Public Board Meeting

Thu 06 June 2024, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Kieran Lappin.

13:00 - 13:00
0 min

2. Declarations of Interest

13:00 - 13:02
2 min

3. Minutes of the Meeting held on the 4 April 2024

Decision *Russell Hardy*

2. PUBLIC BOARD MINS - APRIL LF, KL, FM.pdf (13 pages)

13:02 - 13:03
1 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

3. PUBLIC BOARD ACTION LOG -JUNE.pdf (1 pages)

13:03 - 13:33
30 min

5. ITEMS FOR REVIEW AND ASSURANCE

5.1. Chief Executive's Report

Discussion *Glen Burley*

4. June 2024 - WVT CEO Report - BOD.pdf (5 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

WVT IPR Month 1 April 24 - Final.pdf (31 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:33 - 13:58
25 min

6. ITEMS FOR APPROVAL

6.1. Quality Committee Workplan and Terms of Reference

Decision *Lucy Flanagan*

6. Quality committee ToR and FWD plan.pdf (8 pages)

6.2. Quality Account 2023/24

Decision *Lucy Flanagan*

7. Front sheet Quality Account.pdf (2 pages)
7a. QA2023-24 draft v5 31.05.24.pdf (93 pages)

6.3. Operational Planning: Financial Plan 2024/25

Decision *Katie Osmond*

8. Covering Report Financial Plan 2425.pdf (2 pages)
8a. Financial Planning_202425_June Board_Final.pdf (8 pages)

6.4. Herefordshire and Worcestershire - NHS Five Year Joint Forward Plan Update 2024/25

Decision *Alan Dawson*

10. 20240524 JFP Board Cov Paper.pdf (3 pages)
10a. HW JFP - Main document 2425.pdf (30 pages)
10b. HW JFP - Appendix 1. Core areas of focus 2425.pdf (35 pages)
10c. HW JFP - Appendix 2. Cross cutting themes 2425.pdf (21 pages)
10d. HW JFP - Appendix 3. ICB Duties 2425.pdf (5 pages)

6.5. Update To Standing Orders

Decision *Erica Hermon*

11. Covering Report Public Board FG Standing Orders 2024.pdf (2 pages)
11a. GEH WAHT and WVT Standing Orders 2024-25 - V6 (WAHT Board Approved).pdf (35 pages)

13:58 - 14:23
25 min

7. Items for Noting and Information

7.1. Perinatal Services Safety Report

Discussion *Amie Symes*

12. Maternity Quarterly Report for Board.pdf (14 pages)

7.2. Patient Experience Quarterly Report

Discussion *Lucy Flanagan*

13. Patient Experience Report May 2024- Board report.pdf (11 pages)

7.3. Policy Panel Update

Discussion *Erica Hermon*

15. Covering Report Policy Panel Update.pdf (3 pages)

7.4. Board Assurance Framework and Divisional Very High Risk Report

Discussion *Erica Hermon*

- 16. Covering BAF and Risk Report for Board - June 2024.pdf (2 pages)
- 16a. BAF - Risks for Board 6th June 2024.pdf (3 pages)
- 20240603 Very High Risks.pdf (13 pages)

7.5. Mortality Report

Discussion *Chizo Agwu*

- Covering Report - May Mortality ReportCA.pdf (2 pages)
- 5a. Monthly Mortality Report - May 2024.pdf (5 pages)

7.6. Committee Summary Reports and Minutes:

7.6.1. Foundation Group Board Minutes and Action Log 2 May 2024

Discussion *Russell Hardy*

- 16.1 Draft Public FGB Minutes - 2 May 2024.pdf (14 pages)
- 16.2 Public FGB Actions Update Report - 2 May 2024.pdf (2 pages)

7.6.2. Integrated Care Executive Report

Discussion *Frances Martin*

- 17.2 Covering Report Public Board ICE Update.pdf (3 pages)

7.6.3. Quality Committee Report and Minutes 29 February 2024 and 28 March 2024

Discussion *Ian James*

- 16.3 QC Summary Feb 24 Public.pdf (2 pages)
- 9.3.1 QUALITY COMMITTEE MINUTES - FEBRUARY.pdf (2 pages)
- 16.3a QC Summary March 24 Public.pdf (2 pages)
- 17.3bb. QUALITY COMMITTEE MINUTES.pdf (17 pages)

14:23 - 14:25
2 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

14:30 - 14:30
0 min

10. Acronyms

- Z Acronyms - updated 08.09.23.pdf (3 pages)

14:30 - 14:30
0 min

11. Date of Next Meeting

The next meeting will be held on 4 July 2024 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 4 April 2024 at 1.00 pm
Via MS Teams

Present:

Frances Martin	FMa	Chair and Non-Executive Director (NED)
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Jon Barnes	JB	Chief Transformation and Delivery Officer
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)

Minute		Action
BOD01/04.24	**Apologies for Absence** Apologies were received from Glen Burley, Chief Executive, Russell Hardy, Chairman, Eleanor Bulmer, Associate Non-Executive Director and Sharon Hill, Non-Executive Director.	
BOD02/04.24	**Quorum** The meeting was quorate.	
BOD03/04.24	**Declarations of Interest** The Chief Strategy and Planning Officer advised that his wife is now an employee of Taurus Healthcare. **Resolved – that the Declarations of Interest be received and noted.**	
BOD04/03.24	**Going The Extra Mile Awards** Kate Harding has received the Chief Midwifery Officers National Award. Mrs Martin (Chair and Non-Executive Director) read out the nomination from the Trust for this award. Team of the Quarter – Quarter 3 – Chemotherapy Nursing Team – Mrs Martin (Chair and NED) read out the reasons why the Chemotherapy Nursing Team were nominated for this award.	

Employee of the Quarter – Quarter 3 – Maddy Roberts, Speech and Language Specialist – Mrs Martin (Chair and NED) read out the reasons why Maddy had been nominated for this award.

Runner Up Employee of the Quarter - Quarter 3 – Ericson Mojares, Health Care Assistant, Wye Ward – Mrs Martin (Chair and NED) ready out the reasons why Ericson had been nominated for this award.

BOD05/04.24 **Minutes of the meeting held 7 March 2024**

Resolved – that the minutes of the meeting held on 7 March 2024 be confirmed as an accurate record and signed by the Chairman.

BOD06/04.24 **Matters Arising and Action Log**

BOD15/03.24 - Patient Experience Quarterly Report - (B) - The Chief Nursing Officer will review the age profile for the national Care Quality Commission led Maternity Survey. The Chief Nursing Officer provided the percentage of figures - No Service Users under the age of 18 responded to the Maternity Survey. 7% were between the ages of 19 and 24, 21% between the ages of 25 – 29, 43% between the ages of 30 and 34 and 29% over the age of 35.

Resolved – that the Action Log be received and noted.

BOD07/04.24 **Chief Executive's Report**

The Managing Director presented the Chief Executive's Report and the following key points were noted:

(a) WVT Further Improved in the NHS Staff Survey – Three out of four of the Trusts within the Foundation Group are within the strong and improving quadrant for staff engagement. This has always been a strong focus for the Chief Executive (CEO) making sure we focus on staff experience and staff engagement.

(b) The Budget and the NHS – When the CEO wrote his Report, the Operational Guidance had not been received that came out at the end of last week, but we had received the Budget. The Budget is what we call "flat cash" with no additional funding for growth. We do see growth in demand but this does assume that inflation will remain where predicted. Therefore, this makes it a challenging financial future. It is pleasing to see in the Budget additional investment in digital. We have a long way to go in the NHS to have fit for purpose digital systems for staff and patients. The Operational Guidance is broadly as expected. As we review our Financial Plan for the rest of the year, we are going to have to look at how ambitious we can be at reducing our waiting times. The Outpatient target around the proportion of patients we see who are new patients or are having a procedure as part of their Outpatient appointment has been set at 46%. Reviewing our data, this is around 45% so we are already nearly at this national target. Productivity was also included in the Budget and what the NHS has signed up to in terms of productivity targets over the next few years. This is an area we regularly review within our Cost and Productivity Improvement Plan. This is regularly discussed in our Valuing Patients Time Board and our Productivity Board.

As the CEO notes in his Report, we are also going to be doing some cross Foundation Group productivity work. This allows us to delve into the detail with teams.

(c) Foundation Group Improvement Week May 13-17 – The first of these was run last year. This is an opportunity for staff across the Group to share and celebrate some of the innovations and improvements we have been working on.

(d) Mrs Twigg (NED) felt it would be useful if the NEDs could be invited to the Foundation Group Improvement Week. **JI**

<u>Resolved</u> – that:

(A) The Chief Executive's Report be received and noted.

(B) The NEDs will be included in the invites for the Foundation Group Improvement Week. **JI**

BOD08/04.24 **<u>Integrated Performance Report</u>**

The Managing Director presented the review of Integrated Performance Report and the following key points were noted:

a) We finished the year with some strong performance across a number of important areas.

b) Staff Survey – Autonomy and Control – Three questions in the Survey around how much staff feel empowered to either suggest improvement in their area or to actually make improvements in their area. We match the best nationally on all three measures which is very positive. We are also very proud of the Management Teams who create this environment.

c) We will finish the year with nearly 150 patients waiting over 65 weeks. The Operating Framework Target is for no 65WW by September. We also need to ensure we review the patients waiting near this target as well. The Managing Director was confident we will meet this target.

d) Patients waiting over a year is not in the Target. This year we reduced our 52WW from just over 2 thousand to just under 1200 which is a significant achievement.

e) Emergency Care – A real focus across the NHS occurred in March to do everything possible to improve waiting times for patients in Urgent Care. We were given additional resource to invest to enable further improvement. We managed to improve our performance by about 11% from January, which puts us in the top ten Trusts nationally with the improvement that we made. There was a cash incentive with this – with the potential to earn £2m capital to spend in the 2024/25. This is good performance but we need to improve further and it is one of the priorities for our One Herefordshire work as this is a system measure. Despite these improvements, we still have a number of Boarders on our wards which effects quality for both our patients and staff. We are aiming towards having no Boarders in our wards over the course of the year.

Resolved – that the Integrated Performance Report be received and noted.

BOD09/04.24 **Quality (including Mortality)**

The Chief Nursing Officer (CNO) and the Chief Medical Officer (CMO) presented the Quality Report (including Mortality) and the following key points were noted:

(a) The Report summarises the Quarter 3 for our CQUINS. It is pleasing to note that we achieved all of the CQUINS with the exception of the Fully Vaccinated CQUIN for Frontline Staff. Many NHS organisations also failed to achieve this due to low uptake of the flu vaccination this year compared to previous years. This was felt due to the additional vaccinations required during Covid.

(b) The Flu Campaign for 2024/25 has just been launched.

(c) We do not have to report on the quarterly performance against our communication with the Community Pharmacists, but we do track this internally and are on target to achieve this at the end of Quarter 4.

(d) The CQUIN Programme for 2024/25 has been paused subject to a review.

(e) PLACE Results – Included in the Report are our scores for each of our Community Hospitals and the Acute Site. Also provided is a comparison to our ICS colleagues and across the Foundation Group. It is pleasing to note across all of our sites that we are either almost achieving or just above the national score for our cleanliness which is good progress. Food service is measured by three domains – an organisational survey that occurs prior to the Audit, the food service is observed on how we present and deliver food to our patients and the taste. Unsurprisingly given other feedback mechanisms, the results highlighted the need to improve the food offer, what it tastes like and the presentation. Sodexo colleagues are working hard to improve on these elements. We are well below the national average for areas relating to privacy and dignity, wellbeing, dementia and disability. This is a similar issue for our Foundation Group colleagues. Some of this is due to the estate that we are working in and therefore difficult to change to improve our scores. The CNO provided a list of the areas of improvement required which are difficult to put right and lower our scores in these domains.

Some improvements are easier to make, which the CNO noted. Next steps – We have a Working Group who are prioritising the number of actions that we need to consider and from this month we will be introducing a rolling programme of PLACE Lite. This involves continuing to use the audit tool to assess areas on an ongoing basis.

(f) Our SHIMI remains within the expected range at 101.4.

(g) Focus continues on our outlier diagnostic groups which include heart failure and fractured neck of femur including coding and ways to improve care.

(h) The Medical Examiner Services across the Community are now ready to be rolled out. We have developed the Mortality Module on InPhase and have contacted our GP practices. Once it is mandatory for us to scrutinise our community deaths we are in a position to do this.

(i) The Learning From Deaths Committee is being set up and we have appointed Mortality Leads in all specialties to ensure that they are reviewing this in their specialties and learning from them. The Committee will therefore be an assurance Committee so that they can present the trends and themes and what quality improvements they have put in place as a result of their review. A Training Session has been arranged and the meeting will commence in May

(j) Mr James (NED) commenced Ross Community Hospital regarding the improvement in their PLACE results.

(k) Mr James (NED) noted the follow up work planned following the PLACE Audit, and was struck by the work that our Going The Extra Mile Award winner Maddy Roberts is doing which shows what enthusiasm we have among many of our staff to address some of the challenges that we have and asked that we ensure that we involve these front line staff who are in a position to help with a lot of this. The CNO advised that the Vulnerable Persons Group that was mentioned by Maddy Roberts is the group who will be focusing on the findings of these scores. It will therefore be these frontline colleagues who help us to prioritise these improvements.

Resolved – that the Quality Report (including Mortality) be received and noted.

BOD10/04.24 **Activity Performance**

The Chief Operating Officer (COO) presented the Activity Performance Report and the following key points were noted:

(a) Reflecting on the winter period, the COO wanted to remind colleagues and members of the pubic of the difficult challenges including industrial action etc over this period.

(b) Regarding our SSNAP Stroke Audit, which measures how well stroke care is being delivered in the NHS across the United Kingdom, we have achieved Level A. This is the first time that we have achieved this which is the highest grade achievable. The time frame was between October and December which is even more impressive as we were dealing with industrial action and entering the winter period as well during this time. We were one of only two Trusts that achieved this scoring in the Midlands.

(c) The Frailty Same Day Emergency Care (SDEC) team have been highlighted as providing good practice by NHS Providers in their March publication Health Service Innovation in supporting people with frailty.

(d) The COO thanked the efforts of staff across all of our Divisions in achieving the improvements in emergency care. We now have to learn from the achievements during March and what we can embed, what we can focus on and what we can build on for 2024/25 so that we can achieve 78% in 4 hours.

(e) Cancer data is always reported 2 months in arrears in the Report. January was particularly challenging although our Faster Diagnosis Standard within 28 days, improved to 72% from a low of 65% in November and our 62 day patients that started treatment was highest at 142 patients in January and we have made significant improvements in this area in February and March, achieving 79%. We have to deliver 77% by the end of March 2025 which puts us in a good position to achieve 80% in March 2026 which has recently been announced. The number of patients who waited over 62 days for treatment were reduced to 62 by the end of March which was below our trajectory of 71.

(f) Mrs Martin (Chair and NED) noted the significant improvements made particularly with the difficulties faced during this time and formally thanked the COO and his team for their resilience and achievements to continually try to provide the care we would want for our family and friends even if this is not always possible.

(g) The Managing Director questioned how confident the COO was, in particular regarding the cancer work, that this can be sustained. The COO was relatively confident that this can be achieved. It has required a significant amount of effort on behalf of the Divisions to get to this stage. Now that we are using the information we have in a better structured way and the Cancer Manager has put a good foundation in place working alongside the Divisions we are in a really good place. It will be difficult, but we should be able to build on this level of improvement.

Resolved – that the Activity Performance Report be received and noted.

BOD11/04.24 **Workforce**

The Chief People Officer (CPO) presented the Workforce Report and the following key points were noted:

(a) Workforce KPIs – We are starting to see a reduction in sickness absence with a further reduction expected over the coming months, with the interventions put into place.

(b) The Health and Wellbeing Strategy has also been developed which is about calling on colleagues to take on more ownership and responsibility for their health and wellbeing.

(c) Through our Divisional Recruitment and Retention Working Groups, we are maintaining low staff turnover and taking active steps filling our vacancies.

(d) Through Ramadan, we provided guidance to our Line Managers in terms of supporting our Muslim staff.

(e) The Staff Survey is very positive regarding our ongoing commitment to equality, diversion and inclusion.

(f) Performance Appraisals – We have written to all Divisional Leaders asking them to complete any outstanding appraisals by the end of June. This will be reviewed in the monthly Finance and Performance Executive meetings.

Resolved – that the Workforce Report be received and noted.

BOD12/04.24 **Finance Performance**

The Chief Finance Officer (CFO) presented the Finance Performance Report and the following key points were noted:

(a) Mrs Martin (Chair and NED) formally thanked the Associate Chief Finance Officer for all her hard work covering during the CFO's absence. The CFO echoed this thanks and to the Finance Team.

(b) This Report covers up to Month 11, end of February. The deficit year to date stands at £12.7m. This is adverse to plan but remains in line with the revised forecast. The forecast was revised at Month 10 following confirmation of some additional national support.

(c) We have maintained strong elective performance throughout the year and benchmark well against value weighted activity but we know much of this is delivered at premium costs.

(d) In terms of our efficiency programme, we have delivered just under £8m of financial improvement year to date. This is less than we planned to deliver and we have inevitably been affected by some of the challenges that have impacted us this year, such as the industrial action.

(e) Our prompt payment performance has improved in February and our cash support request we have been making nationally linked to the deficit have all been supported to date. A further application has been made and is being processed for Quarter 1 2024/25. The CFO asked the Board to formally endorse support for ongoing submission for revenue support requests linked to our cash flow requirements.

(f) Planning Guidance was very late being received, but not withstanding this, we broadly knew what we were expecting. The usual planning process has been undertaken in the organisation. Over the course of the planning cycle, the Board of Directors have been updated on the Financial Plan and the assumptions that underpin it. Our Plan was submitted last week and reflects the deficit plan of £36.8m in 2024/25. Ordinarily the final plan and the corresponding Divisional budgets would be brought to this meeting for ratification, but due to timing issues and the late guidance coming out, this will be presented to the next Board of Directors meeting. The CFO is confident that our Divisions and Directorates have been fully engaged in this planning process and are clear on the financial parameters within we are expecting them to operate in in 2024/25.

(g) Mr Lappin (ANED) noted that we have secured an additional £13m from national resources against a very challenged NHS financial position and complimented the team on securing this.

Resolved – that the Finance Performance Report be received and noted with formal Board endorsement to support cash support requests for ongoing submission for revenue support requests linked to our cash flow requirements.

ITEMS FOR NOTING AND INFORMATION

BOD13/04.24 **Staff Survey**

The CPO presented the Staff Survey and the following key points were noted:

(a) The Trust achieved above average for all key areas in the Staff Survey which is very positive.

(b) There were significantly higher scores achieved in five areas – learning and development, flexible working, staff engagement and staff morale. This improvement is due to the concerted efforts that we have put in in terms of leadership and development, health and wellbeing and ongoing staff engagement.

(c) The paper covers the staff groups and Divisions with the lowest scores and actions to be taken locally with our leaders over the next few months

(d) There have been significant improvements in the Surgical Division. The CPO was also pleased to see the positive feedback on the support provided by immediate Line Managers.

(e) Although there are some areas to improve upon, the Trust has not been rated in the worst performing Trusts in any areas. Overall, we are among the top performing Trusts in the Midlands.

(f) As occurred last year, from May this year for three to four months, there will be a number of events focusing on staff engagement in the Trust. This will enable local teams to come up with local solutions to address some of the areas of concern in the Survey.

(g) The Report also includes all the work that is being carried out in regards the eight elements of the People Promise in the Survey.

(h) Mrs Martin (Chair and NED) thanked, on behalf of the Board of Directors, the CPO and his team for all their hard work in achieving such high scores overall.

(i) Ms Quantock (NED) noted under the “Voice That Counts” section scores are not where we would want it to be and questioned what our response to this is. The CPO advised that we are working on this with our new Freedom To Speak Up Guardian. Since she started in post, we have gone from twenty two Freedom To Speak Up Champions to nearly one hundred. She is actively engaging with teams across the board and will obtain better traction over the coming months, with better scores expected in this area next year. We also provide training on Civility Saves Lives.

(j) Mrs Twigg (NED) noted the huge improvements made in the scores which is a difficult task in most circumstances, but even more so during recent years. She went on to note that the Staff Survey is the place for all staff to have a voice and we need to improve the percentage who complete this – Wye Valley Trust had 34% with the peer average 45%. The CPO advised that he and the Managing Director had discussed this with plans in place including potentially giving staff time to complete the survey and having more laptops available for staff to use for this purpose. The Managing Director agreed on the importance of increasing the number of staff completing this Survey. There has been a real stepped change in energy and engagement regarding Freedom To Speak Up which is bound to have a positive impact on staff. A number of videos have been recorded by the Executive Team to go out to staff around what it means as an Executive to have Freedom To Speak up working which can highlight areas that we are not always aware of to act upon.

(k) The Managing Director highlighted, regarding the Divisions and the Specialties of staff, there have been some positive changes in the Surgical Division with some strong leadership in place over the last year. Our Medical Division however has gone down with some unstable leadership, with the pressures in the Emergency Department (ED) and boarding patients noted. She was confident with the new leadership in place, improvements will be seen. The Professional, Scientific and Technical staff results were also been lower than across the rest of the organisation. The Managing Director and Mr James (NED) undertook a walkabout recently in Pathology with a new leadership team in place which is having a positive impact on staff. It was also very pleasing to see the Nursing and Health Care Support Workers are at or above average in these scores. Regarding our doctors, we are doing a lot of work with leadership development with our senior medical staff which should be reflected in next year's results.

(l) Mrs Martin (Chair and NED) advised all staff of how they can contact the Freedom To Speak Up Guardian or one of the Champions or to speak with an Executive Director of any concerns.

Resolved – that the Staff Survey be received and noted.

BOD14/04.24 **Health and Wellbeing Strategy**

The CPO presented the Health and Wellbeing Strategy and the following key points were noted:

(a) The Strategy has been developed with the Trust's Health and Wellbeing Group. This sets out our aim to try to encourage every single member of staff to take more ownership and responsibility for their own health and wellbeing. This enables staff to have less time off work and to enable a better service to our patients.

