	£0	£104,944	£92,944	-£12,000
Other	IFRIC 12 and Equipment/P&W schemes to be allocated	£1,737,000	£583,500	£19,232	-£564,268
P&W	A Block Lift	£20,000	£15,000	£1,175	-£13,825
P&W	CAP2425 C Block Roof	£30,000	£20,000	£89,296	£69,296
P&W	CAP2425 Generator upgrade	£60,000	£40,000	£54,340	£14,340
P&W	P&W Backlog Maintenance	£0	£0	£50,708	£50,708
Strategic	Acute Service Review	£4,000,000	£5,647	£14,705	£9,058
Strategic	Internally funded Fire Scheme	£2,600,000	£2,254,972	£1,792,021	-£462,951
Strategic	LINACS WRH Replacement	£967,000	£0	£548	£548
Strategic	National Diagnostics - Cath lab	£0	£0	£17,241	£17,241
Strategic	National Funding Fire Scheme	£0	£0	£419,899	£419,899
Strategic	RAAC A Block Link KTC	£396,000	£200,166	£203,313	£3,147
Total		**£11,363,000**	**£3,723,563**	**£2,945,917**	**-£777,646**

Understanding the performance

Month 2 YTD capital actual expenditure is £2.946m the majority of which is spend on the strategic schemes (£2.2m spend on ALX fire scheme and £0.2m on RAAC) .

This is £778k lower than the expected Internal YTD Budget due to the delay in the procurement of the 2 Radiology US leases that will be later in the year than expected. A short-term extension has been arranged in the interim.

Actions (SMART)

The phasing in the annual external plan is phased in 12th , work continues to improve the internal phasing of the approved capital schemes.

The Trust has bid for a number of externally funded schemes. These will be added to the programme once formally approved. The MOU for external PDC for the Linac has been approved @ £2.354m. The Trust has received notification of approval of £3m for Critical Infrastructure PDC funding.

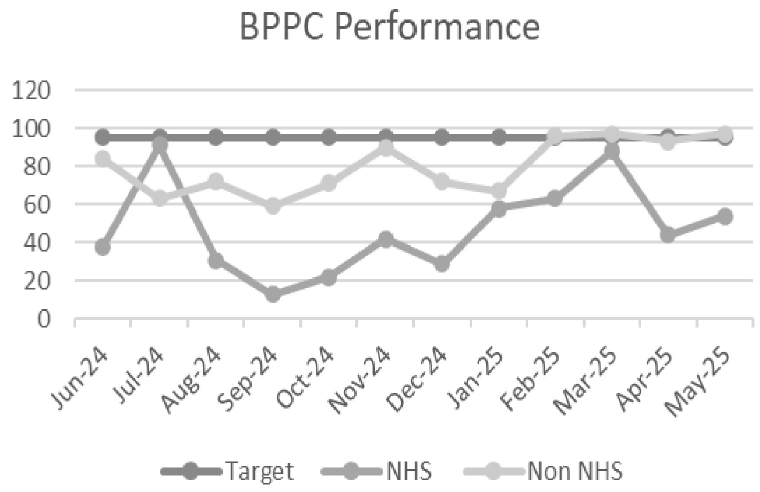
Risks

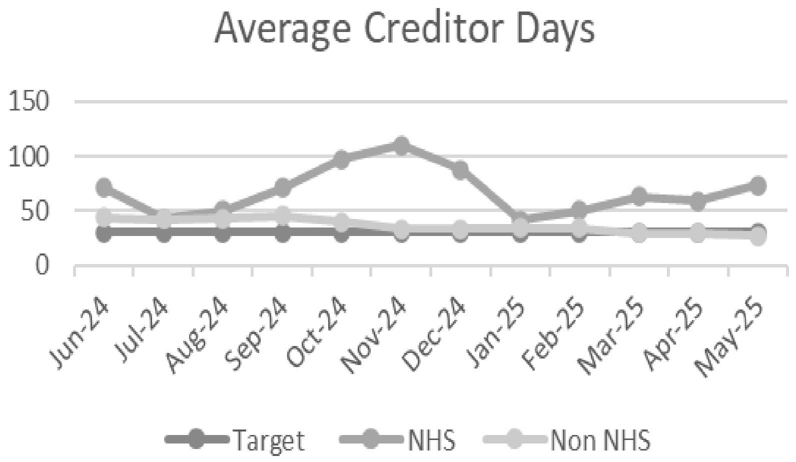
There is a significant risk that the Trust has insufficient funding to support backlog maintenance requirements, much need replacement schemes and a contingency for any unforeseen events.

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.





Understanding the performance

The Trust cash position at the end of month 2 was £21.473m. The Trust has received the notified deficit support of £3.942m in May (£7.884m year to date, a total of £47.3m for 2025/26) from Herefordshire and Worcestershire ICB.

The submitted plan for 2025/26 assumes that the income will be received as per the phasing of the plan, the deficit funding of £47.3m will be paid in 12ths from April, £3.942m per month and the CPIP plans are cash releasing in line with the phasing of the plan. If the deficit support funding ceases due to the system CPIP and the Trust does not deliver all the expected CPIP's the trust will have to apply for revenue support loans.

The BPPC performance for the <u>month</u> of May is 94% (92% in April) based on volume of invoices paid and 94% (91% in April) based on value.