(b) The Strategy uses the NHS Health and Wellbeing Framework and puts forward the enablers and health interventions which are important in terms of trying to optimise the health and wellbeing of our colleagues. This also talks about everyone taking responsibility for their own health and wellbeing. We can provide the support and interventions, but fundamentally staff need to take responsibility for their own health and wellbeing.

We have also put actions in place through the Halo Leisure Programme to further help to support colleagues.

(c) This Strategy is to support staff, including with mental health, as this remains one of the highest reason for staff being off sick.

(d) Ms Quantock (NED) queried if there was a timeline when we might get some intelligence of what peoples most common blocks are on taking that responsibility, ie the actions they know that they need to take for their health and wellbeing and what we can do to support them with this. The CPO advised that we will be using the local intelligence from our Mental Health Wellbeing Nurse and our Wellbeing Champions who are out and about in all areas talking with staff and offering support. We will be providing quarterly reports based on that local intelligence in addition to local intelligence from Occupational Health and from HR Business Partners. The CPO and the Managing Director had also been discussing holding more surveys with health and wellbeing one of the areas that we will be focusing on.

(e) Mr James (NED) noted that a Strategy is only as good as the actions that we take to complement it and asked for more information around how we are promoting this across the Trust. The CPO advised that now this has been presented to the Board of Directors, we will be using this as part of the HR Roadshow we are promoting in 2 weeks' time. The Strategy will also form part of the local staff engagement sessions previously discussed. This will also be displayed across the Trust, eg as a Screen Saver.

Resolved – that the Health and Wellbeing Strategy be received and noted.

BOD15/04.24 **Maternity Perinatal Quality Surveillance Report**

The CNO presented the Maternity Perinatal Quality Surveillance Report and the following key points were noted:

(a) There were no exceptions to report to the Board.

(b) The CNO Chaired the monthly Maternity and Neonatal Safety Champion meeting the previous day. Mrs Martin (NED), our Non-Executive Maternity Safety Champion also attended the meeting. The meeting is about receiving feedback from staff and service users and different intelligence sources. The Maternity and Neonatal Partnership recently held their quarterly meeting and their Chair fed back that our communication, support and engagement to our service users is really strong and positively received, particularly in the antenatal and postnatal periods. However, there is still further work to do around the perinatal phase. They advised that sometimes our communication and engagement, informing and enabling them to have joint decision making with us is not always where it needs to be. Part of this feedback used to be around induction of labour and we have coproduced, with our Maternity Neonatal Voices Partnership, a video and leaflet which has recently been launched to support decision making and understanding for our service users.

(c) Kate Harding attended the meeting earlier in acknowledgement that she had received the Chief Midwifery Officers National Award for her contribution to maternity services as a Maternity Support Worker which is a huge achievement. Also, during the feedback yesterday at the Maternity and Neonatal Safety Champion meeting, we also heard that one of our other Maternity Support Workers, Mel Webb, consistently features in service user feedback about how she supports individuals on our ward and out in the community.

(d) We have planned our annual 15 Steps of Maternity and Neonatal Services for mid-April. This is where we bring service users into our services to provide feedback on their first impressions of the environment, communication and the feel of the services that we offer.

(e) In the last month, the Neonatal Unit have received Stage 1 for their Baby Friendly Initiative, which is a fantastic achievement for the team. We are also awaiting the Baby Friendly Initiative Stage 3 feedback for Maternity, with the expectation that this will be achieved also.

(f) The Safety Standards for Maternity Services, the CNST (10 standards) for Trusts has just been launched. We are reviewing this guidance with a view to committing compliance against all 10 Standards for next year.

Resolved – that the Maternity Perinatal Quality Surveillance Report be received and noted.

COMMITTEE SUMMARY REPORTS

BOD16/04.24 **Audit Committee Report 22 February 2024 and Minutes 14 December 2023**

Resolved - that the Audit Committee Report 22 February 2024 and Minutes 14 December 2023 be received and noted.

BOD17/04.24 **Charity Trustee Report 14 March 2024 and Minutes 14 December 2023**

Resolved – that the Charity Trustee Report 14 March 2024 and Minutes 14 December 2023 be received and noted.

BOD18/04.24 **Quality Committee Summary and Minutes 25 January 2024**

Resolved – that the Quality Committee Summary Report and Minutes 25 January 2024 be received and noted.

BOD19/04.24 **Any Other Business**

There was no further business to discuss.

BOD20/04.24 **Questions from Members of the Public**

Q1. Thank you for the response to last month's question on Assaults upon WVT staff. I find this situation appalling. 71 verbal assaults and 66 physical assaults in six months and only 7 warning letters from the Trust to protagonists! No apparent feedback from the Police. What more can the Board do to support its staff? Could you improve liaison with the Police so that they report back regularly concerning Hospital staff assaults? Could/should the Trust write more warning letters to protagonists? Will the Board include the response from the requests to the Police made as a result of last month's question, within the minutes of this meeting? Should there be increased de-escalation and restraint training for staff? Could more security staff be available at times and locations when incidents are likely to occur? How many of the 66 physical assaults were RIDDOR reportable and what was the feedback from the Health and Safety Executive on these matters?

A1. The Chief Strategy and Planning Officer advised that the data hides a lot of nuance. Multiple incidents are attributable to a small number of individuals, which is one of the reasons for the high number. All of the incidents were on one particular ward during that period were down to one particular patient. Some of these incidents relate to patients who are clinically unwell and do not have capacity at the time and so are not necessarily the type of incidents for which we would call the police or issue a warning notice. We have a good relationship with the West Mercia Police. As reported in the Hereford Times this week, someone was successfully prosecuted for verbally abusing staff in the Trust, which shows that we do follow this through with the police. Warning letters are sent when we feel that they are necessary, but following our Policy, we try to resolve incidents informally with the patient/relative/member of the public face to face before taking it further to a Warning letter. We do have key staff trained and are looking at potentially doing more and we have implemented a security service last year with our Sodexo partners. None of the physical assaults were RIDDOR reportable. There was a Report presented to the Board of Directors a few months ago which contains a lot of this information.

Mrs Martin (Chair and NED) reiterated that it is not acceptable for people, who have capacity, to abuse our staff in any way. We will of course, always be sensitive to people's individual circumstance. It is positive to have high reporting and we can then make any appropriate adjustment to keep everyone safe.

Q2. WVT is heavily dependent upon overseas trained nurses. Nationally it has been suggested that a significant number of non UK/EU trained nurses are leaving the NHS for better paid jobs in countries such as New Zealand, Australia and the USA. It should be possible, from exit interviews with WVT staff who are leaving, to ascertain whether or not this is a problem for WVT. Is it? I understand that the Government has now changed the visa rules for overseas nurses who want to come to the UK to work. This change removes the right for such staff to bring dependants with them. It is likely to be unpopular with applicants. How is this change anticipated to affect WVT recruitment of overseas nurses?

	A2. The CPO advised that the Trust has a very successful recruitment and retention programme for our international nurses, retention rate of 94% which is amongst the best in the Health Service. However, we are aware of the need to grow more of our own staff, so one of our strategic ambitions is to grow more of our own qualified nurses with a programme in place to support this. In terms of the visa requirements, NHS organisations are currently exempt from the visa rule changes, so overseas nurses are still able to bring dependents into the UK so long as they work for a NHS Trust as a qualified nurse. **Resolved – that the Questions from Members of the Public be received and noted.**
BOD21/04.24	**Date of next meeting** The next meeting was due to be held on 6 June 2024 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 6 JUNE 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD07/04.24 Chief Executive's Report 04.04.24	(B) The NEDs will be included in the invites for the Foundation Group Improvement Week.	JI	Completed.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on the reflections of the CEO on current operational and strategic issues.

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

Assurance can be provided that the information within this update report is accurate and up to date at the time of writing.

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

Quality Improvement

☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes***

☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)***

☒ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care***

Digital

☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy***

☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways***

Productivity

☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations***

☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***

Sustainability

☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff***

☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process***

Workforce

☐ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners***

☐ ***Develop a 5 year 'grow our own' workforce plan***

Research

☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

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1. Foundation Group Improvement Week 2024

The week was designed, planned, and delivered by collaborating across the Foundation Group's Improvement teams and offered free to all colleagues and place and system partners. The five days were themed around Prof Helen Bevan's conditions for "positive deviants" to achieve change. Guest speakers included Prof Helen Bevan, Sonia Sparkles, Russell "Rusty" Earnshaw, NHS England, Dr Emily Rowe and the Coventry and Warwickshire Maternity and Neonatal Partnership Chair. Topics ranged from failing forward, co-production, sketch-noting, self-improvement, connections, and a 'mash-up' of the four improvement forums sharing improvement projects. In addition, 9 training sessions were offered that blended VMI, QSIR and bespoke training in data, prevention and health inequalities.

The week was well attended throughout, with good representation from all four organisations, and 132 people outside the foundation group attending. In total there was an attendance of 1868, by 771 individuals, averaging 104 colleagues at each session. This improved on last year's average of 45 and had the highest attendance in a session of 337. Feedback is overwhelmingly positive, with participants rating it as varied, interesting and a good use of time. Two learning points were to ensure managers encouraged attendance and facilitated time to attend. Colleagues unable to attend can watch back on the digital 'goody-bag' being shared. Overall, a theme came through about the power of connections in improvement, and improvement week helped these to form and strengthen. The sessions were engaging, informative and permissive, generating enthusiasm and discussion outside of the sessions. The week offered insight into topics that supported all 5 of the NHS IMPACT domains and the Big Moves to support our improvement culture. Participants were up-skilled and encouraged to return their learning to their teams, find their foundation group counterparts and take their next step in improvement.

2. Elective Hub Development

Our new Elective Surgical Hub is nearing completion ahead of its operational start date of early July. Last week I was taken on a tour of the Unit alongside one of our Consultant Ophthalmologists. As the Board is aware, part of the Hub will be a dedicated Ophthalmology space which has been designed to optimise patient flow to increase the quality and productivity of our day case cataract capacity. On the left hand side of the Hub are our two new Day Case operating theatres and supporting space.

The contractors Speller Metcalfe Ltd, based in Malvern have done a tremendous job in bringing to life the design of the project team who in turn have actively engaged the clinical specialties who will use the facility. I was incredibly impressed with the space that has been created which will be great for both patients and our staff. The Ophthalmologist who joined me was similarly impressed and I saw his face light up as he entered the cataract theatre.

The transformation of that part of the County Hospital site over the last few years has been truly remarkable with the hutted wards removed, the new corridor and frailty block in place now complimented by the fantastic Elective Surgical Hub. I would like to congratulate everyone involved in the project for delivering such a great facility on plan.

3. Financial Escalation Meetings

Following the second submission of 2024/25 Financial Plans to NHS England, all systems in deficit have held escalation meetings with Regional and National colleagues. For us, the meeting took place on 10th May. The view of NHSE is that all systems have been given sufficient funding to ensure that their financial plan for this year broadly matches that of last year. Unfortunately, many Systems, including our own are not able to confirm this 'steady state' position. In most cases this is

due to a combination of factors including the impact of using non-recurrent funding to support last year's plan. Much of the challenge from NHSE where deficits have increased has been scrutiny on overall increases in headcount which have not delivered increases in activity or reductions in temporary labour costs. Improvements in Urgent and Emergency care pathways should protect elective capacity better to secure elective recovery fund payments for reducing the waiting list. Increases in elective activity, alongside reductions in premium temporary labour costs feature heavily in our challenging financial plans, a situation replicated across the Group.

The overall System financial plan still delivers a large deficit. Both WVT and Worcestershire Acute Hospitals NHST currently have deficit plans in part driven by a loss of non-recurrent income compared to last year. At the stage of writing this report the deficit plan has not been signed off as acceptable by NHSE.

4. Workforce Productivity Diagnostic Tool

The tool was launched shortly before the May national CEOs meeting as part of a suite of tools to support productivity improvement. The data supporting it will be regularly updated and will include more timely data than we have previously seen within the Model Hospital analysis. The first release of the tool included data up to month 5 of 2023/24 and allowed comparison between this and the 2019/20 financial year (last comparative year prior to Covid) and the 2023/24 full year. Trusts are encouraged to work through the data and to assess correlation to staff survey results and relevant workforce management initiatives such as job planning compliance and electronic rostering.

Increases in headcount are compared to value-weighted activity volumes. Based on the national analysis, adjusted productivity in 2023/24 was felt to be around 11% lower than before the pandemic or 8% when adjusted for the impact of industrial action. Nationally four factors are said to explain roughly half of the decline: increasing costs as infrastructure and tech is upgraded; increased length of stay for patients; increasingly expensive new medicines; and temporary staffing costs. However, this still leaves a gap which has not yet been explained from national data. In particular, we cannot yet estimate the impact of reduced staff discretionary effort as we have come through the pandemic and industrial action. NHSE have also suggested that the loss of experienced workers after Covid could have contributed. In relation to length of stay, it said this was partly due to rising acuity, but also disruption to operational processes and constraints on out of hospital capacity in particular social care where domiciliary care capacity has been recovering post-pandemic.

The service has faced criticism for its major increases in staffing and funding whilst not delivering significantly more activity. Current measurements of productivity need to be improved, particularly where service delivery models have changed. Particularly as certain activity types, including diagnostics, advice and guidance, and same day emergency care, are not included in the analysis.

The local data shows that a workforce growth of 16.5%, delivered an activity increase of 4.7%, which equates using their methodology to an 8.1% overall implied productivity fall. The year-on year data showed a productivity increase of 4.8%. These new tools are likely to feature heavily across the NHS over the next few years. We will therefore ensure that they are captured in our performance dashboard.

5. Further Capital Incentives for A&E Performance in 2024/25

NHSE announced earlier this month that its capital incentives scheme for improved emergency care performance will return this year. Up to £150m of funding will again be available for 2025-26 capital budgets for trusts which can demonstrate improved performance against the four-hour waiting time standard and category two ambulance response times. It will also be used to reduce 12-hour accident and emergency delays for the first time.

I am delighted to report that WVT finished March in the Top 10 Most Improved list of Trusts against the 4-hour emergency access standard. As a consequence we secured £2m more capital for this year. I would like to pass on my appreciation to the hospital and community-based teams who helped to deliver this.

6. Reducing Premium Temporary Labour Costs

I recently took part in a BBC interview to highlight the excessive costs to the NHS of using off-framework staffing agencies. The specific example used, the Thornbury Agency, charge the NHS up to £2,000 for individual nurse shifts with only a proportion of the fee going to the clinician. Off framework agencies are those who refuse to operate within the cap set by NHSE which is deemed to be a realistic maximum charge to cover vacant shifts.

The NHS has set an objective to completely irradiate the use of off framework agencies from July of this year. This will not be an easy task as some agencies have targeted recruitment of staff from specialist areas in the NHS where staffing is most challenged. We hope that by making a coordinated effort, the NHS could potentially rid itself of these high-cost agencies, or at least significantly reduce the volume of activity they undertake. The nurses who work for these agencies are being encouraged to take up roles within the NHS or to move to those agencies which are willing to work within the framework pricing model. All four Trusts in the Group offer flexible working patterns for clinical staff which are able to match those offered by these agencies. Direct employment in the NHS is potentially even more flexible and convenient as we generally leave high-cost agency requests until the last minute when all other options have been exhausted.

7. MORE FROM OUT GREAT TEAMS – Update from the Surgery Division – June 2024

The Surgical Division's key areas of focus over the last three months has centred on improving theatre throughput, devising new productivity objectives for 24/25, reducing long waits to treatment and continuing the operationalisation plans for the Elective Surgical Hub, while also improving suspected cancer access to endoscopy.

March 24 saw a record month for the number of patients treated in our theatres during 23/24. In total, 808 cases were completed during the month, marking the third consecutive month of improving activity levels. This is set against an average of 688 patients for the first 6 months of 23/24 and 751 for the second 6 months of the year, demonstrating a steady improvement over the last 6 months. While this level activity delivered an in month improvement in theatre utilisation to 79.8%, this remains below target and the objective is to sustain these improvements over coming months and improve utilisation further towards 85%.

Further improving productivity in both theatres and outpatients is a key objective for 24/25. The Division has set 25 productivity aims for the current year. These are largely set against the benchmarked Getting it Right First Time data and include delivering a virtual fracture clinic in Trauma and Orthopaedics to improve access, flow and slot availability; increasing the number of theatre cases on ENT lists to 8 and delivering high volume outpatient clinics. Job planning is also being undertaken with the objective of creating an additional 201 flexible sessions over a 12 month period in General Surgery for example to reduce lost sessions.

The Division continues to focus on reducing long waits to treatment. Orthopaedics and Ophthalmology are the Division's most challenged specialities, but recovery plans are delivering ahead of plan: as at 9th May, Orthopaedics' backlog stood at 508 against a recovery projection of 525, and Ophthalmology 663 against a target of 687.

Delivering an improved suspected cancer endoscopy service has also been a key objective in recent months. Revised operational management processes and more robust and cross Divisional working has delivered improved wait times, reducing these below the 7 day target on average for the 4 key areas. Only waits for colonoscopies averaged just over the target at 7.28 days, but plans are in place to drive this down further.

8. Going The Extra Mile Awards - Winners from Quarter 4

Team Winner – Quarter 4 – Medical Division Team

Citation – 'Yesterday the Medical Division colleagues managed an extremely challenging position. I was level 3 on call yesterday and was extremely impressed with the way the team managed all the challenges that were presented. Laura Morris was not fazed by the constant barrage of requests and expectations of the day, and was largely the only site manager on duty, her work impacted hugely on the overall bed position.

Becky recognised the risk of having one site manager overnight and so worked half the morning and returned home to bed to come back and do the night shift. Other site managers came in early and took on extra hours to fill gaps. Katie Richards should have finished shift at 3pm but stayed until 6pm to support Laura.

Lou Weaver & ED staff were under constant pressure but showed a caring and supportive attitude throughout a difficult day. Sarah Holliehead was always at the end of the phone for advice and action to solve problems. Toni Robinson and Leah Savage spent most of the day walking the wards, moving patients and supporting staff'

Employee Winner – Quarter 4 – Gajendran Kanagalingam

Citation - 'Gaje has driven and organised every aspect of our BPS course which we are running in Hereford this week. Gaje has been presented with problem after problem and has sorted each and every one of them. Gaje has been unbelievably accommodating with the bombardment of questions, queries and issues presented with setting up this course. Gaje has taken on this mammoth task in a very short space of time and has never faltered on his kindness, impeccable manners, understanding of the subject, organisational skills and approachability. There are also comments about Dr Kanagalingam on "Your Hereford" on Facebook praising him for his work'

Glen Burley
Chief Executive Officer

Integrated Performance Report

June 2024 (data as of April 2024)

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives

Managing Director

It is really good news that our vacancy position has fallen from over 11% to under 4% in the last 2 years in part due to a reduction in turnover from 14.5% to 9%. Although we have seen a reduction in nurse agency alongside this it is not as low as would have been expected from the vacancy position. The additional staff required in ED to care for around 20 patients waiting for a bed (in effect an additional ward), the increase in staffing on our wards to care for around 30 patients who are boarding over and above our bed base and the increase of 11 community beds is the driver of additional staff over our budgeted establishment.

The highest risk in the organisation is the level of patients being cared for over our bed base, it affect the quality of care we are able to deliver, the experience of patients and the impact that it has on our staff.

Delayed discharged have reduced from over 60 to under 30 over the last 3 months. This has been achieved by exceptional joint working facilitated by the BCF in Herefordshire to improve productivity and discharge to assess capacity and there are further improvement planned in the coming year. This added to a much improved position for commissioned home care led by the local authority has sustainably improved capacity for discharge. The reduction in delayed discharges for our patients from Powys has been welcome but has been a more reactive approach so far that may not prove to be as sustainable.

Despite this significant improvement it has not been accompanied by a commensurate drop in demand for acute beds as we have seen increasing acuity of patients and increased demand which is concerning. The increase in demand since last April is an additional 366 admitted patients of which 366 (or 12 per day) were treated through SDEC and 178 (or 6 per day) were admitted. This is a 15% growth in demand for admission (and 28% growth in emergency demand). In effect the winter levels of demand have continued into April and have continued into May.

Given the congestion in ED the improvements in the key safety and flow metrics in ED are remarkable. The 'tests of change' in March that meant our performance was the 7th most improved in the country in March have been continued and we have maintained that performance in April and May.

It is a testament to our clinical and operational teams that against this very difficult backdrop we have also achieved higher levels of elective activity than planned that have reduced waiting times and have helped to support our financial position. This will be further enhanced when the elective surgical hub open in early July with high levels of productivity planned in the operating model and the design of the facility.

In addition a reduction in mortality that should see SHMI drop below 100 for the first time has been achieved. The CMO led approach to improving patient pathways and proactively acting when indicators show mortality outliers as the key feature of our approach to mortality continues to be effective.

Our month 1 financial positon will show an adverse variance to plan of circa £200k once income is cashed up. This is not a good start to the year and the main driver is under delivery of our cost and productivity improvement plan which needs to deliver saving of £20m over the course of the year. All our teams are focussed on delivering this target but we are under no illusion that it represents a mountain to climb.

Our Quality & Safety – Executive Narrative

Chizo Agwu
Chief Medical Officer

Infection prevention and control—mortality outliers (clostridioide infection (CDI) and E-coli bacteraemia)

The Trust's 30 day mortality rate for CDI stands at 19% at the end of March 2024. The national benchmark is 13.7%.

The overall Trust mortality rate for E.coli bacteraemia related deaths is 21%. This is higher than the national mortality rate of 15 %

A mortality review has been requested of the patient cases to enable further analysis and support Trust learning. Additionally, discussions with the mortality manager in relation to our outlier status are underway.

PSIRF—Patient Safety Incident Response Framework

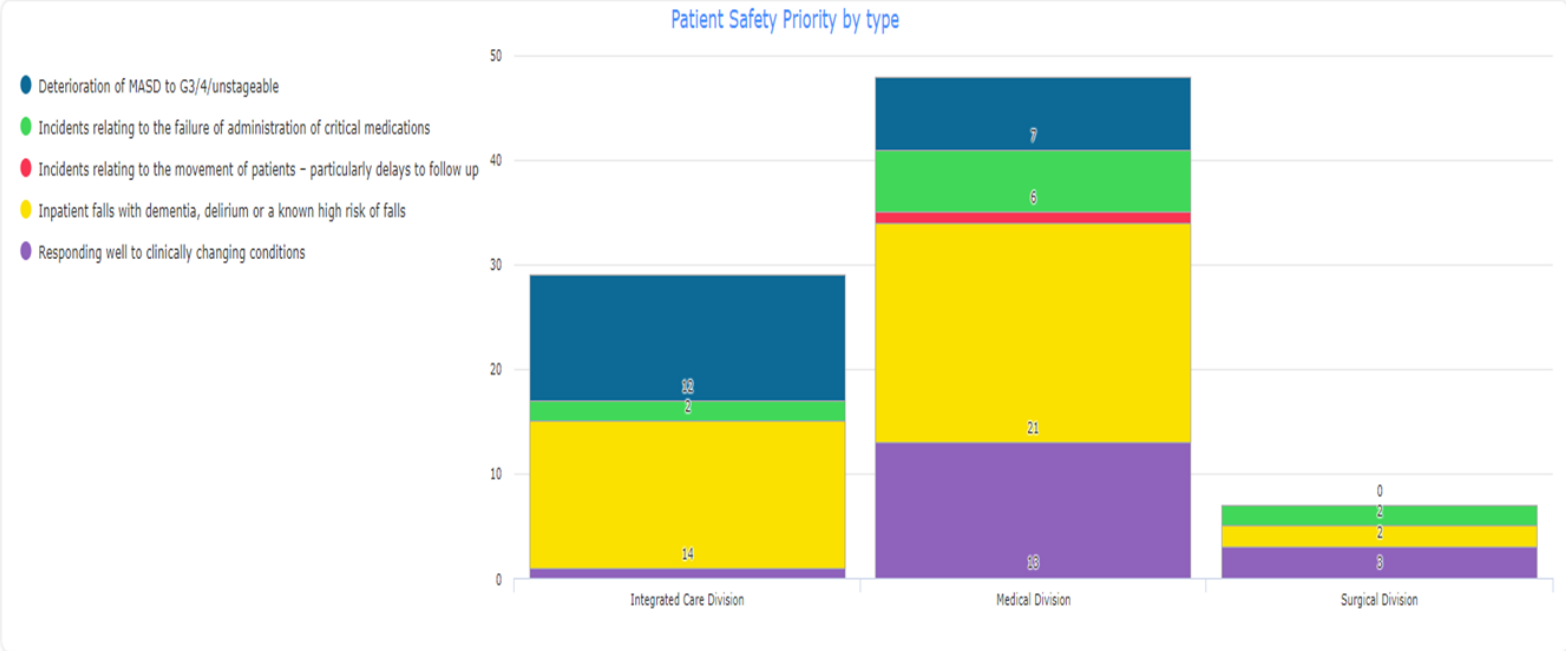
36 incidents were discussed at Patient Safety Panel in April

- 1 Comprehensive rapid review and action plan for Moisture Associated Skin Damage (MASD), which has deteriorated to an unstageable pressure ulcer to the buttocks whilst under the care of the District Nurses
- 1 Nationally defined PSII for a Never Event - Ophthalmology incident—immediate learning identified requirement to amend safety checklist

Lucy Flanagan
Chief Nursing Officer

Patient Safety Priorities—6 months at a glance

The chart below highlights the number of incidents reported against our agreed patient safety priorities (6 months data). Quality Committee received a deep dive into patient falls and time critical medications at the meeting in May 2024.



Quality and Safety – Mortality

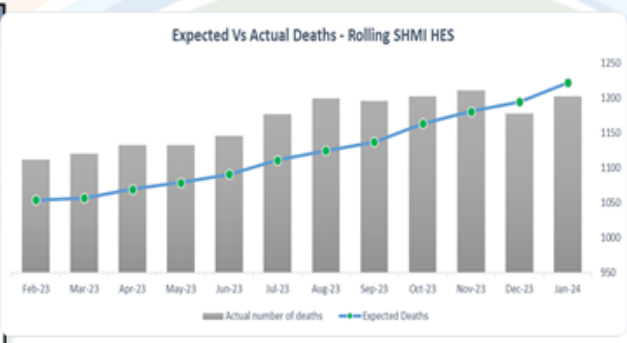
We are driving this measure because:

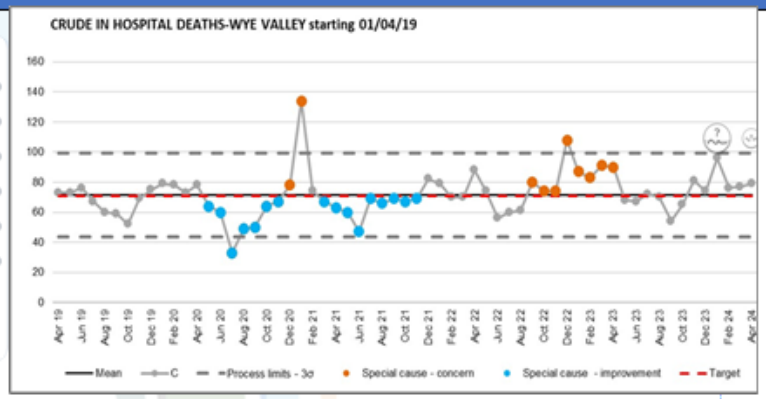
Mortality was previously reporting a 'higher than expected' level of mortality at WVT, based on our SHMI. The past few months have shown significant continued reductions in our SHMI, and has since returned to an 'as expected' level of mortality for our demographic.

Data

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Jan 23 - Dec 23	101.7	1.1

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Feb 23 - Jan 24	98.4	-0.3
SHMI (in hospital)			92.7	-0.4
SHMI (out-of-hospital SHMI)			111.5	-0.05





What the chart tells us:

- Latest nationally reported **SHMI** (*NHS Digital*) from January 2023 to December 2023 shows an encouraging reduction of 1.1 to **101.7** for Wye Valley NHS Trust. A similar positive position is reflected in the provisional HES-based SHMI, which for the 12 month period from February 2023 to January 2024 is **98.4**.
- In regards to our key **mortality outlier groups**, there has been several significant reductions in the latest SHMI data, most notable in pneumonia with a reduction of 5.2 to 97.4. Our heart failure mortality rates have also reported a welcomed reduction to 112 in the latest NHS Digital data, and now sits back within 'as expected' ranges. The #NOF mortality rates remain at 'higher than expected' levels with the latest NHS Digital SHMI (*Jan 23 – Dec 23*) at 146. The #NOF mortality lead will be providing feedback at the May Learning from Deaths Committee, which will include the findings from the current mortality audit and proposed actions.
- **Clinical Coding KPI's** (*February 2023 – January 2024*) indicate a continued strong and improving performance for our co-morbidity scores for live and deceased patients, both of which remain above our peer and the National means. In addition, the number of cases with a 'sign or symptom' coded as their primary diagnosis has significantly reduced. This improvement has been in response to Clinical Coding conducting a monthly reconciliation review of all deaths with a sign or symptom in their primary diagnosis, upon review they seek out the clinical teams involved with the aim of identifying an appropriate diagnosis.
- **Crude mortality** rate for April 2024 was **1.68%** for all admissions, which includes both planned and unplanned admissions to the Trust, equating to 79 deaths. Please note that this does not include any deaths occurring in the Emergency Department deaths.
- The **extended perinatal mortality** and **stillbirth** mortality rates remain unchanged since the last reported with the latest data indicating both rates are at **2.38 deaths** per 1000 live births.

• Key Actions and Updates:

- The first Learning from Deaths Committee was held earlier in May with presentations and updates from Care of the Elderly, #NOF, and Learning from Legal. In addition, the first Mortality Review Panel will be held in June, which will comprise of deep dives into escalated cases. A half day training sessions was held in April for all clinical mortality leads focussed primarily on the Structured Judgement review process, and an understanding of the plans and expectations for implementing across the Trust.
- During April, there were 91 in-hospital and ED deaths. The Medical Examiner Service reviewed 100% of cases, of which 10 cases were highlighted as requiring further in-depth specialty review. In addition to the above acute cases, there have been 53 community deaths reviewed by the Medical Examiner Service during April 2024. Primary care leads have been approached to develop an appropriate route to feedback learning, key themes, and / or potential issues in care. The Medical Examiner service continues to invite early adopters, prior to the National go-live in September.

Quality and Safety – Trust Quality Priorities and Patient Safety Priorities 2024-25

Topic	Quality Priority
Tissue Viability	Reduction in cases of grade 2 pressure ulcers
VTE	Ensure patients receive a timely VTE risk assessment in line with NICE guidance
Deteriorating Patient	Improving care of deteriorating patients and implementing Martha's rule by January 2025
Patient Experience	Improve responsiveness to patient experience data
Time Critical Medications	Fully implement the Get it on Time campaign for Parkinson's medications Implement quality improvement project to target high risk time critical meds as locally defined.
NATSIPS2	Implementing the NATSIPS2 standards and improving management and oversight of safety in relation to interventional procedures

Patient Safety Priority	Description
Tissue Viability incidents	Deterioration of MASD to G3/4 or unstageable pressure damage
Inpatient falls	Inpatient falls in patients with dementia, delirium or a known high risk of falls
Delays in assessment, diagnosis or treatment	Responding well to clinically changing conditions
Admissions and discharges	Incidents relating to the movement of patients, particularly delays to follow up
Medication incidents	Incidents relating to the failure of administration of critical medications
Emergent patient safety incidents	Incidents with extreme level of risk, and where there is significant potential for new learning and improvement

Quality and Safety – CQUINS 2023-24 Final Results

We are driving this measure because:

The CQUIN programme is a contractual measure of quality improvement. The Trust participated in 5 programmes and submitted data to a further 2 CQUINS. The year end results are presented below.

Data

The five national indicators adopted by the Trust for 2023/24											
No	Area	CQUIN	Compliance Measure	Q1	% Q1	Q2	% Q2	Q3	% Q3	Q4	% Q4
CQUIN 05	Medical	Identification and response to frailty in emergency departments	10% - 30%		73%		80%		86%		89%
CQUIN 06	Clinical Support	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service.	0.5% - 1.5%	Whole period result - local result to be verified nationally							1.5%
CQUIN 07	Trustwide	Recording of and response to NEWS2 score for unplanned critical care admissions	10% - 30%		26%		45%		76%		62%
CQUIN 12	Trustwide	Assessment and documentation of pressure ulcer risk (acute & community)	70% - 85%		81%		89%		93%		86%
CQUIN 14	Integrated Care	Malnutrition screening for community hospital inpatients	70% - 90%		88%		86%		77%		86%
Additional CQUINs that will be reported on in 2023/24											
CQUIN 01	Trust wide	Flu vaccinations for frontline healthcare workers	75% - 80%	N/A	N/A	N/A	N/A		38%		38%
CQUIN 13	Integrated Care	Assessment, diagnosis and treatment of lower leg wounds	25% - 50%		54%		55%		61%		60%

What the chart tells us:

- The Trust exceeded the targets in 4 out of 5 participated in and met the target range for the fifth.
- The Trust exceeded the target for one of the two CQUINS where data was submitted only.
- The Trust did not meet the target for CQUIN 01– Flu vaccination. This was anticipated and linked to vaccine fatigue in healthcare workers.

Key Actions:

- Share and celebrate good practice and learning from the projects.
- The national team have suspended CQUINS for 2024-25 and the trust is focussing on the Trust Quality and Safety Priorities for 2024-25.

Quality and Safety – Mixed Sex Accommodation Breaches

The Trust remains an outlier nationally for the number of mixed sex breaches reported.

Data

Mixed Sex Accommodation Breaches	Chief Nursing Officer	0	81	49	28	24	65	74

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Total admissions	2270	2187	2215	2326	2435	2339	2306	2643	2912	1746
Patients affected by MSB	**45 (1.98%)**	**68 (3.1%)**	**39 (1.76 %)**	**37 (1.59 %)**	**35 (1.43 %)**	**20 (0.85 %)**	**16 (0.69%)**	**65 (2.5%)**	**74 (2.5%)**	**54 (3%)**
Occasions	17	39	14	23	13	8	7	17	21	14
Areas	AMU Frome Day Case Wye	AMU ITU Primrose Redbrook Wye	AMU Frome Wye	AMU Wye	AMU Wye	AMU Wye	Ross Wye	AMU ITU Primrose Wye	AMU Garway Wye	Day Case ITU Wye

Top 3 Breach rate (Midlands region)

Jan	Rate	Feb	Rate	Mar	Rate
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	13.3	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	37.2	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS	25.6
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	4.5	WYE VALLEY NHS TRUST	10.0	WYE VALLEY NHS TRUST	9.4
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	3.8	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	6.7	THE SHREWSBURY AND TELFORD HOSPITAL	7.1

Findings and Actions:

The number of individual breaches reported in line with national policy is shown in the first table and reported in the Board performance pack.

The second table breaks this down to total number of patients affected and the number of occasions a breach occurred. As can be seen the number of occasions a decision is taken to allow a breach can lead to a large volume of breaches and a number of patients who are affected multiple times due to the counting rules.

In the context of total admissions month on month patients affected by a breach is a small percentage of patients. The numbers of patients affected spiked again in February and March 2024 however of concern is April where total admissions were low but breaches remained high.

In Q4 breaches were encountered in inpatient areas that do not typically report breaches. This was a consequence of using the Enabling Flow SOP, and the need to 'board' patients. A review of the process is required to understand how to mitigate mixed sex breaches whilst maintaining patient flow and safety.

The national team report the rate of breaches per 1000 finished consultant episodes (from the previous year sourced from HES). The Trust is flagging as a outlier regionally. In Q3 the Trust were in the top three highest breach rates for the region (Midlands), however this is reducing. In January the Trust did not flag as an outlier regionally however numbers increased in February and March and WVT were identified as having the second highest breach rate in the Midlands region.

Quality and Safety – Paediatric Audiology Service Review

An independent expert review was undertaken in NHS Lothian Scotland in 2023, which found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children. Subsequently this prompted concern and an assessment of services in England.

In response to national concerns about the quality and safety of Paediatric Audiology services, the Trust has engaged with and actively participated in the West Midlands Incident response process to be assured the service is safe and meets the national quality standards for Paediatric Audiology testing.

Trust Update

- July 2023—WVT submit desktop review information of its paediatric audiology service to the regional NHSE systems improvement team.
- August 2023—Desktop review outcome: identified areas of concern to be addressed through the regional incident response process.
- October 2023—WVT join the existing system level Bronze cell incident response process to undertake detailed service review, working toward a planned site visit, and both a prospective and retrospective Auditory Brainstem Response Tests (ABR) peer audit by external Subject matter expert
- February 2024—site visit to Paediatric Audiology department at the Child Development Centre, undertaken by the regional NHSE physiological science lead, an SME - senior paediatric audiologist and local ICB Chief Medical Officer.
- February 2024—WVT's paediatric audiology service rated as **SAFE**. A number of recommendations on the report, which have been addressed in an action plan (detailed below).
- March 2024– Successful capital bids to planning committee to address equipment concerns that were raised.
- April 2024—Quality Committee updated on the report and the action plan.
- April 2024– Prospective ABR audit (>50 cases) sent to external SME—no concerns flagged to date—review ongoing
- April 2024—Retrospective audit of ABR discharge patients complete—no requirement to recall patients
- April 2024– Retrospective audit of ABR non-discharge patients - review ongoing with look back over 5 years (31 cases)
- April 2024– CQC letter requesting board assurance of service safety and quality, and progress toward IQUIPs accreditation—complete

Clinical Governance	Evidence Type	RAG Rating	Action and update
Clinical Protocols	Documents on shared drive	Emerging	Review protocols, put in Trust format, make contact with other local Trusts. To gain access to i-passport
Audit	Audit to feature on the Governance agenda for monthly staff meeting	Emerging	Include in Governance meeting – audits to be placed on Q drive. All staff to contribute to audit. On agenda from 15.4.24
Waiting List Management	Waiting lists on Maxims		Capacity and demand for room utilisation to be carried out
Staffing Levels	Staff are registered with either AHCS/RCCP or HCCP		Annual registration Job advert for Band 6 Audiologist, 1 year fixed term contract on NHS jobs In-sourcing being investigated to reduce waiting times
Appraisals	All staff appraised annually		Appraisals recorded on ESR – 100% compliance
Education and Training	Staff have attended courses/conferences when requested. Mandatory training completed by all staff.		Current apprenticeship being undertaken by Band 3. 'Sharing of learning' time to be identified in monthly staff meetings 2024/25 Training plan submitted to the Education Department by 10.04.2024
Equipment and clinical environments	**Evidence Type**	**RAG Rating**	**Action**
Equipment age and functionality	Site visit identified issues with accommodation and equipment		• Rolling replacement of equipment to be identified. • Some equipment replaced this year. Inventory of expected lifecycle of equipment underway
			• Equipment needs to be on the Trust asset register – request awaiting action
			• ABR system to be digitally connected • New laptop arrived and software installed Training to use new software arranged with expert Peer Reviewer
			• Diagnostic OAE system required
			• Digital VRA re-enforcers to be considered • Re-enforcers installed and in use
			• Distraction toys need replacing and updating • New Distraction toys purchased and in use
Maintenance and Calibration	Noted at site visit: VRA Re-enforcers need to be re-positioned and daily calibration records kept		• Re-enforcers moved prior to calibration • Daily calibration records were available but not requested at time of the visit
Room Configuration	Observation screen required for VRA		• Discussion scheduled for WMAG June 2024
Adherence to Standards	Change of BSA recommended guidelines for VRA testing		• New BSA guidelines implemented April 2024
			• Identify a specific governance/audit lead
Workforce	Named community paediatrician for audiology		• Discussions ongoing, unable to identify at this time for discussion at workshop end of June

Next steps

- Ongoing participation in bronze cell incident response process
- Conclude retrospective Auditory Brainstem Response audit review process
- Community paediatric workshop due to be held on 25th June
- Quality Committee to maintain oversight of action plan and review outcomes

Quality and Safety – Staffing April data

Fill Rate and CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPP
Primrose Unit	102%	81%	93%	91%	9.2
Maternity Ward	100%	93%	100%	95%	6.8
Children's Ward	125%	143%	118%	90%	14.1
Lugg Ward	116%	90%	143%	129%	6.7
Wye Ward	128%	79%	114%	96%	6.9
Cardiac Care Unit	100%	96%	100%	96%	11.6
Leominster Community Hospital	157%	103%	102%	156%	7.1
Bromyard Community Hospital	101%	148%	100%	176%	7.4
Ross Community Hospital	102%	125%	102%	146%	6.8
Teme Ward	121%	66%	93%	55%	11.1
Redbrook Ward	96%	94%	100%	116%	6.8
Special Baby Care Unit	98%	-	98%	-	16.2
Intensive Care Unit	121%	-	101%	-	27.5
Gilwern Ward	151%	129%	100%	148%	7.0
Acute Medical Unit	131%	81%	97%	133%	8.1
Ashgrove Ward	158%	88%	151%	122%	8.3
Dinmore Ward	123%	88%	100%	128%	6.5
Garway Ward	109%	96%	99%	117%	6.9
Frome Ward	125%	79%	103%	101%	6.6
Arrow Ward	156%	74%	159%	90%	8.1
Women's Health	121%	97%	100%	-	10.3

A number of areas were above establishment (>100% fill rate) as follows:

Children's Ward – Due to Children's Nurse and HCA supporting Paediatric ED, still not within funded establishment.

Lugg Ward – Establishment review undertaken, formal agreement for additional staff, based on acuity and dependency of patients, awaiting additional budget.

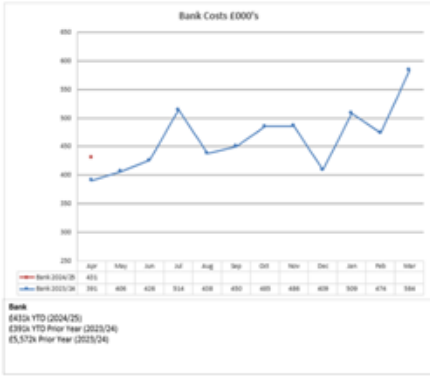
Community Hospital – Due to high dependency patients and patients needing 1:1 care. Additional Beds in Leominster and Bromyard.

Dinmore Ward and Ashgrove Ward – Due to high patient dependency and additional boarding patients during the day and night. Business Justification agreed for Dinmore Ward advising increase in establishment, in line with other Frailty wards. Nursing provision for Frailty SDEC, agreed but not yet within funded establishment.

Wye Ward, Frome Ward and Teme Ward - Due to Band 5 backfill for band 4 posts.

Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV). Band 5 registered nurse backfilling Band 4 gap.

Gilwern Ward – Required staffing levels greater than establishment, and patient dependency



March and April have seen the lowest spend on agency in 12 months. The reduced reliance on agency is largely being driven by an improving vacancy position, improved sickness levels and additional controls and scrutiny.

The use of off framework has also decreased significantly as the Trust prepares to cease use of all off framework agency by the end of June.

We have introduced a revised rate card for agency workers brining us closer to the NHS capped rate. The rate card will come into effect in June 2024.

Our Performance – Executive Narrative

Andy Parker

Chief Operating Officer

Improving our Urgent and Emergency Care [UEC] pathway remains one of the operational key priorities for 2024/25.

After the success of March and the huge effort by staff, our 4hr Emergency Access Standard (EAS) improved by 11% from February to March. We had confirmation that WVT were 7th most improved in the country, which is an amazing achievement when you consider the challenges we face.