Actions (SMART)

The cash position is kept under regular review with 12 week rolling forecasts provided to the CFO.

Risks

If cash is not received in line with the plan then there is a risk that creditors payments will need to be held back to ensure that the Trust can meet monthly payroll costs.

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**08/07/2025**
Title of Report:	**Midwifery Safe Staffing Report May 2025**
Lead Executive Director:	**Chief Nursing Officer**
Author:	**Justine Jeffery – Director of Midwifery**
Reporting Route:	**Quality Governance Committee**
Appendices included with this report:	**None**
Purpose of report:	**☒ Assurance ☐ Approval ☐ Information**

Brief Description of Report Purpose

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

Recommended Actions required by Board or Committee

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

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.

[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director 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:

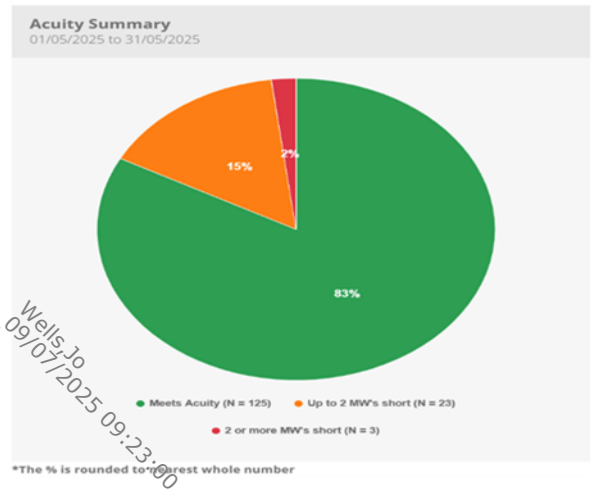
Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	5,7%	7.2%
Turnover rate (rolling)	11.5%	5.83%	19%
Vacancy rate (MW)	7%	0.5%	20%
Maternity Leave	-	3.1%	0.5%
Midwife to birth ratio (in post)	1:24	1:19	
1:1 care in labour	100%	Achieved	
Shift leader SN	100%	Achieved	

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.



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From the information available the acuity was met in 83% of the time and recorded at 17% when the acuity was not met prior to any actions taken. This is a sustained position. Safe staffing levels were maintained on all shifts in May following mitigation.

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=14) of when staff are reallocated from other areas of the inpatient service. There were 0 reported occasion when the community/continuity teams were deployed to support the inpatient area. There were 3 reports of staff not being able to take a break.

Number of Management Actions
01/05/2025 to 31/05/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	14	74%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	3	16%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	1	5%
MA7	Manager/Matron working clinically	1	5%
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		19	

*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 one reported delays in time critical activity, no other red flags were reported.

Number of Red Flags recorded
01/05/2025 to 31/05/2025

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

*The % is rounded to nearest whole number

Birth Centre

In month the completion rate for the acuity app for the birth centre was at 74%. The acuity was reported as being met 99% of the time. The number of women accessing the birth centre continues to rise.

Intrapartum & Non-Birthing Categories
01/05/2025 to 31/05/2025

Categories	Number in Categories	Percentage
Cat I	82	69%
Cat II	7	6%
Cat PN	30	25%
Cat X	0	0%
TOTAL	119	

*The % is rounded to nearest whole number

Staffing incidents

There were three no harm staffing incidents:

1. Pt requesting female doctor only – Consultant declined to attend
2. Cancelled training
3. CMW not responding to on-call for homebirth – CoC midwife attended to avoid delay in care

Medication Incidents

There were six medication incidents – 1 causing harm:

1. Self-administration of insulin resulting in hypoglycaemia
2. Incorrect frequency of Paracetamol
3. IVAB administered early (baby)
4. Prescription not dated
5. Uncontrolled hypertension
6. Incorrect infusion regime for management of hypertension/PET

Monitoring the midwife to birth ratio

The ratio in May was 1:19 (in post) and 1:19 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

Maternity SitRep

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

National Maternity SitRep

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

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	83%	100%	100%	n/a
Antenatal Ward/Triage	88%	90%	87%	92%
Delivery Suite	97%	100%	39%	97%
Postnatal Ward	98%	98%	89%	84%
Meadow Birth Centre	86%	90%	85%	97%

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the unit bleep holder, midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Deputy Director of Midwifery with an escalation to the Director of Midwifery as required. Additional huddles were held in May 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.

Vacancy

There are two unfilled midwifery roles (Fetal Medicine & Sonography Lead)– vacancy rate now at 0. 5%. There are 9 WTE MCA posts vacant with interviews taking place in June.

Sickness

Sickness absence rates for midwives were reported at 5.7% and 7.2% for non-registered staff – this has significantly dropped in month for both registered and non-registered staff.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Quarterly confirm and challenge meeting held by DoM
- 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 5.8% for midwives and at 19% for non-registered staff – this is a slight decrease for non-registered staff.

***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.

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

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 14 occasions to maintain safety. The community and continuity of carer midwives were not required 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 were achieved. Of the 9 datix reports for staffing and medication incidents submitted there was one harm incident.

Sickness absence rates for midwives and non-registered staff remains above the Trust target but significant decrease in both groups is now noted.

The vacancy rate is 0.5% for MWs and 20% for MCA's. Further recruitment is planned for the MCAs.

Recommendations

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