Throughout March, and within WVT, we used this opportunity to test new ways of working. We are still evaluating and adapting the full impact of the changes we tried and some of these changes are being considered to establish new models of working as we strive to deliver the 78% EAS target before March next year.

During April and early May our teams have continued at this level of performance and continue to deliver improved 4hr Emergency Access Standards:

In April we improved our 4hr EAS even further by achieving 68% 4hr EAS by delivering:

- Type 1 ED attendance 4hr EAS performance at 62.5%. The highest WVT Type 1 performance for over two years.
- 94% 4hr EAS for patients on a minor injury / illness pathway
- 94% 4hr EAS for paediatric patients attending our Emergency Department [ED]
- A reduction in the number of patients waiting greater than 12 hours in our ED to 11%. This had been previously as high as almost 16% during 2023/24.
- Over 60% of patients attending our ED being seen and treatment started within the first hour. We are one of the best performers in the Midlands region and in the top quartile of English Trusts

We are starting see a constant reduction in the our Pathway 1 to 3 discharge delays over the last two months. In March this averaged 54 patients across our Acute and Community sites each day of the month, this dropped to 46 in April with a significant improvement in Pathway 1 and 2. Delays for Herefordshire which peaked at almost 720 bed days lost in February this year dropped to 500 in April and continues to reduce further in May Powys Pathway 1 and 2 delays remained high in April , still at 320 beds days lost each month since January, but we are seeing more significant improvements in May.

However, despite the improvements in Pathway 1-3 delays our use of escalation beds, across acute and community sites, remain along with the use of unconventional care beds which requires patient to “Board” in additional spaces on our wards overnight. We continue to work through our Valuing Patients Time Agenda to resolve this require by focusing on inpatient flow across 7 days and embedding and reviewing our Way we Work standards across our wards and the acute floor and increasing the utilisation and expansion of our Virtual Wards.

In April our Elective activity also continued to be strong, both against our Month 1 plan and the same volumes of activity delivered pre-pandemic in April 2019. Compared to 2023 we delivered almost 1,300 more new Outpatient appointments and over 800 more elective procedures.

Theatre productivity, and the management of Theatre Scheduling and Pre-Operative processes, remaining a key focus of our month Productivity Programme Board. Although there are still a significant number of improvements that the Surgical Division teams have progressed there are still many opportunities to improved efficiency and reduce patient waiting times.

Some the recent improvements include:

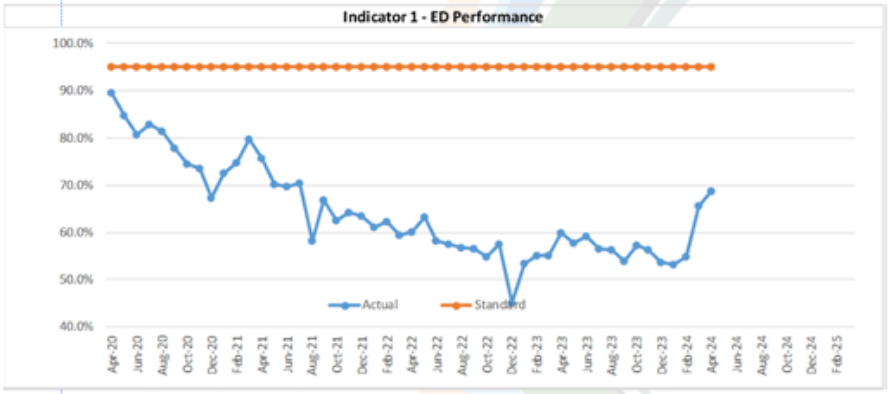
- Increasing the number of Pre-Operative appointment clinic slots per week. In March this totalled 105 per week. This has increased in May to 175. June will see 275 substantive clinics per week going forward within current nursing resource and with productivity improvements
- Improved forward scheduling for Theatres following the 6-4-2 weekly scheduling process with a reduction in the number of lists not with confirmed and populated with patients at 4 weeks before surgery from 60% in November 2023 to 11% in at the end of April this year. This allows for improved Theatre list management, profiling the correct staffing and equipment, and time to assess planned Theatre Utilisation to increase the number of cases per list.

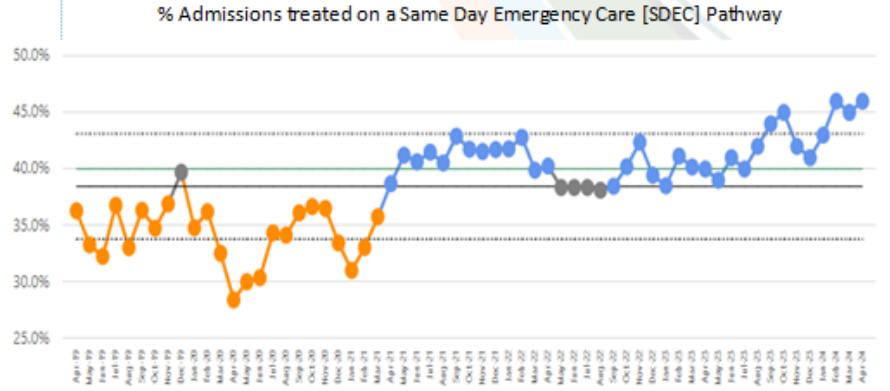
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

We are driving this measure because:

The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation to our ED.

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation - cause for concern (indicator where LOW is a concern)	Reasonable Assurance





Performance and Actions

- 6,297 Type 1 patients attended ED in April. The range of attendances varied from 167 to 251 with 210 being the average daily attendances. Average daily Typ1 ED attendances in March 2024 was 205 and April 2023 was 188
- 1, 718 ambulances conveyed to the Trust in month. The range in month was 47 to 71. This includes 11% from Powys [184]
- Ambulance handover delays over 1hr were 9% [158] of all conveyances and 74% [1,134] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,141 of all admissions [46% of all admissions] via a Same Day pathway within no overnight admissions.

Our Valuing Patients Time Programme Board [VPTB] has oversight of the current UEC improvement schemes including embedding our "Test of Change" UEC schemes into sustainable improvements:

- Implement senior streaming at ED reception. Streaming involve staking a brief history and performing basic observations if appropriate. This information may also be used to streaming a patient to the most appropriate pathway early and their support triage prioritisation including streaming to Primary Care to receive an increased number of patients booked into in hours and out of hours clinics
- Increase the capacity within our minors area, both workforce and physical capacity
- Increase use of Virtual Ward and focus on increased use of Outpatient Parenteral Antibiotic Therapy (OPAT) Service
- Increase Medical SDEC capacity by undertaking some clinical task outside of the acute floor footprint, increase the capacity within Surgical SDEC and improved flow across our Frailty SDEC and Frailty pathways.

Risks:

- Sustained pressure in Type 1 ED attendances and continued challenges with demand and high acuity with fluctuating high levels of attendances and Ambulance conveyances
- Workforce constraints due both medical and nursing teams across the acute floor and our inpatient areas due to increased use of escalation beds and unconventional care beds.
- System patient flow constraints due to workforce and capacity.

What the chart tells us:

Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
April 4 hour Emergency Access Standard [EAS] Performance was 68.8%

Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [March 24]

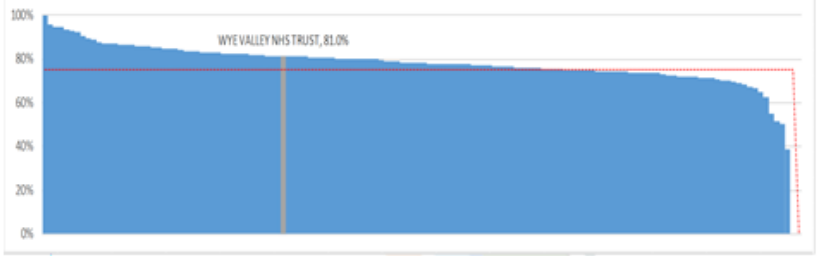
We are driving this measure because:

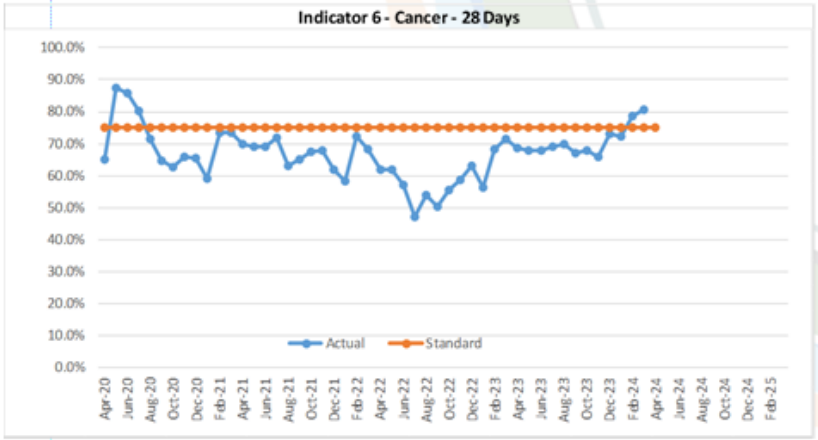
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 75% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer and 85% start first treatment within 62 days.

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

28 Day Performance

Wye Valley NHS Trust ranks 45 out of 139 Trusts.





Performance and Actions

Referrals

- Cancer referrals remain high with a 31.7% increase compared with 3 years ago which equates an additional 2880 patients.
- Gynaecology referrals are 55% higher compared to three years ago (492 additional referrals). It has been identified that a number of referrals are made to Gynaecology as an Urgent Suspected Cancer referral (USC) with symptoms of post menopausal bleeding despite this often being due to a benign cause. Therefore as part of national objective, a post menopausal bleeding pathway (PMB) is currently being designed to ensure patients can be seen in an appropriate clinic thus reducing the number of USC referrals the Trusts receives.

Main Issues impacting on 28 day performance and actions:

- Histology still have a number of consultant vacancies and therefore specimens continue to be sent out to insourcing companies and bank locums. Work is progressing with the dashboard to provide better visibility of turn around times which will show a true representation of bottlenecks within the specialty pathways.
- First seen outpatient capacity is an area of concern in Breast however additional clinics have been set up to manage the demand. Reassuringly, despite the pressures, Breast continue to meet the 28 day target achieving 95% in March.
- Computed Tomography (CT), Colonography CT (CTC) and Magnetic resonance imaging (MRI) have increased their access targets to between 12 an 14 days. An increase in demand has driven this position although reporting has improved. Additional workforce and clear plans in place should improve the position in June.

Improvements

- Endoscopy booking were previously exceeding 14 days rather than the internal target of 7 days, however following implementation of an action plan the endoscopy bookings are now under 7 days.
- Whilst there are still vacancies within histology, we have successfully recruited to two substantive histopathologists who will be joining the Trust in the next couple of months.

Risks:

- Cancer referrals continuing to remain above 19/20 levels / Histology Endoscopy and Radiology capacity still remains to be an issue.

What the charts tells us:

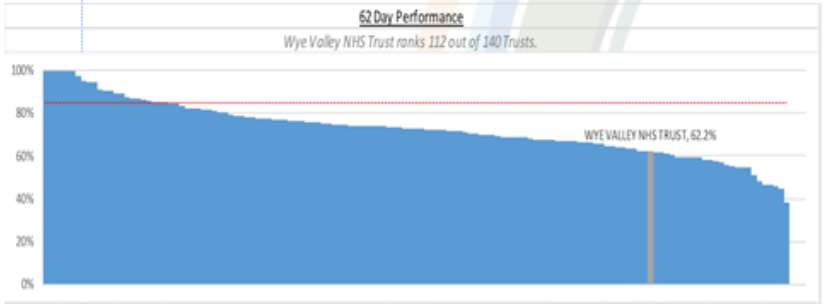
- 28 Day faster diagnosis = Performance against this target was 81% and remained below the target of 75% and below our trajectory for the month.

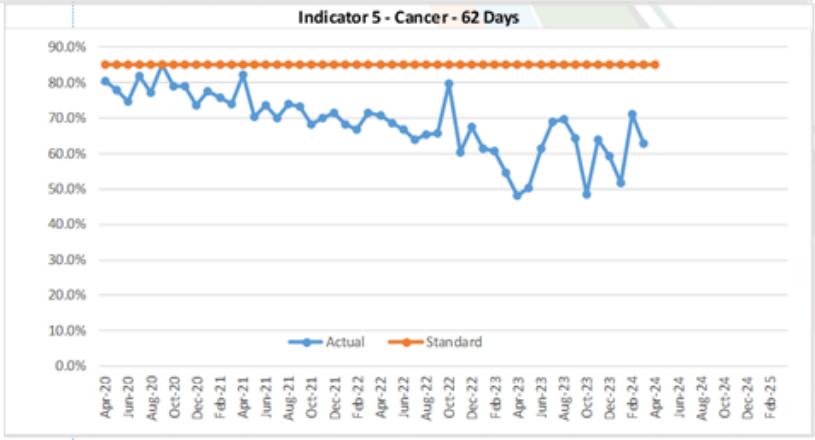
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [March 24]

We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two key measures are monitored below. 75% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer and 85% start first treatment within 62 days

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance





Performance and Actions

62 Days:

- In March, the Trust's compliance with the 62-day cancer referral target of 85% was at 63%, with 32 patient breaches. Breaches are being contributed to the delays facing the 28 day target and theatre capacity.
- With regards to the Trusts cancer back log position, in March we exceeded our fair shares target of 71, finishing at 57 patients over 62 day on the cancer Patient Tracking List.
- The trust continues to work towards an internal target of 5 days to review results and inform patients. This has slipped slightly over the past month due to capacity constraints however weekly deep dives continue and are relayed back to clinical teams at the cancer PTL meeting, to ensure visibility of latest performance and actions required as part of the cancer action plan.

Key Actions:

- Endoscopy are looking at increasing the number of patients who are reassured at the point of endoscopy where clinically appropriate to reduce the wait to be reassured.
- Continue to work with teams regarding our electronic patient system to be updated with cancer performance targets, to support with teams being able to booking in breach order.
- Cancer navigators to start utilising a pathway analyser tool to assess compliance against the Best Practice Timed Pathways as defined by West Midlands Cancer Alliance.
- Best practice timed pathway dashboards continuing to be developed to show Wye Valley Performance in relation to targets set.

Improvements

- The Non Specific Symptom pathway went live on 7 May, with a referral being received the same day.

Risks:

- Histopathology / Radiology vacancies—further workforce challenges ongoing
- Gynaecology and Lung first outpatient appointments earlier in the pathway impacting on 62days treatment standard

What the charts tells us:

- 62 day Treatment standard = The Trust performance was 63 % against a target of 85%.
- Number of patients waiting over 63 days did increase to 57 patients at the end of March compared with 118 the end of January.

Operational Performance – Referral to Treatment Performance / Activity / Productivity

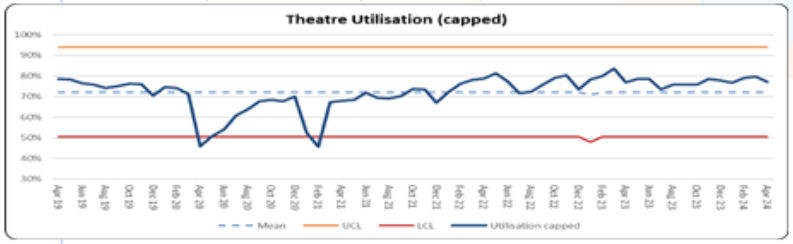
We are driving this measure because:

Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks for English patients and 26 weeks for Welsh patients from when the referral is received by the Trust either booked through the NHS e-Referral Service, or when a referral letter received. Activity plans are measured against the Trusts agreed plans as part of the annual Business Planning process with commissioners

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

		Year To Date
New	2019/20	5026
	Plan This Year	5207
	This Year	5691
	Diff vs 19/20	665
	Variance	13%
	Diff vs Plan	484
	Variance	9%
Follow Up	2019/20	10402
	Plan This Year	10771
	This Year	11903
	Diff vs 19/20	1501
	Variance	14%
	Diff vs Plan	1132
	Variance	11%
New	% Virtual	13%
Follow Up	% Virtual	22%
Total	% Virtual	19%

Admissions		Year To Date
Elective Inpatient	2019/20	289
	Plan This Year	193
	This Year	228
	Diff vs 19/20	-61
	Variance	-21%
	Diff vs Plan	35
	Variance	18%
Elective Daycase	2019/20	1537
	Plan This Year	1505
	This Year	1739
	Diff vs 19/20	202
	Variance	13%
	Diff vs Plan	234
	Variance	20%
Elective Endoscopy	2019/20	782
	Plan This Year	756
	This Year	886
	Diff vs 19/20	104
	Variance	13%
	Diff vs Plan	130
	Variance	17%
Total Elective	2019/20	2608
	Plan This Year	2453
	This Year	2313
	Diff vs 19/20	305
	Variance	12%
	Diff vs Plan	460
	Variance	19%



Performance and Actions

Activity Summary:

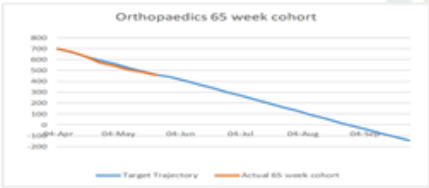
- New Outpatients [OP] activity was 9 %above plan for April 24. / Elective inpatient was 18% above plan for April 24 / Elective Day Cases was 20% above plan for April 24.

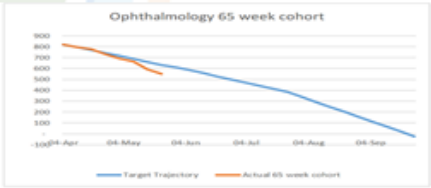
78 weeks waits:

- 5 English patients were waiting greater than 78 weeks at the end of April. These were 2 Orthopaedic patients, 2 Cornea Transplant Ophthalmology patients and 1 Cardiology patient . No Welsh patients awaiting in April
- Our prediction for May is 6 English: 3 Cornea Transplant Ophthalmology patients, 1 Orthopaedic, 1 Oral Surgery and 1 Ear Nose and Throat patient. 4 Welsh patients: 2 Cornea Transplant Ophthalmology patients and 2 Orthopaedic patients
- The Cornea patients are awaiting tissue, all other patients are dated in June.

65 week waits:

- 65 week position at the end of April was 100 English and 30 Welsh patients. This is predicted to be the same position at the end of May. Our plan is to eradicate all patients waiting our 65 weeks by September. The main two specialities driving 80% of our 64 week issues are Orthopaedics and Ophthalmology and weekly monitoring is in place. Both specialities are current at / under trajectory:





Theatre Productivity

- Capped Theatre Utilisation was 77.2% for April, a reduction on March performance 2.6%. Fall back in performance from March was largely driven by capacity constraints. And increased cancellations after an extremely positive March .
- Increased number of used Theatres sessions in April 2024 at 293 compared with 182 in April 2023 and 231 in April 2019 . Along with steady improvements in the use of forward planning for theatre session with only 14% of list at 5-6 weeks now having a confirmed surgeon/anaesthesia cover in place.

Risks

- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff . Along with continued high level of referrals and the impact of high cancer referrals. Month 1 at 14% above 2019/20.

What the chart tells us:

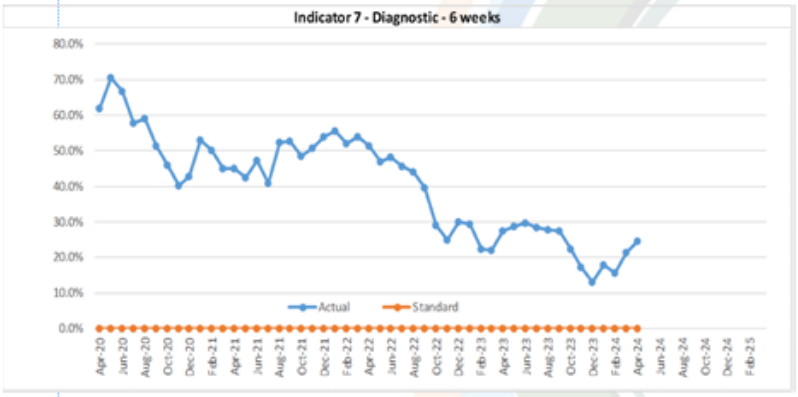
- Performance against English RTT standards in April was 54.5% - 0.9% decrease since last month. Performance against the Welsh RTT standards in February was 67.8% - 0.6% decrease since last month

Operational Performance – Diagnostic Performance

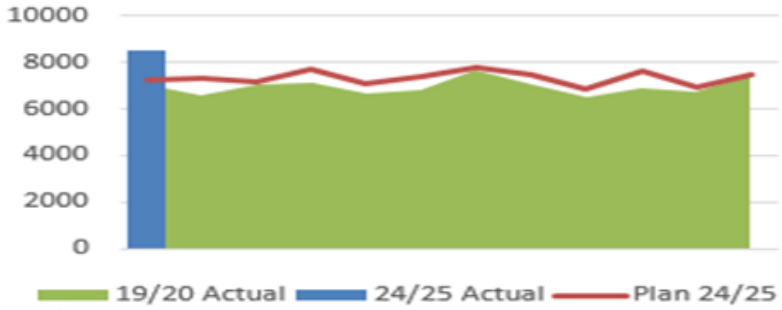
We are driving this measure because:

Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within 6 weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks / 26 week standard . Less than 1% of patients should wait 6 weeks or more for a diagnostic test.

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance



Total Activity [all Modalities]



Performance and Actions

Overall Diagnostics delivered 118% of Aprils Activity plan and 121% of the same month 2020:

Imaging:

- Magnetic Resonance Imaging [MRI] achieved 168% of 2019/20, 120% of 2024/25 plan activity last month, with support of mobile 2 weeks per month for all of 24/25, funded by CDC programme.
- Computerized Tomography [CT] achieved 143% of 2019/20 and 112% of 2024/25 plan activity last month
- Non-Obstetric Ultrasound [NOUS] achieved 98% of 2019/20 and 125% of 2024/25 plan activity last month.
- Bone Density Scans [DEXA] scanning restarted in March, while reporting is being restarted in May.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] were 8 and 10 days respectively compared to 7 and 12 days last month.
- Average report turnaround times for MRI prostate and CTC were 1 day for both modalities, while all cancer reporting turnaround for MRI and CT is achieving less than the 72 hour NHSE key performance indicator.

Audiology:

- Audiology 13 week waiters at the end of April were 43 a slight deterioration from 36 in March. With annual leave effecting capacity, the position is predicted to deteriorate next month—an additional insourcing option is being explored with support and oversight of the divisional management team. Increasingly the proportion of longest waiters are driven from paediatric audiology.

Echocardiography [Echos]:

- Echo capacity continues to be a concern with the waiting time push out to over 13 weeks. We have 106 patients waiting over 13 weeks currently which has deteriorated over recent weeks due to loss of capacity. A plan for bridging the current B7 Cardiac Physiologist vacancies has been worked through, however is not resilient and has been impacted due to leave and sickness in recent weeks. We have seen a 30% increase on referral demand so far this financial year which needs diving into further. Mitigation plans are currently being worked through.

Endoscopy:

- Delivered 17% above 2024/25 planning levels in April. Revised oversight and management in place since March has provided better cross Divisional oversight of Endoscopy performance and mitigation planning to maintain Endoscopy sessions and backfill of vacant sessions.

Risks:

- Workforce challenges to deliver activity plans and the ability to backfill Endoscopy sessions.
- Audiology and Echo capacity and workforce challenges

What the charts tells us:

- Diagnostic 6 weeks waits, overall, continue to recover from the impact Covid had on the overall waiting lists. Fluctuations in the recovery mirrors operational pressures with Covid through the various surges over the last two years.
- End of April 75 % of patients now waiting less than 6 weeks for a diagnostic test. Deterioration driven mainly by Audiology and Echo increases in waiting lists.

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

1 Page summary of key points

Following constructive talks between the government and the BMA, a revised offer has been made to SAS doctors with a pay uplift of between 9.5 % & 19.4 %. The deal includes further support to provide career progression opportunities for SAS doctors, and job security for those on locally employed doctor contracts equivalent to SAS roles. The BMA will put this offer to its members with voting to take place between 31 May to 14 June. Strike action will continue to be paused during this time. For drs in training, the BMA junior doctors committee and the government have agreed to seek to resolve their dispute through mediation, facilitated by an external provider. This is a positive step in seeking to resolve this disruptive dispute and strike action will not be called while the talks continue. Consultants have accepted the revised pay offer to end their dispute with the government.

We are taking active steps to maintain sickness absence at below 4.5% over the next few months. The main reasons for sickness absence are mental health conditions, gastro problems conditions and infleunza. HR teams supported by OH, the staff physiotherapist and staff mental health & wellbeing nurse continue to sensitively support the management of sickness absence and the close monitoring and management of sickness absence remains a key priority area for the HR team. The monitoring of sickness absence will continue through monthly F&PE meetings.

Staff turnover has now reduced to 9.0% and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover. Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 7.28% (April 24). Staff turnover for band 2 hcsw staff now stands at 13.52% (April 24) from a previous high of 28.3% in 2022

We promoted mental health awareness week to our employees with our mental health and wellbeing nurse running awareness sessions for teams and clinics for staff to support their wellbeing at work. We are also promoting the new Herefordshire & Worcestershire wellbeing recovery college which offers a wide range of free online and face-to-face programmes to increase awareness and understanding of recovery and self-management, while breaking down the stigmas relating to mental health.

As part of our equality & diversity programme, we supported the NHS equality, diversity and human rights week with executive directors and divisional leaders committing to the NHS inclusive leadership pledge which is in line with our leadership charter.

Faced with the NHS wide challenge to generate cost efficiencies and address productivity, we now have a workforce opportunities working group in place with HR, finance and trade union representatives working on a number of schemes to generate cost savings and enhance productivity through implementing IT solutions in transactional areas

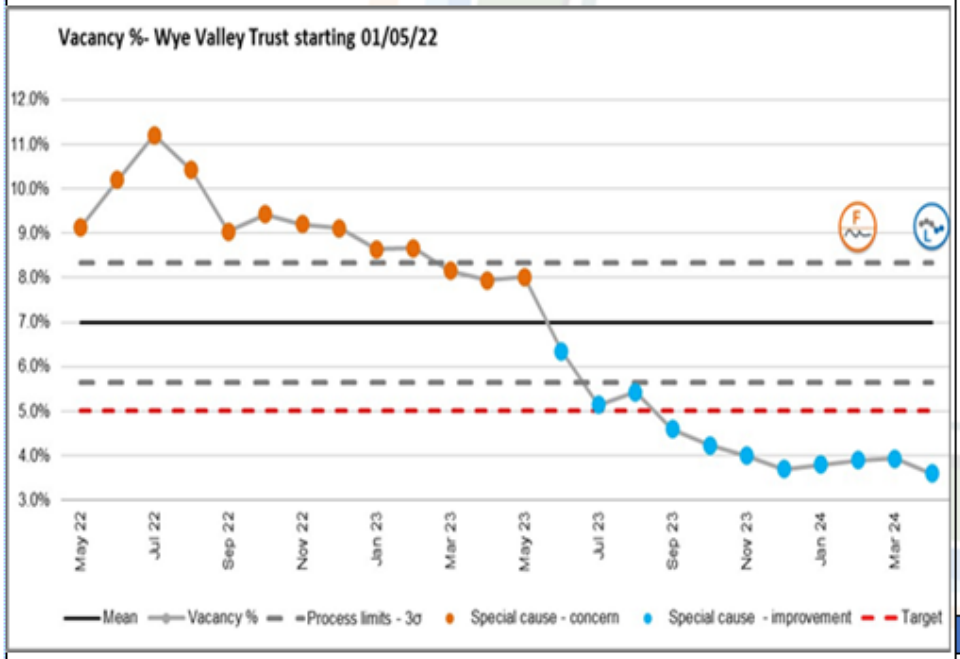
Our Workforce – Vacancy

We are driving this measure because:

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
7.9%	8.0%	6.3%	5.1%	5.4%	4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance



Performance and Actions

HCSW – our WVT pay and career progression framework is supporting our grow our own staff strategy with healthcare support workers undertaking apprenticeships. The framework has enabled the trust to avoid grievances about pay and progression.

N&M - our target this year until March 2025 is **77** international nurses and to date we have welcomed our first cohort in April and 7 nurses have arrived. They will be the first to enrol in the new 8 week OSCE programme.

Surgical Elective Hub – HR continues to work closely with the surgical division on the workforce required for the elective hub workforce, currently we have recruited and welcomed 22 theatre nurses for scrub/recovery plus 3 ophthalmology nurses. We are now sourcing additional theatre nurses and ODPs for the Hub which is due to open in June.

M&D - fortnightly meetings with chief medical officer, medical staffing manager & strategic medical HR lead to review progress with vacancies and cases of concern. The new medical appointments are 1 consultant in obstetrics & gynaecology, 2 consultants in histopathology. Overseas recruitment of medics to continue in 2024/25. We currently have 48.31 wte medical vacancies

Pharmacy - taking a number of steps to fill vacancies including advertising all jobs as open to flexible working, extending relocation packages, highlighting opportunities for personal and career development. 3 junior pharmacists recruited recently.

Working with the ICS recruitment & retention leads, we are extending our recruitment events and promoting our vacancies Herefordshire wide with a series of events over the coming year. We are also extending WVT presence at regional and national fairs to promote our job opportunities. Our WVT Ambassadors are supporting recruitment teams by attending events to promote vacancies and careers in the NHS.

Risks: Clinical vacancies

What the chart tells us:

The rolling 12 month position shows a significant reduction in vacancies over the past year.

Our Workforce – Turnover

We are driving this measure because:

To improve retention of staffing levels, maintaining standards to provide high quality care as well as reducing the reliance on temporary staffing namely agency.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
12.6%	12.0%	11.5%	11.0%	10.9%	10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	9.19%	9.0%

Assurance	Variation	Data Quality Mark
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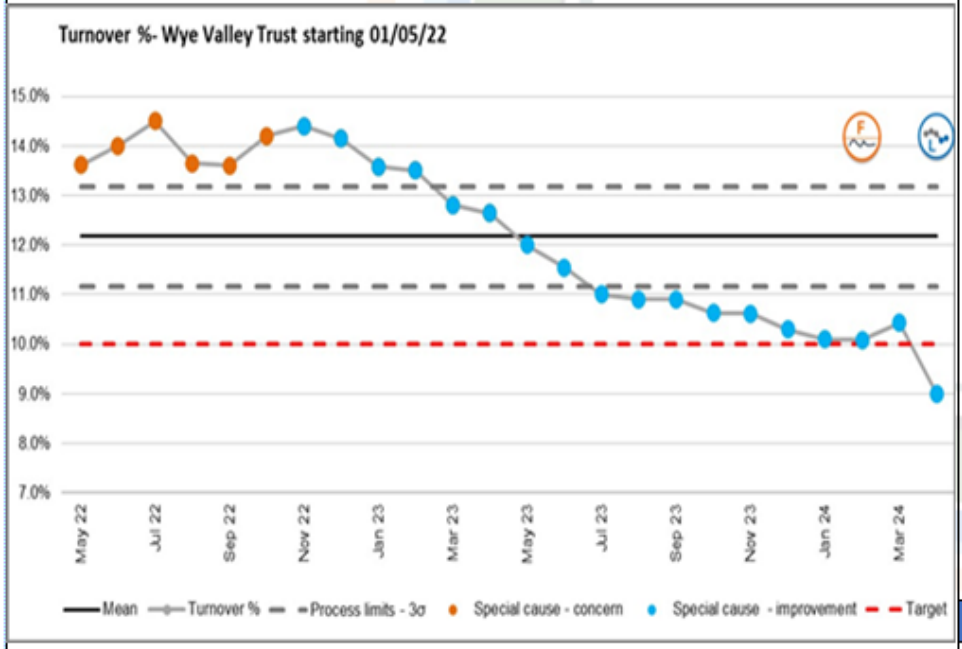

Performance and Actions

The overall rolling 12 month turnover at Trust level is at 9.0% for April 2024.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 9.0 % in the past 4 years.

Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 7.28% (April 24). Staff turnover for band 2 hcsw staff now stands at 13.52% (April 24) from a previous high of 28.3% in 2022.

To support our grow our own staff strategy, 16 healthcare support workers have now commenced the trainee nursing associate programme through the University of Worcester programme so they can become qualified nurses in future. This will enhance recruitment & retention of nursing staff at the trust over the coming years and reduce our reliance on international staff. We will continue to develop more support staff into qualified nurses.

To aid recruitment & retention, we used the quarterly HR Roadshows to promote apprenticeships to clinical and non clinical staff across all sites. We currently have 147 apprenticeships in different departments including wards areas, finance, hr, pharmacy and podiatry.

All divisions have a comprehensive call to action retention plan and divisional recruitment & retention working groups are in place to analyse new starter surveys and exit interview data so local actions can be implemented as appropriate.

The WVT recruitment & retention working group oversees the work of divisional groups with a focus on exit interview surveys and recruitment & retention areas of concern. This ensures actions are being progressed in a timely manner to aid recruitment & retention of staff across the trust.

We now have volunteers supporting HR and Occupational Health teams.

Risks:

What the chart tells us:

The rolling 12 month position shows significant improvements in staff turnover over the past year.

Our Workforce – Sickness

We are driving this measure because:

Due to increased scrutiny and higher levels over the pandemic, aiming to reduce this so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staffing namely agency.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
4.8%	4.4%	4.1%	4.3%	4.6%	5.1%	5.9%	5.4%	5.6%	6.0%	5.6%	4.8%	4.6%

Assurance	Variation	Data Quality Mark
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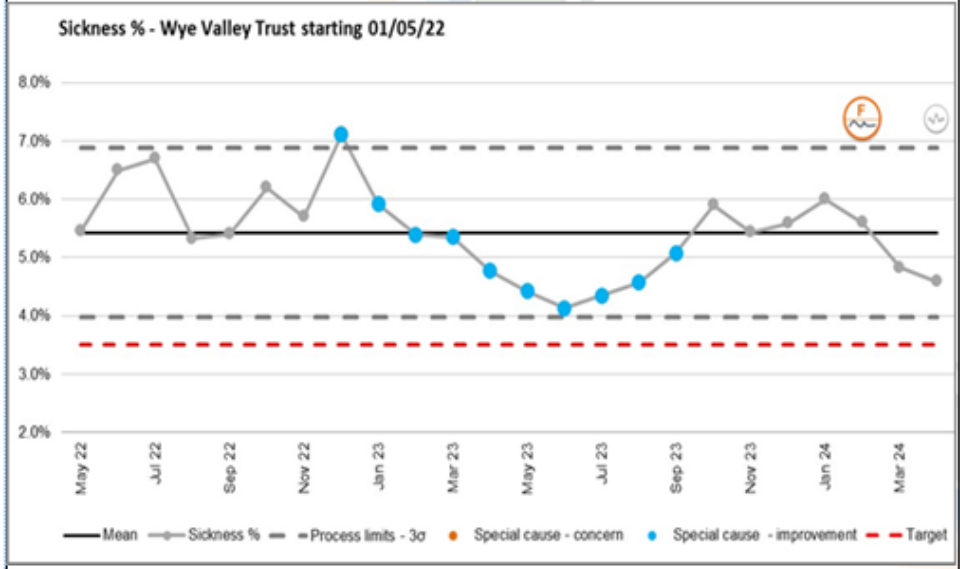

Performance and Actions

Sickness at Trust level now stands at 4.6%, following a robust review of late returns from line managers in March. The main reasons for absence are mental health issues, colds/flu and long term conditions.

To ensure we can maintain sickness absence at below 4.5% over the coming months, the close monitoring and management of sickness absence will continue through the monthly F&PE meetings. Divisional teams will continue to present detailed absence reports at F&PE meetings with absence heat maps, costs, no. of sickness reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

HR teams will continue to sensitively support the management of long and short term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team based wellbeing support for staff. The wide range of health & wellbeing initiatives (mental health wellbeing nurse, staff physiotherapist, schwartz rounds, employee assistance programme, NHS apps and support lines, face to face counselling, clinical psychology) are still in place for staff.

The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for all long term sickness absence and short term absence cases of concern to ensure the absence process is being managed appropriately. The HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence. The comprehensive health & wellbeing strategy (*Helping You To Help Yourself)* is now in place offering support programmes and calling on staff to take more ownership and responsibility for their wellbeing.

What the chart tells us:

The rolling 12 month position shows a fluctuating picture and we should see a reduction in sickness absence over spring / summer months

Our Workforce – Appraisal

We are driving this measure because:

To make sure staff feel heard and valued maintaining high standards set.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
77.5%	78.6%	79.0%	78.5%	77.1%	75.7%	74.1%	70.9%	72.7%	70.6%	71.8%	70.8%	75.9%

Assurance	Variation	Data Quality Mark
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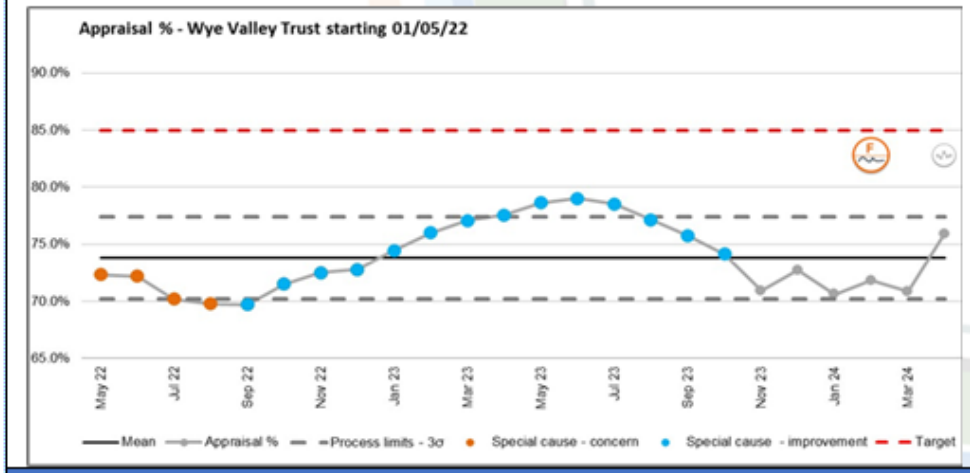


Performance and Actions

We have seen an increase in the % of completed performance appraisals from 70.8% to 75.9% and line managers are taking active actions to ensure all outstanding appraisals are completed by July.

Operational pressures continue to have a significant impact on WVT and NHS wide management capacity to complete performance appraisals. The modified and streamlined appraisal form is being used by line managers in holding wellbeing appraisal conversations with staff. This will continue to be reviewed at F&PE meetings over the year.

Risks:

What the chart tells us:

Operational pressures are impacting on line management capacity to complete performance appraisals.

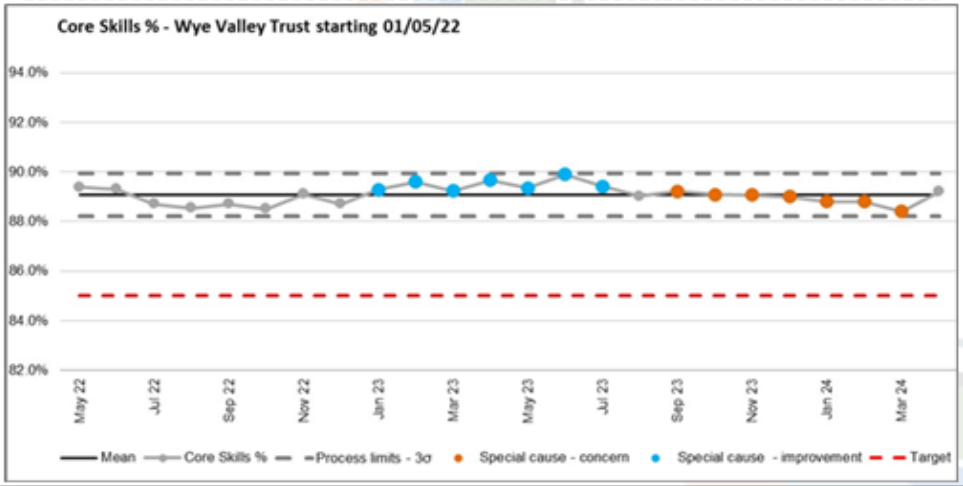
Our Workforce – Core Skills

We are driving this measure because:

To make sure all our staff core training is up to date, to ensure high quality of care.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
89.7%	89.3%	89.9%	89.4%	89.0%	89.2%	89.1%	89.1%	89.0%	88.8%	88.8%	88.4%	89.2%

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance



Performance and Actions

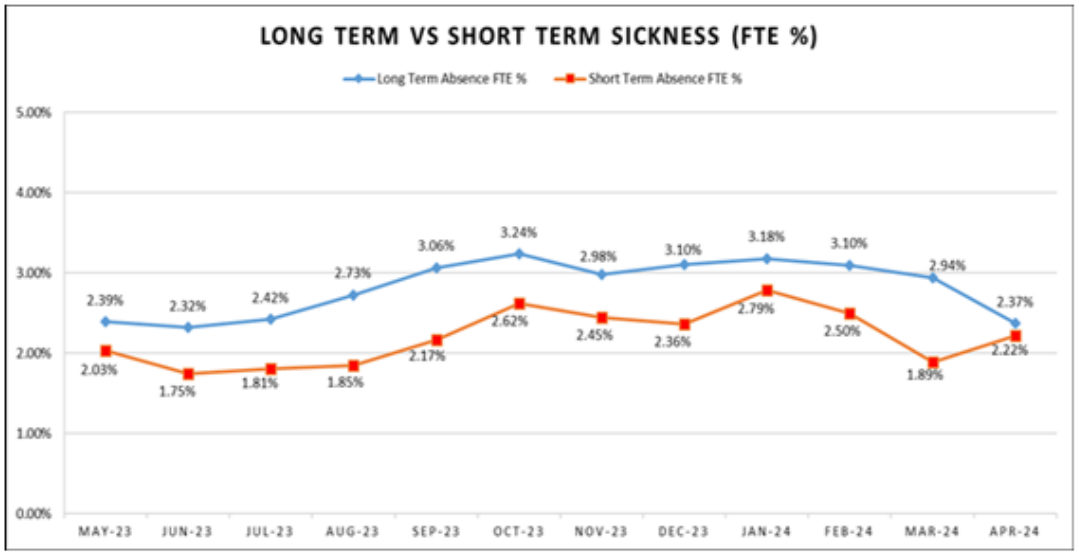
The Trust continues to make good progress in this area. This will continue to be reviewed at F&PE meetings.

Risks:

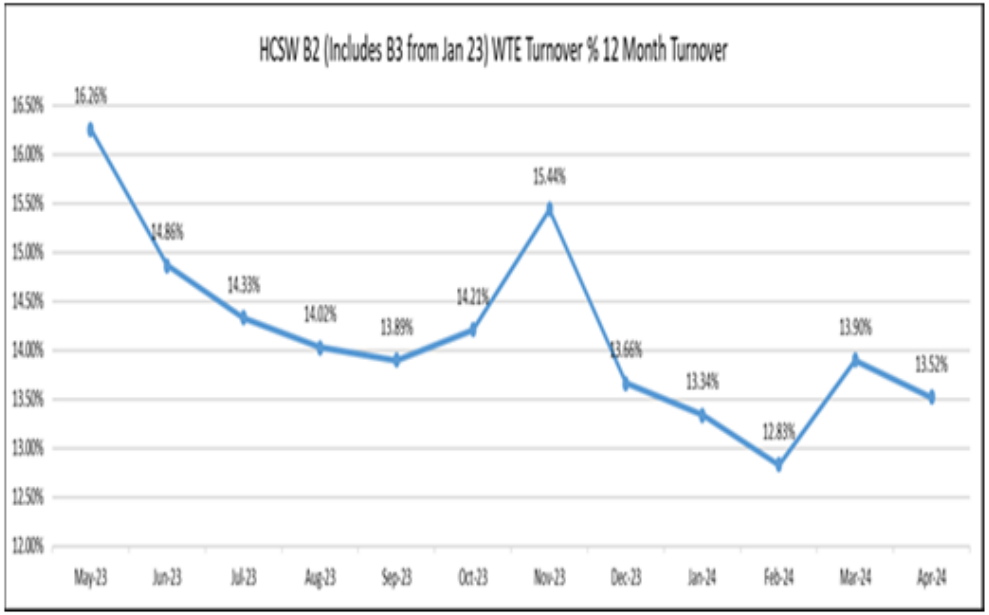
What the chart tells us:

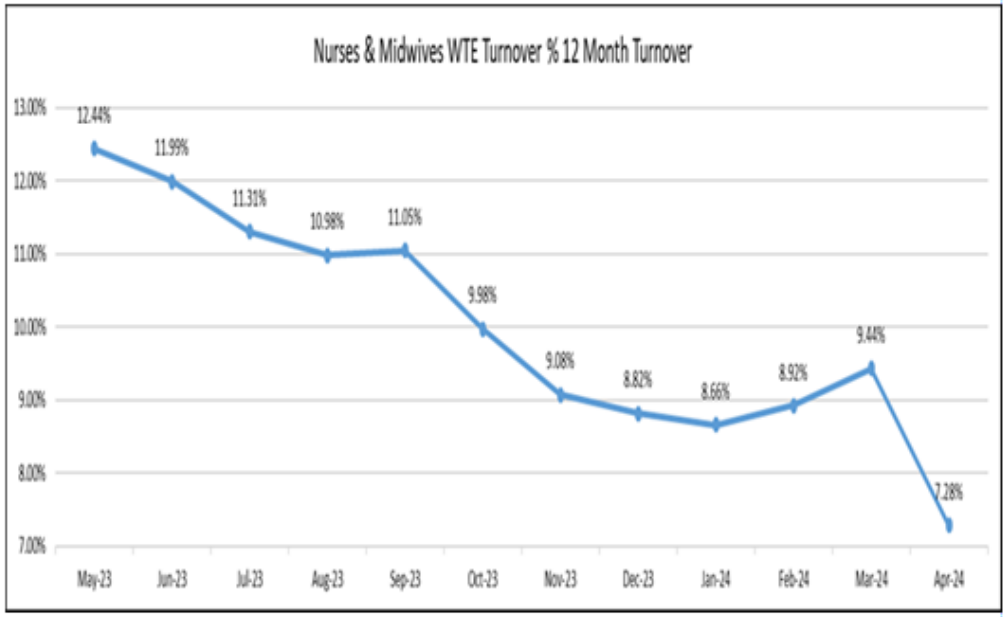
The rolling 12 month position remains fairly consistent above target across the period between May 2022 and April 2024.

The Trust has seen a reduction in sickness absence and this should continue over the coming months. Through our workforce programmes we continue to maintain good performance in staff turnover for key staff groups.



Main reason for absence - Top 5 - April 24	%
S13 Cold, Cough, Flu - Influenza	30.63%
S25 Gastrointestinal problems	15.76%
S10 Anxiety/stress/depression/other psychiatric illnesses	13.72%
S16 Headache / migraine	5.41%
S30 Pregnancy related disorders	5.38%





Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Financial Plan 2024/25

Following the planning round, the Trust has set an income and expenditure deficit plan of £34.4m, and issued delegated budgets on this basis. The plan reflects an ambitious yet credible position based on the assumptions made, and is not without significant risk. A separate paper is presented to Board today setting out the assumptions and risk in more detail. The current plan is not yet accepted nationally and we are anticipating a further review and resubmission exercise in June.

Income & Expenditure Performance

Like many Trusts, recognising the impact of annual accounts and finalising new financial plans, we are reporting only the pay expenditure positon this month. In month one (April), we spent £18.2m on pay expenditure (including bank and agency), £0.5m more than planned, primarily due to slower than planned delivery of efficiency schemes. Agency spend represented approximately 5.5% of the total pay bill in April and remains a key area of focus through our cost improvement programme.

Though not formally reported this month, we saw sustained elective performance which will be positively reflected through our variable elective income. This does correlate with increased spend on medical and clinical consumables though is being reviewed to ensure the triangulation is valid. A level of elective activity continues to be delivered through premium cost capacity such as outsourcing which delivers a lower margin; delivery of our productivity work streams including theatres and outpatients remains key to supporting financial improvement. Significant operational focus and cross divisional working on efficiencies continues to convert opportunities to fully developed plans and mitigate the shortfall.

Capital

Capital availability for 2024/25 is significantly constrained, outside of existing agreed business cases. The programme is being kept under review and reprioritisation to ensure critical asset replacements can be sustained.

Cash

The cash balance at the end of April reduced compared to the start of the previous month and is lower than planned.

Revenue PDC cash support will continue to be required in 2024/25 due to the planned deficit.

Board are asked to approve the submission of the cash support request for Quarter 2.

Our Finance – Year to Date Income and 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.

April 24 (month 1): Pay Expenditure Position

£m	Budget	Actual	Variance
Substantive	16.6	15.6	1.0
Bank	0.2	1.3	(1.1)
Agency	0.7	1.0	(0.3)
WLI	0.2	0.3	(0.1)
Total Pay Spend	**17.7**	**18.2**	**(0.5)**

NB: month 1 reporting pay expenditure only; full I&E reporting from month 2

Performance and Actions

- Pay was overspent overall with high use of temporary staffing, with agency representing 5.5% of overall pay spend.
- At this stage CPIP plans are not fully delivering against targets which is driving the majority of the pay variance; progress is being made.
- Though not reported in month one, an initial assessment suggests non-pay costs remain high particularly for medical and clinical supplies. These are being reviewed and triangulated against strong elective / outpatient activity in the month.

Risks:

Key Financial risks

- Level of Agency (as % of pay)
- Achievement of Elective Recovery Funding
- Variability of additional capacity cost (margin)
- Income / contract assumptions
- CPIP Cost Efficiency delivery recurrently
- Impact of inflation on non pay expenditure run rates

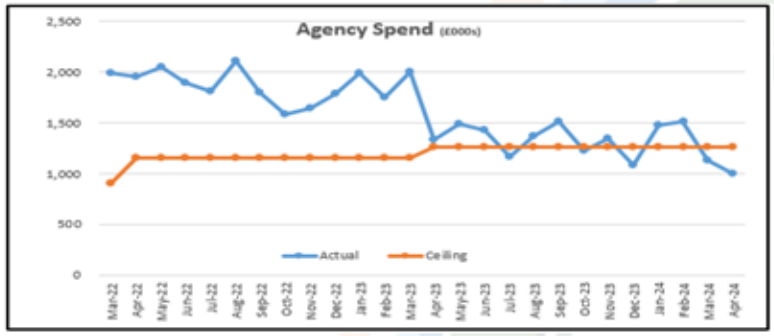
What the chart tells us:

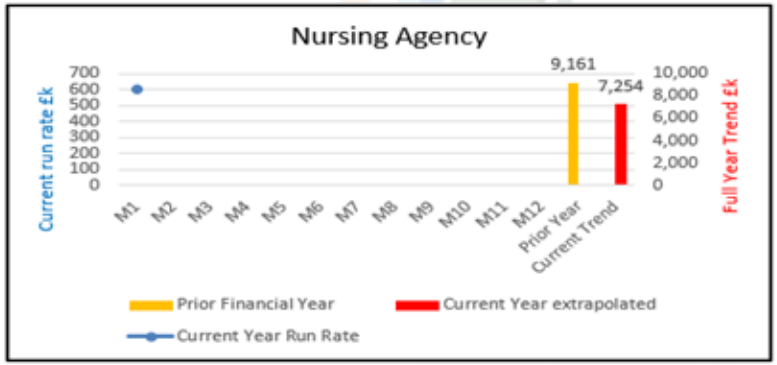
The 2024/25 financial plan includes a number of known financial risks. At month one, our main focus is on driving delivery of our efficiency and productivity schemes to realise financial improvement. Temporary staffing spend remains high and is an area of specific focus.

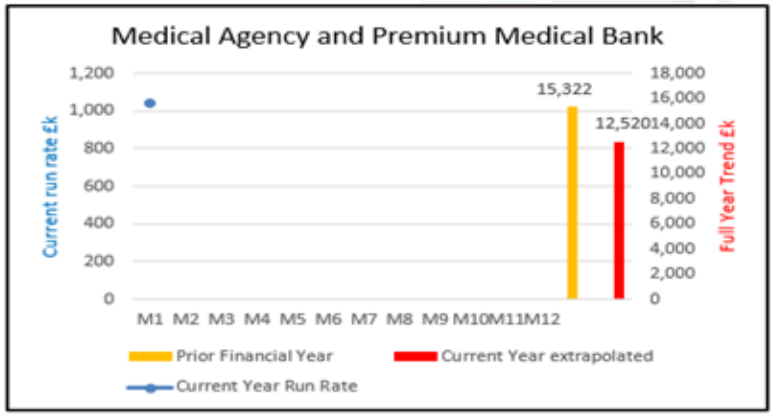
Our Finance – Agency Spend

We are driving this measure because:

Tackling our high agency spend levels (volume and price) is key to successfully mitigating financial risk and delivering the financial plan. Agency spend is well above the NHS Agency Cap Ceiling and is adversely impacting on our use of resources.







Performance and Actions

Nursing agency: Increased control actions through NARP, together with the Master Vend contract rate changes led to improvement last year. (2022/23 £14.0m, 2023/24 £9.2m). These controls remain in place and spend in month one was in line with the prior month. We are working with our Master Vendor to further review contract rates.

Medical staffing agency and premium cost bank: Medical bank typically still involves high premium rates, even if marginally lower than commercial agency on average. Though spend from 2022/23 into 2023/24 was not materially different, targeted MARP schemes including enhanced controls are now showing financial improvement. A specific focus for MARP in 2024/25 is on medical bank requirements and the approvals process. In month one, medical bank spend remained in line with the prior month while we saw a small reduction in medical agency spend.

Risks:

- Level of Agency (% of pay)
- Increased workforce gaps resulting in greater requirement for temporary workforce.
- Supply and Demand price pressures
- Impact of potential further Industrial Action
- Fragile services

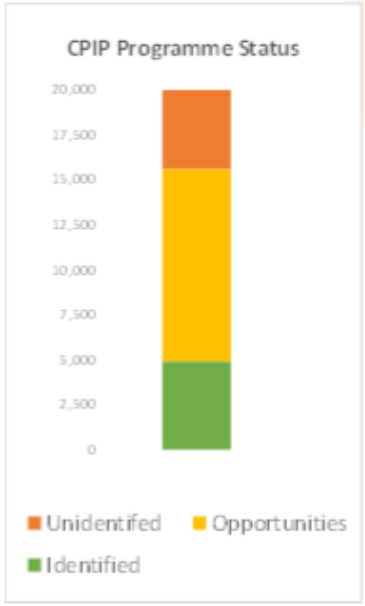
What the chart tells us:

Despite good progress in targeted areas, agency (and premium medical bank) use remains at unsustainable levels and poses a risk to achievement of the financial plan.

Our Finance – Cost Improvement Programme

We are driving this measure because:

Delivering our cost efficiency programme is key to successfully mitigating financial risk and delivering the financial plan. Maximising recurrent efficiencies is critical to our financial sustainability and tackling our underlying deficit in the medium term.



Performance and Actions

The total efficiency target of £19.4m has been delegated based on a fair shares methodology, and adjustments for specific schemes. This includes further reductions in Nurse and Medical agency which total £8m.

The target includes £4m brought forward from 2023/24 where savings were either under-delivered or delivered against non-recurring schemes.

Divisions and Corporate departments have identified a range of schemes and opportunities, which are at varying stages of development.

A cross organisational workshop was held on 22nd May to drive this work forward with further actions planned.

The plan phasing is broadly even across the financial year. In month one there was a shortfall in delivery with £0.2m of CPIP being achieved.

Risks:

- Cost Improvement (CPIP) underachieves or only achieves non recurrent delivery. Mitigation - Refreshed CPIP guidance and governance, training programme launched. CPIP workshop held to refine plans for delivery. Progress will be closely monitored and routinely reported to the Board.

What the chart tells us:

There remains a shortfall in plans to deliver the planned level of CPIP. Focus is on converting opportunities into deliverable schemes, wherever possible recurrent schemes.

Our Finance – Capital and Cash

We are driving this measure because:

With limited capital it is important that we invest wisely to maintain our infrastructure, and ensure benefits are realised from strategic developments. Availability of cash is critical for the Trusts continued operations, and is a key early warning metric given the challenged financial environment.

Scheme Type	Annual Plan £k	Full year Forecast £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Digital	1,267	1,267	43	46	(3)
Equipment	529	529	9	31	(22)
Estates	654	654	22	238	(216)
ESH and CDC Cfwd	2,023	2,023	240	139	101
Total Core Operating (CDEL) Capital	**4,473**	**4,473**	**314**	**454**	**(140)**
ESH	2,161	2,161	432	280	152
Digital	750	750	25	0	25
Clinical Diagnostics Centre	11,352	11,352	946	0	946
Total National Programme Funded schemes	**14,263**	**14,263**	**1,403**	**280**	**1,123**
Donated assets/IES	11,245	11,245	955	3,081	(2,126)
Total Donated and Grant Funded schemes	**11,245**	**11,245**	**955**	**3,081**	**(2,126)**
Equipment and Vehicles	410	410	13	5	8
Total IFRS 16 Funded schemes	**410**	**410**	**13**	**5**	**8**
Grand Total	**30,391**	**30,391**	**2,685**	**3,820**	**(1,135)**

Cash Balance

Month	Performance	Target	Direction	Rating
February	18.9	21.1		
March	26.2	21.7		
April	22.1	34.9		

The cash balance at the end of April reduced compared to the start of the year and lower than planned. The main reason for this decrease is of capital expenditure and increased debtors net of the increase in crediotrs.

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
February	96.3%	95.0%		
March	97.6%	95.0%		
April	98.7%	95.0%		

In March, the Trust paid 98.7% of invoices within 30 days (100% by invoice value). An increase on March and the third month, in a row, that we have achieved the 95% target. This had been previously missed, due to action taken to maintain cash balances.

Performance and Actions

Capital: The table reflects the latest annual capital plan which incorporates local and national funding sources. The year to date expenditure recorded reflects actual expenditure as at Month 01.

Expenditure recorded against the Integrated Energy Scheme relates to invoices in M01 paid not activities completed. Centrica, the principal contractors have invoiced for activity ahead of completion as allowed by the contract.

Cash: The cash balance at the end of April reduced compared to the start of the previous month and is lower than planned. The main reason for this decrease is capital expenditure and increased debtors.

Revenue PDC cash support is being applied for in Q2.

Phasing of contract payments from the ICB continues to assist with payment of the quarterly PFI unitary charge. This arrangement is continuing in 2024/25.

Risks:

- General risk regarding the delivery of the capital programme. National funding approval for ESH and the CDC has now been received but funding gaps identified in the business cases are still to be fully confirmed. Mitigation: work with system and regional partners.
- Insufficient capital to deliver critical / high risk infrastructure replacements. Mitigation: work with system and regional partners.
- Cash availability and prompt payments worsen due to deficit plan. Mitigation: focus on delivery of financial plan, and rolling cash flow forecasts.

What the chart tells us:

Capital expenditure is higher in month 1 than planned due to the phasing of the IES scheme, and cash balances whilst sufficient, continue to require careful management over the next financial year.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High	Yes	69.8%	66.9%	67.9%	65.8%	72.9%	72.4%	78.6%	80.8%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause	Yes	86.3%	78.7%	86.4%	80.4%	88.3%	90.1%	96.9%	95.8%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Common Cause	Yes	71.1%	53.8%	71.4%	53.3%	90.5%	95.8%	83.3%	79.3%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	92.4%	87.4%	78.4%	80.0%	73.8%	69.1%	80.8%	89.2%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause		6	10	14	9	8	12	4	12	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	69.8%	64.3%	48.4%	64.0%	59.2%	51.7%	71.1%	63.0%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause				50.0%	100.0%	100.0%	60.0%	100.0%		
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		80.8%	70.8%	55.2%	81.0%	73.9%	48.1%	76.9%	61.8%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Concern - Low	Yes	87	109	113	126	117	142	121	58	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		114.2%	101.8%	115.3%	104.9%	107.1%	121.7%	115.1%	102.8%	111.9%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low	Yes	90.1%	91.0%	90.8%	90.9%	91.1%	90.0%	89.7%	90.3%	86.0%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		101.8%	101.8%	104.6%	104.7%	103.0%	103.4%	109.3%	104.3%	107.7%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause	Yes	83.1%	76.9%	80.7%	73.0%	73.6%	64.4%	65.8%	71.4%	73.3%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		3.7%	9.9%	6.6%	12.1%	13.2%	20.1%	17.0%	12.2%	10.2%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		112.3%	118.6%	119.0%	112.9%	113.9%	116.8%	123.3%	119.5%	102.5%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		42.0%	44.0%	45.0%	42.0%	41.0%	43.0%	46.0%	45.0%	46.0%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	56.2%	54.0%	57.2%	56.3%	53.6%	53.2%	54.9%	65.5%	68.8%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High		17.3%	15.9%	14.3%	16.0%	17.3%	19.1%	16.9%	12.2%	11.9%
	A&E - Time to treatment	Urgent and emergency care			Common Cause		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care			Improvement - Low		1.7%	1.9%	1.7%	1.9%	1.8%	1.7%	1.7%	1.7%	1.8%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		213	181	213	253	230	305	306	250	292
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		8.5%	9.0%	7.7%	8.6%	8.7%	7.7%	8.5%		
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		57.7%	57.7%	58.6%	59.6%	57.9%	57.2%	56.3%	55.4%	54.5%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		65.5%	64.9%	66.2%	67.4%	65.5%	66.8%	67.6%	68.3%	67.8%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care			Improvement - High		27963	27857	27260	26915	27031	26837	27256	27780	28130
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Concern - High	Yes	1853	1959	1981	1782	1636	1446	1287	1152	1171
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		30	34	33	18	16	7	16	9	6
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		1	1	4	4	3	1	1	0	1

	GP Referrals	Elective care			Improvement - High	Yes	116.6%	118.3%	110.8%	117.1%	97.7%	104.1%	119.6%	134.4%	107.3%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care			Improvement - High		117.8%	113.3%	111.2%	112.9%	100.6%	111.5%	116.0%	129.1%	113.2%
	Outpatient Activity - New attendances (volume v plan)	Elective care			Improvement - High	Yes	121.7%	81.8%	111.8%	88.4%	121.2%	114.3%	112.6%	83.4%	109.3%
	Total Outpatient Activity (% v 2019/20)	Elective care			Improvement - High		117.0%	109.8%	101.4%	110.2%	101.2%	109.3%	109.2%	123.8%	114.0%
	Total Outpatient Activity (volume v plan)	Elective care			Improvement - High	Yes	138.3%	85.6%	112.9%	93.0%	132.6%	126.2%	120.0%	89.3%	110.1%
	Total Elective Activity (% v 2019/20)	Elective care			Improvement - High	Yes	107.1%	99.9%	95.5%	101.0%	91.5%	98.9%	106.5%	121.0%	112.1%
	Total Elective Activity (volume v plan)	Elective care			Improvement - High	Yes	128.3%	79.9%	104.4%	84.2%	112.2%	103.8%	112.6%	83.9%	118.8%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause		75.9%	75.9%	75.8%	78.6%	77.8%	76.7%	79.0%	79.8%	77.2%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care			Common Cause	Yes	36	30	15	29	31	65	36	31	33
	Diagnostic Activity - Computerised Tomography	Elective care			Improvement - High		143.7%	142.8%	129.7%	129.6%	119.4%	124.9%	111.0%	107.5%	111.8%
	Diagnostic Activity - Endoscopy	Elective care			Improvement - High	Yes	93.4%	83.2%	86.3%	131.1%	158.0%	142.8%	150.3%	99.3%	131.5%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care			Improvement - High	Yes	204.4%	185.4%	158.1%	180.9%	148.0%	113.6%	95.3%	148.8%	120.5%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care			Improvement - Low		27.7%	27.6%	22.5%	17.2%	13.2%	17.9%	15.6%	21.5%	24.7%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Common Cause	Yes	93.6%	95.4%	96.2%	92.9%	92.2%	91.3%	92.1%	93.8%	94.4%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Concern - High		17.1%	23.9%	23.3%	22.9%	23.8%	24.3%	24.3%	19.5%	19.0%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High		60.0%	61.7%	63.6%	66.0%	64.9%	63.8%	64.6%	62.9%	60.6%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Improvement - Low	Yes	91.8%	93.4%	92.5%	92.6%	92.5%	88.4%	88.2%	87.0%	85.5%
	Maternity Activity (Deliveries)	Elective care			Common Cause	Yes	106.6%	98.5%	92.7%	97.0%	95.1%	140.6%	115.0%	99.3%	99.2%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.1%	6.4%	6.8%	6.5%	6.9%	6.5%	6.2%	6.0%	6.2%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Common Cause		84.1%	85.1%	81.9%	86.3%	83.6%	83.3%	86.5%	87.0%	86.7%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation			Improvement - High		116.7%	108.2%	97.1%	109.0%	101.5%	108.4%	106.2%	121.5%	114.4%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation			Improvement - High	Yes	147.2%	87.6%	113.5%	95.2%	138.6%	132.2%	123.8%	92.3%	110.5%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Fail	Improvement - Low		21.2%	22.0%	21.7%	20.7%	20.4%	21.1%	19.8%	19.2%	18.9%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term conditions			Common Cause		10.3%	12.2%	5.7%	6.9%	8.1%	2.8%	13.1%	8.7%	

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		95.5%	99.3%	99.6%	99.6%	98.8%	100.0%	100.0%	100.0%	100.0%
	Bed occupancy - Community Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		97.4%	96.1%	96.6%	100.0%	99.2%	89.5%	89.5%	89.5%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<=	0	Variable	Improvement - Low		109	52	81	49	28	24	65	74	54
	Patient ward moves emergency admissions (acute)	Safe, high quality care				Common Cause		10.5%	7.1%	9.3%	8.7%	8.2%	11.0%	10.1%	8.8%	8.5%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<=	5	Fail	Common Cause		6	5	6	7	6	7	7	7	7
	ALoS - General & Acute Elective Inpatients	Safe, high quality care	<=	3	Variable	Common Cause		3	2	3	2	2	2	3	3	2
	Medically fit for discharge - Acute	Safe, high quality care		5.0%	Pass	Common Cause		22.2%	24.8%	26.0%	23.3%	21.0%	22.7%	21.4%	18.7%	18.8%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Concern - Low		45.4%	54.3%	43.6%	39.4%	43.6%	50.1%	51.6%	50.1%	46.2%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Improvement - High		9.7%	9.6%	11.3%	11.5%	11.9%	10.8%			
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Fail	Concern - High		118	115	111	113	112	112			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		103	103	102	102	102				
	Never Events	Safe, high quality care		0	Variable	Improvement - High	Yes	0	0	0	0	0	0	0	0	1
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Common Cause	Yes	0	0	0	0	0	0	1	0	0
	MSSA Bacteraemia	Safe, high quality care				Common Cause	Yes	0	1	4	4	2	1	2	2	1
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care		44	Fail	Common Cause		0	2	3	3	4	3	3	2	6
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause	Yes	4	0	0	5	3	2	2	1	1
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<=	0	Variable	Common Cause	Yes	2	1							
	Serious Incidents	Safe, high quality care				Common Cause	Yes	6	5							
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		91.0%	89.1%	88.5%	89.8%	88.0%	87.4%	89.2%	89.3%	88.2%
	WHO Checklist	Safe, high quality care	>=	100.0%	Variable	Common Cause	Yes		99.4%			99.4%				
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>=	60.0%	Variable	Common Cause		43.8%	44.7%	62.9%	64.3%	48.1%	53.5%	66.7%	63.0%	64.4%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60	Safe, high quality care	>=	90.0%	Variable	Common Cause	Yes	60.0%	33.3%	100.0%	100.0%	0.0%	66.7%	60.0%	33.3%	0.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		79.1%	70.0%	85.2%	90.9%	90.6%	80.0%	78.0%	83.1%	75.0%
	Number of complaints	Safe, high quality care				Concern - High	Yes	21	30	35	34	24	27	29	38	46
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Common Cause	Yes	0	0	1	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Fail	Common Cause		41.9%	36.8%	32.4%	52.2%	17.6%	34.6%	37.9%	35.3%	44.8%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause		73.0%	68.2%	71.8%	73.1%	72.9%	77.0%	75.7%	81.2%	81.0%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low		81.0%	86.8%	85.0%	87.9%	82.0%	85.7%	81.7%	88.6%	86.0%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause		94.0%	96.3%	92.9%	89.7%	87.2%	96.7%	92.6%	91.3%	96.9%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Improvement - High		20.0%	19.0%	20.0%	19.0%	19.0%	21.0%	21.0%	20.0%	19.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High		15.0%	16.0%	15.0%	15.0%	15.0%	18.0%	16.0%	17.0%	18.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause		46.0%	26.0%	22.0%	32.8%	31.0%	23.0%	23.0%	16.0%	28.0%

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low	Yes	7.5%	8.4%	7.0%	7.1%	6.1%	7.9%	8.1%	6.0%	5.5%
	Appraisals	Looking after our people	>= 85.0%	Fail	Concern - Low		77.1%	75.7%	74.1%	70.9%	72.7%	70.6%	71.8%	70.8%	75.9%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.0%	89.2%	89.1%	89.1%	89.0%	88.8%	88.8%	88.4%	89.2%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause		4.6%	5.1%	5.9%	5.4%	5.6%	6.0%	5.7%	4.0%	4.7%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Fail	Improvement - Low		10.9%	10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	10.4%	9.0%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		5.4%	4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Finance	I&E - Surplus/(Deficit) (£k)	Finance			Concern - High	Yes	(£3182k)	(£3173k)	(£1198k)	£425k	(£2906k)	(£2430k)	£9902k	(£9316k)	(£355k)
	I&E - Margin (%)	Finance			Concern - High	Yes	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)	£0k	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance			Concern - High	Yes	(£1089k)	(£1229k)	£221k	£1720k	(£208k)	(£3427k)	(£3019k)	######	£783k
	I&E - Variance from Plan (%)	Finance			Common Cause		(£0k)	(£0k)	£0k	£0k	(£0k)	(£0k)	(£0k)	(£0k)	£0k
	CPIP - Variance from plan (£k)	Finance			Common Cause	Yes	(£1069k)	(£878k)	(£1056k)	(£862k)	(£841k)	(£708k)	(£830k)	£906k	£0k
	Agency - expenditure (£k)	Finance			Improvement - Low	Yes	£1435k	£1410k	£1338k	£1382k	£1087k	£1482k	£1596k	£1127k	£121k
	Agency - expenditure as % of total pay	Finance			Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance			Common Cause	Yes	(£227k)	(£111k)	(£409k)	(£366k)	£520k	(£2959k)	(£689k)	(£1572k)	£0k
	Cash - Balance at end of month (£m)	Finance			Common Cause		£14k	£11k	£15k	£19k	£24k	£23k	£23k	£19k	£22k
	BPPC - Invoices paid <30 days (% value £k)	Finance			Common Cause	Yes	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance			Common Cause	Yes	£1k	£1k	£1k	£1k	£0k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Quality Committee Terms of Reference and Forward Planner
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Documents covered by this report:	Quality Committee Terms of Reference and forward plan

1. Purpose of the report

To present the Quality Committee terms of reference and forward planner for approval.

2. Recommendation(s)

Board is asked to approve the terms of reference and forward planner. Quality Committee were happy to recommend these for approval to Board.

3. Executive Director Opinion[1]

The Terms Of Reference have been revised to reflect changes in membership and have been updated to include the quality and safety priorities as set by the Quality Committee.

Further work is required to conduct our annual review of the sub-committee structure and associated work programmes; given this review the forward plan may be subject to minor changes in terms of the scheduling of some reports.

[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.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Wye Valley NHS Trust

Quality Committee

Terms of Reference

1. Purpose

1.1 The purpose of the Quality Committee is to provide assurance to the Board that the services provided by the Trust are being delivered in a high quality and safe manner, and provide a quality of care we would want for ourselves, our families and friends'**.**

1.2 The Quality Committee has delegated responsibility to ensure that the Trust is fulfilling its statutory duties, complying with national standards and achieving its own strategic objectives in respect of the provision of high quality clinical care

1.3 As a Sub-Committee of the Board, the Quality Committee will fulfil this purpose through; receiving reports that cover the breadth of the quality agenda and from those committees that report into the Quality Committee*.

1.4 Reports will be provided for assurance and provide the opportunity for scrutiny and challenge with regard to all aspects of quality, clinical safety and patient experience and ensure that where necessary lessons are learnt and implemented throughout the organisation.

1.5 The Committee will promote an organisational culture, aligned with the Trust values; **Compassion**, **Accountability**, **Respect** and **Excellence**, that strives for continuous improvement through oversight of the Trust quality priorities.

2. Membership

2.1 Members of the Committee are:

- Three Non-Executive Directors
- Chief Nursing Officer
- Chief Medical Officer
- Managing Director
- Deputy Chief Medical Officer
- Associate Director of Quality Governance

2.2 In attendance:

- Deputy Chief Nurse Herefordshire and Worcestershire ICS
- Associate Chief Nursing Officer
- Associate Chief Medical Officers for each division (when divisional reports are due)*
- Divisional Associate Chief Nursing Officers /Associate Director of Midwifery/Professional clinical leads for each division (when divisional reports are due)*
- Associate Chief Operating Officers will be expected to attend when their divisional report is due

- Clinical Director, Pharmacy
- Quality and Safety Matron (Corporate)
- Chair of the Clinical Effectiveness and Audit Committee
- Chair of the Patient Safety Committee
- Chair of the Patient Experience Committee
- Chair of the Learning from Deaths Committee

*Divisional management representatives are invited but not mandated to attend all meetings

2.3 Other officers of the Trust will be invited to attend for appropriate agenda items where they are the lead.

2.4 Where a member is unable to attend routinely, an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.

3. Duties of the Committee

3.1 In order to support the wider objectives of the Trust, the Quality Committee will focus on the following priorities for the year ahead as published in the Trust Quality Account and Patient Safety Incident Response Plan.

Quality Priorities 2024-25

- Reduction in cases of grade 2 pressure ulcers
- Ensure patients receive a timely VTE risk assessment in line with NICE guidance
- Improving care of deteriorating patients and implementing Martha's rule by January 2025
- Improve responsiveness to patient experience data
- Fully implement the Get it on Time campaign for Parkinson’s medications

  Implement quality improvement project to target high risk time critical meds as locally defined.

Patient Safety Priorities

- Tissue Viability- Deterioration of MASD to G3/4 or unstageable pressure damage
- Falls- Inpatient falls in patients with dementia, delirium or a known high risk of falls
- Delay in assessment, diagnosis or treatment- Responding well to clinically changing conditions
- Admissions and discharges- incidents relating to the movement of patients, particularly delays to follow up
- Medication incidents- Incidents relating to the failure of administration of critical medications

3.2 In furtherance of achievement of its purpose, particular duties of the Committee are to:

- Oversee the development and implementation of the Trust’s Quality Priorities
- Receive, review and sign off the annual Quality Account (given timings of data and audit requirements, sign off may well be virtual)

- Receive data and trends relating to quality priorities, patient safety priorities and patient experience metrics, provide assurance to the Board on performance and undertake 'deep dives' as appropriate at the discretion of the committee
- Receive reports demonstrating compliance with relevant national standards and regulatory requirements
- Receive reports in line with the Trust External review process and any associated actions pertaining to any national enquiry, regulatory review or relevant external inspection undertaken
- Have oversight of all Quality Impact Assessments related to, clinical service developments or transformation through assurance reporting of the Clinical Effectiveness and Audit Committee
- Agree the terms of reference and work plans for each of the sub committees it is responsible for
- Receive reports related to the workforce safeguards and establishment reviews
- The Committee will receive a quarterly update from each division plus obstetrics and maternity. These reports will include quality improvements and remedial action being taken to address any quality, outcome, safety or patient experience concerns.

3.3 In addition the committee will:

- Delegate authority to the sub committees of the committee for the approval and ratification of relevant policies
- Ratify any significant policy/ procedure, identified by the Chief Nursing Officer/Chief Medical Officer/ Associate Director of Quality Governance that the Board may need to be sighted on
- Receive reports on any Internal Audit of a clinical nature following a referral via the Audit Committee.

4. Chair

The Board shall appoint one of the Non-Executive members to be Chair of the Committee

5. Agenda setting and work plan

The Chief Nursing Officer shall have:

- Corporate oversight of agenda preparation
- Corporate oversight of an annual programme of work for the Committee to approve
- Ensure that the annual programme aligns to the commissioner quality contractual requirements

6. Quorum

A quorum shall be two Non-Executive Directors (one of which could be the Committee Chair), two Executive Directors (one of which must be the Chief Nursing Officer or the Chief Medical Officer) and the Associate Director of Quality Governance or a delegated deputy.

7. Frequency of Meetings

The Committee shall normally meet monthly. The Chair may call an additional or special purposes meeting if they consider one is necessary.

8. Notice of Meetings

Unless otherwise agreed, notice of each meeting, including venue, time, date agenda and supporting papers, shall be provided with members no later than five working days prior to the date of the meeting.

9. Minutes of Meetings

The Committee shall be supported by the Executive Assistant who is appointed to oversee the Quality Committee, whose duties in this respect will include:

- Ensuring the collation & distribution of the Committee papers at least 5 working days in advance of the meeting.
- Ensuring the minutes accurately reflect the business of the meeting & keeping an accurate record of matters arising and issues to be carried forward are maintained.
- Ensuring that minutes and actions are circulated to the Chair for comments within 5 working days of the meeting and to the other members for comments within 10 working days.

10. Accountability

10.1 The Committee is accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference, seek the relevant information from employees and all employees are directed to cooperate with any request made by the Quality Committee

10.2 In line with NHS England publication 'Enhancing board oversight A new approach to Non-executive director champion roles' the Committee has Non-Executive representatives as members to provide oversight to the Board on Quality and Safety priorities.

10.3 The Board of Directors has delegated responsibility to the Quality Committee for oversight of the Workforce Safeguards, establishment reviews and staffing reports.

11. Reporting Responsibilities

11.1 The minutes of the Quality Committee will be formally recorded and submitted to the Board. Any confidential matters will be identified as such in the minutes and separately recorded. The Chair will provide a brief written report to the Board (a month in arrears) meeting drawing attention to significant developments, highlighting areas where further assurance is required and matters requiring Board decisions.

11.2 The Committee will review its work annually to highlight key issues in the development of the Trust's clinical activities and their management, as well as the effectiveness of the Committee.

12. Review

These Terms of Reference will be reviewed annually and recommendations made to Board of Directors for approval.

13. Approval

Date of approval: Approving Body: Board of Directors

	Reporter/ Author (Lead)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Divisional reports													
Surgery	Emma Smith	x			x			x			x		
Maternity	Amie Symes		x			x			x			x	
Medicine	Sarah Holliehead		x			x			x			x	
Integrated Care	Sarah Assinder/ Sue Moody			x			x			x			x
Clinical Support	Claire Carlsen			x			x			x			x
Sub- committee reports													
Clinical Effectiveness and Audit Committee (CEAC)	Hamza Katali/ Natasha Owen		x		x		x		x		x		x
Patient Safety Committee (PSC)	Tom Morgan-Jones/ Natasha Owen	x		x		x		x		x		x	
Patient Experience Committee (PEC)	Natasha Owen	x	x	x	x	x	x	x	x	x	x	x	x
Infection Prevention and Control Committee (IPC) *to include sub group reports where required*	Lucy Flanagan/ Laura Weston	x	x	x	x	x	x	x	x	x	x	x	x
Learning from deaths Committee	Chizo Agwu	Update will be included in the monthly mortality paper as required.											
Quality Priority deep dives/ Patient Safety Priority Updates													
Ensure patients receive a timely VTE risk assessment in line with NICE guidance	Chizo Agwu/Tom Morgan-Jones			x				x			x		
Reduction in cases of grade 2 pressure ulcers	Sue Moody/ Natasha Owen		x			x			x			x	
Improving care of deteriorating patients and implementing Martha's rule by January 2025	Chizo Agwu				x				x				x
Implementing the NATSIPS2 standards and improving management and oversight of safety in relation to interventional procedures	Chizo Agwu/Tom Morgan-Jones			x			x			x			x
Improve responsiveness to patient experience data	Natasha Owen		x			x			x			x	
Fully implement the Get it on Time campaign for Parkinson's medications Implement quality improvement project to target high risk time critical meds as locally defined.	Tony McConkey				x			x			x		
PSP- Falls	Natasha Owen			x								x	
PSP- Admissions, Discharges and Transfers	Natasha Owen					x					x		
Childrens Services - trust objective													
Annual reports/ Board Oversight reports													
Committee TOR and forward planner	Natasha Owen	x Planner 24-25											x TOR and planner 2025-26
Quality Priorty proposal 2025-26	Lucy Flanagan/ Natasha Owen												x
Quality Account	Lucy Flanagan/ Natasha Owen		x										
IPC annual report	Lucy Flanagan/ Laura Weston				x								
Safeguarding annual report	Lucy Flanagan/ Rachael Hebbert												
Research and Developemnt annual report	Chizo Agwu/Ingrid Du Rand												
PLACE Audit results	Laura Weston	x											
Additional routine reports													
Infection Prevention Quarterly Report	Laura Weston		x			x			x			x	
Safeguarding quarterly reports	Rachael Hebbert	x			x			x			x		
PSIRF report	Natasha Owen	x	x	x	x	x	x	x	x	x	x	x	x
Staffing Reports	Emma Smith	x	x	x	x	x	x	x	x	x	x	x	x
Mortality monthly report- ***will include LFD committee update as appendix***	Chizo Agwu	x	x	x	x	x	x	x	x	x	x	x	x
Research	Ingrid Du Rand			x			x			x			
Boarding	Sarah Holliehead/Emma	x	x	x	x	x	x	x	x	x	x	x	x
PQSM	Amie Symes	x	x	x	x	x	x	x	x	x	x	x	x
Colposcopy	Kate O'Shea					x						x	
Safety walkabout report	Natasha Owen				x			x			x		
External review reports													
ED CQC report and action plan	Lucy Flanagan/ Natasha Owen		x		x		x		x		x		x
HTA escalation letter	Chizo Agwu	Update will be included in the monthly mortality paper as required.											
Audiology (paediatrics)	Claire Carlsen/ Dan Harding	x			x			x			x		
National Surveys (exception report)													
Inpatient survey	Natasha Owen					x							
Cancer Patient Experience Survey	Stephen Heptinstall					x							
UEC patient survey	Lou Weaver					x							
Maternity patient survery	Amie Symes					x							
Sub committee TOR/ forward planners													
Patient Safety Committee	Natasha Owen	x											
IPC	Lucy Flanagan		x										
CEAC	Natasha Owen		x										
PEC	Natasha Owen	x											
Adhoc papers added during the year													

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Quality Account
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Rachel Murray, Clinical Quality Improvement Manager
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To present the Trust Annual Quality Account 2023-24 for approval.

2. Recommendation(s)

Quality Committee reviewed the document and recommended it for approval at the Board of Directors.

3. Executive Director Opinion[1]

The Quality Account has been prepared in line with national guidance, as per previous years the account is no longer subject to an audit opinion. The account contains all elements that are deemed best practice and meets national requirements.

The Quality Account will be subject to the following prior to publication;

- A final grammar and formatting check
- Inclusion of the statement of assurance from the ICB

The account is being presented to Board in advance of the annual accounts and annual report due to the timeline for external publication which is set as 30th June 2024.

[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.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Wye Valley
NHS Trust

Quality Account 2023-24

Compassion • Accountability • Respect • Excellence

Contents

Introduction to Quality Accounts

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Quality Account for Wye Valley NHS Trust (the Trust) reflects on the achievements made in the past year against the goals set. It also looks forward to the year ahead and defines what the priorities for quality improvements will be and how the Trust expects to achieve and monitor them.

How will the Quality Account be published?

In line with legal requirements, all NHS healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30th June 2024. The Trust also make the Quality Account available on the Trust website.

About the Trust

The Trust are an acute and community service provider, with a wide range of services to people of all ages living in Herefordshire and some of the population of mid- Powys. To do this, the Trust employs over 4000 staff who operate from the County Hospital, many community sites and in people's homes.

The Trust deliver joined up services, helping people to remain independent at home for as long as possible by providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, the Trust offer a wide range of services to keep you and your family well.

The Trust work as a member of a Foundation Group that includes South Warwickshire University NHS Foundation Trust and George Eliot Hospital NHS Trust. 2023-24 saw Worcestershire Acute Hospitals NHS Trust become a full member of the group.

Having been rated as 'Requires Improvement' by the Care Quality Commission the journey to 'Good' is continuing and the Quality Account illustrates what the Trust are doing to achieve this.

Wye Valley NHS Trust Mission and Values

Our Mission:
To provide a quality of care we would want for ourselves, our family and friends.

Our Values:
Compassion - We will support patients and ensure that they are cared for with compassion.

Accountability - We will act with integrity, assuming responsibility for our actions and decisions.

Respect - We will treat every individual in a non-judgemental manner, ensuring privacy, fairness and confidentiality.

Excellence - We will challenge ourselves to do better and strive for excellence

Introduction from the Chief Executive

The last year has been a positive year for Wye Valley NHS Trust with much to celebrate and I am proud to see so many good news stories from across our services for 2023-24 highlighted in the Quality Account.

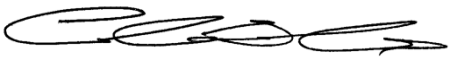
This year saw the Trust implement the National Patient Safety Strategy, going 'live' with the Patient Safety Incident Response Framework and connecting to the new national incident reporting system within national timeframes. This fundamentally changes how we learn from safety events and implement improvement that tackles local level risks. This is a welcome change and one that staff have adapted to with enthusiasm.

Quality and Safety remains a top priority for the Trust despite the challenges we face, like many other Trusts, seeing increasing hospital attendances and increasing need for our services in the community. We have worked closely with system partners to address delays in discharge, ensure ambulances do not have long waits outside our Emergency Department and continue to review our process to enable patients to access the right services at the right time.

In June the Care Quality Commission (CQC) inspected our maternity services and I am delighted that the service rating improved to good. In particular noting; the service engaged well with women and birthing people. Women and birthing people spoken with during the inspection were positive about their experience of maternity services.

A second visit from the CQC in December to our Emergency Department identified safety issues faced by many departments across the country. Improvement efforts have seen changes to our staffing in the department and a revised triage process to ensure patients are seen in the right place as soon as possible. The dedication of the team in responding to the CQC concerns is a reflection of their passion to provide high quality care to our patients.

I welcome the Quality Priorities we have set for 2024-25 and the introduction of Patient Safety Priorities. The Trust has aligned these where there is benefit to more focused improvement in these domains.



Glen Burley, Chief Executive

2023-24 – A year in numbers

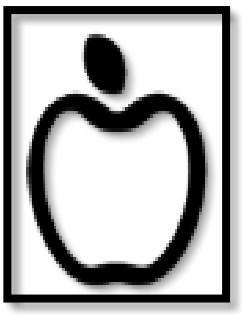
WYE VALLEY NHS TRUST HAS HAD ANOTHER BUSY YEAR SUPPORTING OUR PATIENTS

112,000

Patients using our services

34,000

Patients seen in the community



95,000

Patients seen in Herefordshire

11,000

Patients seen in Powys

Please note figures are based on the number of individual patients seen and not number of appointments, i.e. one patient may have had three visits to the Emergency Department, five outpatient appointment and two admissions but these figures are counting the patient once and not the number of visits.

Celebrating External Recognition

By Royal appointment...

WVT Theatre nurse Joy Varghese Eapan and Practice educator Kate Hickin were lucky enough to be part of the King's 75th birthday celebrations and attended drinks and canapés at the Palace to help HRH celebrate last week.
To celebrate the work of International Nurses and Midwives, the King requested an evening reception and invited 400 nurses and midwives to Buckingham Palace.
After her soiree with the King, Kate said: "I've worked on the International Nurse Programme with the Trust since 2019 and have seen the incredible impact that these nurses have made on our NHS and it was truly amazing to see their hard work, efforts and sacrifices being rewarded.
"It was a great experience and one I will never forget, just receiving the invite was exciting. We got to drive through the gates and park in the palace, we then were served drinks and fine food while the King, alongside Ruth May (Chief Nursing Officer of the NHS), circulated the room to personally meet and thank people for their services to the NHS. It was a real privilege to be there".
Joy, who has been working in the Trust since 2019, had been nominated for his work to support the local Indian community through the HEMA group in Hereford.
"HEMA (Hema Malayalee Association) is committed to providing education about our rich and diverse culture history, language and heritage through cultural and social events to bridge the gap between Hereford and our Motherland," said Joy. "HEMA also work with other organisations of similar interest in order to maintain our heritage by sharing and exchanging concepts and enhancing the quality of life and to preserve the inherit established traditions, cultural diversity and national identity to future generations for a better tomorrow."
Joy added: "Meeting the King was an amazing experience in my life and I will never forget. I feel proud and thank to all for nominating my name."

Sophie Prothero finalist at Student Nursing Times Awards

Sophie recently attended the Student Nursing Times Awards as a finalist.
Although she didn't win, Sophie has said "I had a really lovely time at the awards and very happy to have been a finalist. To be a finalist is an amazing achievement"

Well done Sophie!

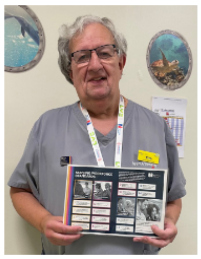
Fellowship success in Podiatric Surgery

Last Friday (22 September), Derek Protheroe attended the House of Lords to officially receive his Fellowship in Podiatric Surgery. The Fellowship, which Derek received after successfully completing his final exam in May, recognises the practitioner's dedication to their patients, to their careers and the academic advancement of both themselves and the profession.

Derek says this is a great deal to him, "It provides recognition for the hard work over the last several years from myself but also the dedication and patience from all members (consultants, nursing and admin) of the podiatric surgery team in facilitating that transition from trainee to registrar level. I hope now that I can continue in my role and develop the service in the future. The award also demonstrates the recognised development and training programme which has been annotated via HCPC and Huddersfield University."
The team are so proud of him and his hard work!

Tim achieves "champion" award

Tim Woods, HCA on Oxford Suite, has been awarded the Nursing Workforce Standards Champion status by the Royal College of Nursing. The award was achieved after Tim completed two cases of work in the Trust using some of the Standards. Going forward, this means that he is available to talk to members of staff and give them advice on how best they can use the standards in their place of work. Tim would welcome members of staff to contact him if they wish to know more. Timothy.Woods@wvt.nhs.uk



First Prize for clinical case poster at the British Dental Association (BDA) Community Dental Services group (CDS group) Annual Presidential and Scientific meeting

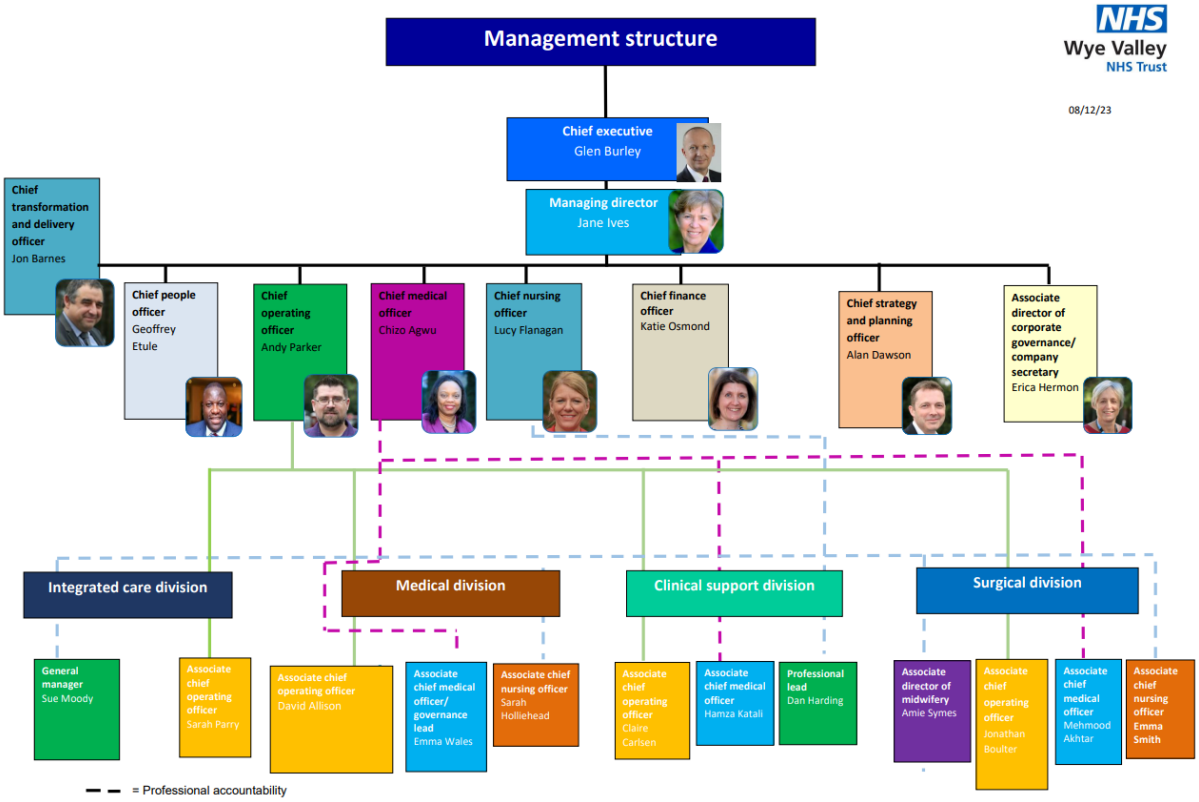
Amy Jukes, one of our Community Dentists, has achieved First Prize for clinical case poster at the British Dental Association (BDA) Community Dental Services group (CDS group) Annual Presidential and Scientific meeting 5-6 October 2023.
Her submission on the "Perils of DIY dentistry" showed the disastrous consequences of an attempt at dental veneers using a product purchased on-line. It is sadly well-timed given current access issues to NHS dentistry nationally but in extremis in Herefordshire at this time. The case displays the complex and sometimes unusual cases that present at our Dental Access Centres and the collaborative approaches that are often necessary to resolve. It also reinforces that the disadvantage is often focussed on the most vulnerable members of Herefordshire community.

Organisational Change

Wye Valley NHS Trust is part of a Foundation Group that includes South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and Worcestershire Acute Hospitals NHS Trust. Each Trust retains its own Trust Board with the common link being a shared Chief Executive Officer and Trust Chairman.

The Foundation Group enables the Trust to strengthen opportunities available to help secure a sustainable future for all four organisations and allows each Trust to maintain its own governance while benefitting from scale and learning across the wider group.

In September, the Trust appointed Chizo Agwu as Chief Medical Officer, following the retirement of David Mowbray.



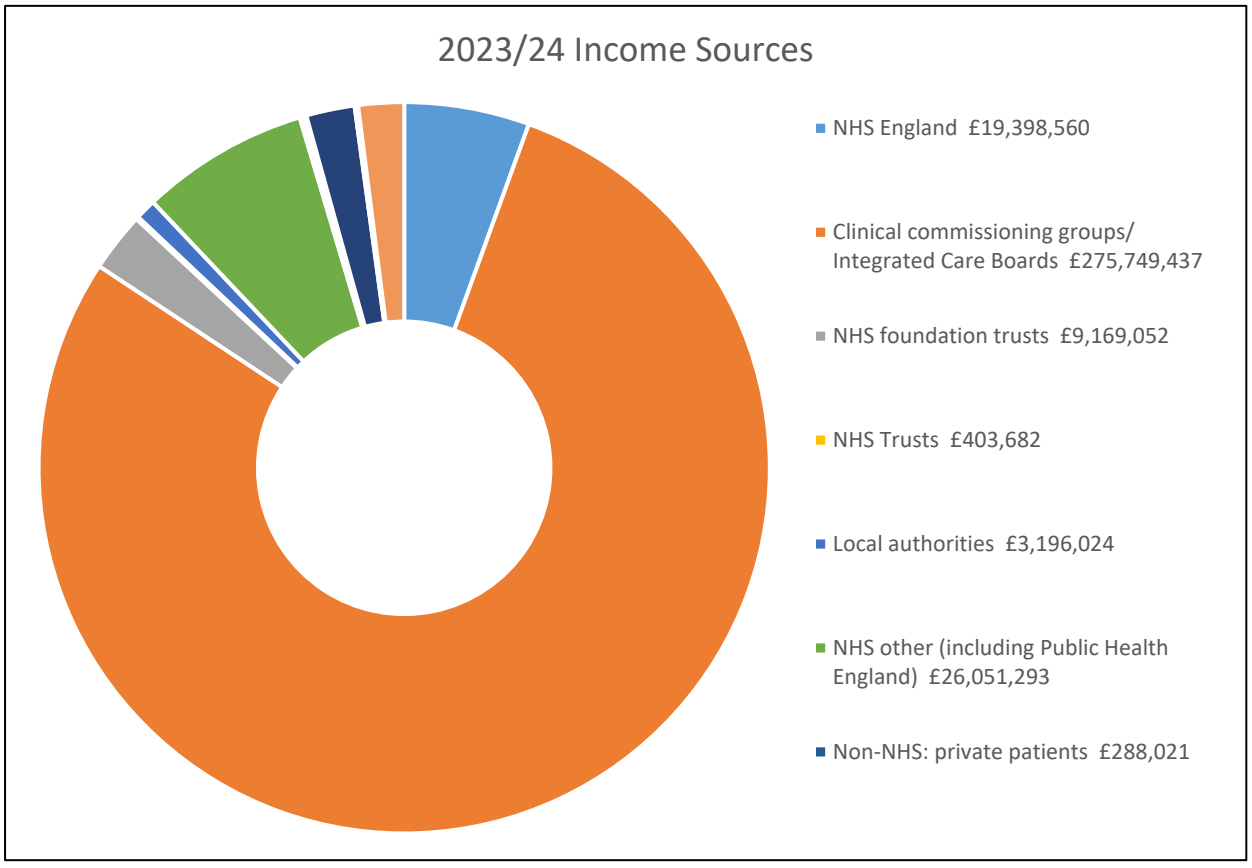
Statement of Assurance

The Trust provided and/or subcontracted 58 acute and community services for the population of Herefordshire, bordering English counties, and mid- Powys (details on these services is provided in Appendix 4). The Trust has reviewed all the data available on the quality of care in all of these services.

More detail on the income of the Trust can be found in the Annual Report 2023-24.

The income generated by Wye Valley NHS Trust for services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services.

A breakdown of income received from each body for 20243-24 is illustrated below.



Care Quality Commission (CQC) Overview of Progress

The Trust witnessed a busy year for CQC inspections, starting in June 2023, with the Trust welcoming a team of inspectors from the Care Quality Commission who undertook a focused inspection of the trusts maternity services at the County hospital.

The inspectors were able to recognise a wide range of improvements on the maternity ward confirming staff are delivering a “good” service.

The report published in October 2023, praised staff who the inspectors said were working “incredibly hard” to deliver a high standard of care to those using their services. They added that they found a “well-respected and supportive leadership team” in the maternity service with skills and experience to run the service well.

Jane Ives, the Trust’s Managing Director, said: “Our excellent maternity team deserves this recognition. They have worked very hard to continually improve the service to women and families. Listening to the users of the service and responding to feedback, as well as implementing clinical best practice, latest research and national guidelines.

Wye Valley Trust Maternity Team

Later, the same year, the Trust’s Emergency Department was subject to an unannounced core service three-day inspection from the Care Quality Commission with a team of inspectors visiting in December 2023.

The Care Quality Commission (CQC) recognised staff are very caring, although it gave the department an overall “Requires Improvement” rating due to concerns over patient safety. The report published in February, frequently refers to overcrowding and “difficult” conditions in ED caused by the limited size of the department and large number of patients. However, they reported that staff were kind and trying to provide good care to patients, describing them as “discreet and responsive” treating patients in a “respectful and considerate” manner. In turn, patients told the inspectors that staff treated them well with kindness.

Jane Ives, managing director, said the inspectors had highlighted a number of issues the Trust was aware of and had been already addressing. In response to the inspection, the Trust held a summit to discuss issues raised. The CQC’s return visit confirmed progress in a number of areas with improved governance, improved child specific training for staff, improvements to the children’s area, and an increase in the number of clinical staff, which included the introduction of a nurse and healthcare assistant to monitor patients in the waiting room 24 hours a day. The Emergency Department have an improvement plan monitoring progress made against the CQC recommendations.

To complete our year, in February 2024, our maternity department received further good news, seeing the Trusts maternity care being scored in the top five performing Trusts in the region for key areas and above the national average in a recently published patient survey.

The national survey undertaken by the Care Quality Commission, which was published in February, provides direct feedback from women about their experience of maternity care, including antenatal care, labour and birth and postnatal care.

The County hospital's overall rating remains requires improvement. For the full breakdown of service ratings see Appendix 1.

The Trust is currently registered with the Care Quality Commission without any compliance conditions and is licensed to provide services.

National Audit and National Confidential Enquiries (NCEPOD)

We participated in 48 (94%) of National Clinical Audits

Data submission ranged between 25-100% of eligible cases for individual audits

Clinical teams present reports and improvement action plans to their Specialty Audit Meetings

The Trust had lower case submission rates for Acute Coronary Syndromes – Acute Myocardial Infarction (MINAP) and National Heart Failure Audit due to staffing pressures and patient care taking precedence over data collection

There were 3 eligible audits that the Trust did not participate in during 2023/24:
1. National Ophthalmology Audit Database
2. National Cardiac Arrest Audit
3. Inflammatory Bowel Disease (IBD) Registry

During 2023/24, Wye Valley NHS Trust was eligible to participate in 51 national clinical audits. The Trust participated in 48 (94%) of these national clinical audits. In addition, the Trust participated in 100% of the National Confidential Enquiries. Detailed in Appendix 1.

National Data opt-out

The national data opt-out is a service that allows patients to opt out of their confidential patient information being used for research and planning.

Before the Trust submit data to the relevant national audits, we have to follow the process of identifying and removing patients who have opted out. In some cases this means that the number of our patients who are included in the audit is reduced, and in the event of low patient numbers, this can have an impact on the results of the audit, which will be considered when reviewing outcomes and putting in place actions.

Learning from Audit

In 2023/24, the Trust Clinical Audit Programme included 271 projects (national & local combined). The programmes monitored by the Trust's divisional and directorate governance groups on a monthly basis with oversight through the Clinical Effectiveness & Audit Committee. Results from national and local clinical audits are reviewed at specialty level, by the clinical teams involved in the audit. If the review indicates that improvements are required, action plans are devised and monitored within the divisions.

Highlights from Various Published National Audit Reports during 2023/24

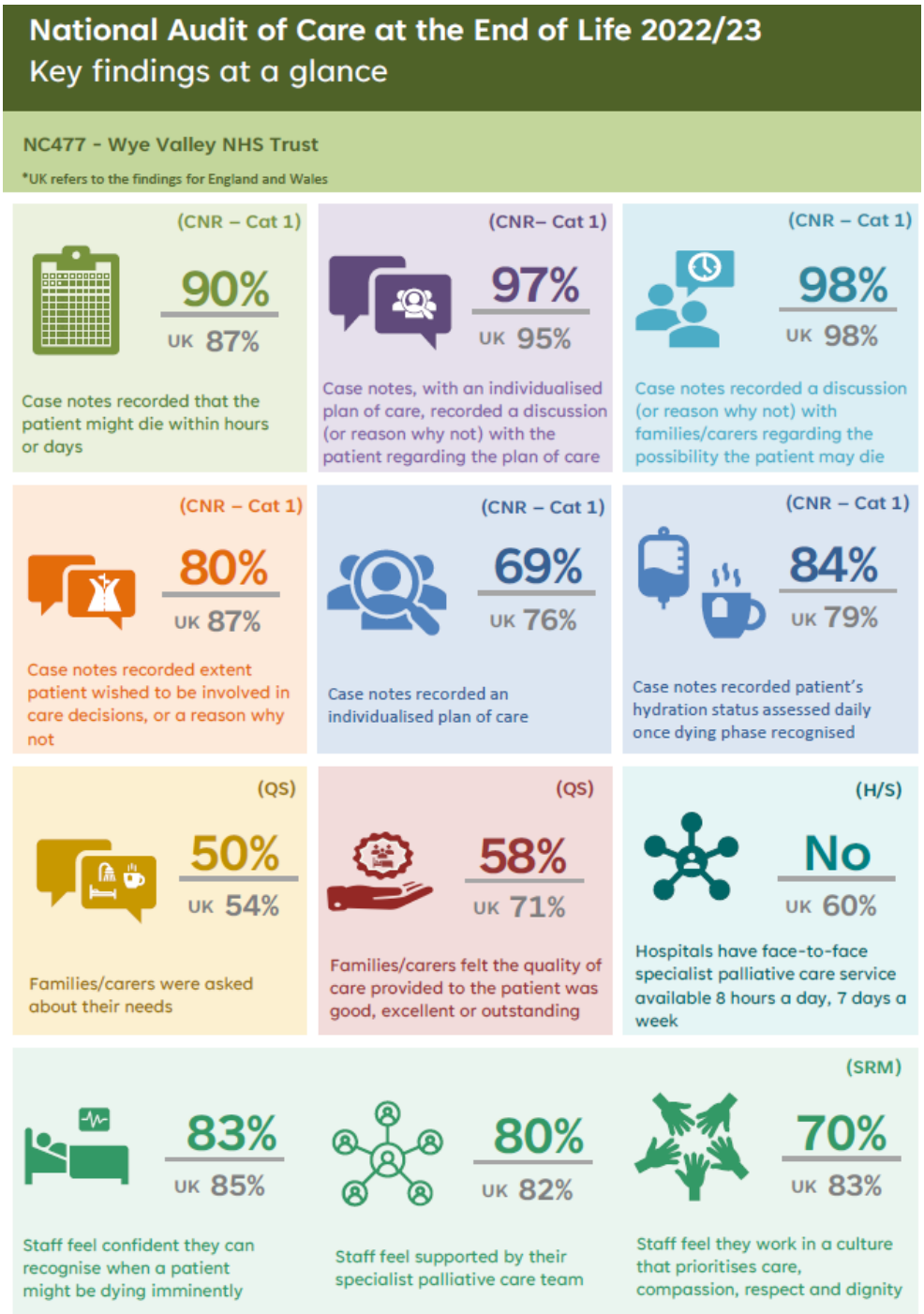
There were 31 national clinical audits that published reports in 2023/24 and 12 reports for the National Confidential Enquiry programme. These have been sent for review by the relevant specialty and, where appropriate, action plans have been developed.

A number of these reports are highlighted, including areas of good practice and what the Trust intends to do where standards are not met.

National Audit of Care at the End of Life

National Audit of Care at the End of Life
Fourth round of the audit (2022/23) report

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during their last admission leading to death in acute hospitals and community hospitals in England and Wales.



National Audit of Care at the End of Life

Areas reflecting good practice:

- Recognition of patients who are approaching the end of life and documentation of a discussion about this with the patient and their family/carers.
- Recording the extent to which patients wished to be involved in care decisions or the reason why not.
- Case notes recorded patient's hydration status being assessed daily once the dying phase had been recognised.

Areas requiring improvement:

- Overall scores for communication with families and others, including addressing their needs and experience of care.
- Use of an individualised plan for end of life care.
- Lack of a face-to-face specialist palliative care service in the hospital during the day at weekends and bank holidays, resulting in families not feeling as supported as much as they could be.
- Staff feeling confident, supported, and that they work within a culture that prioritises care, compassion, respect and dignity.

Local actions to be taken:

- Improvement in Advance Care Planning – Implement the use of digital ReSPECT across the Trust.
- Improvement in the end of life care and support for patients and their families – more proactive end of life care training for Trust ward and community staff through the appointment of a non-medical Community Education Facilitator (CEF) for end of life care.
- Explore how the electronic version of the WVT End of Life Care Record (Individualised Plan) can be made fit for purpose.
- Explore the value/possibility of making End of Life Care training mandatory across the Trust.
- Review of hospital based Specialist Palliative Care Clinical Nurse Specialist capacity and scope for 7 day working.

Key Results demonstrated from a local audit report

The Cappuccini Test

Maintenance of a robust clinical supervision pathway is key to ensuring patient safety in anaesthetic care. In 2012, Frances Cappuccini tragically passed away following post-partum haemorrhage, and it was ruled that lack of anaesthetist supervisor contact played a role in this potentially avoidable loss of life.

To address this issue, the Cappuccini test was created, which aims to establish whether supervisor arrangements within a department meet the required standard set by the Royal College of Anaesthetists.

It consists of auditing junior and consultant level anaesthetists to determine whether they are aware of who is supervising who and that there is a functional method of contact between them.

It would be expected that 100% of supervisees:

- Are aware of who their supervisors are and vice versa
- Supervisors know what work their supervisees are doing
- All contact methods are functional

Areas reflecting good practice:

- 100% of trainees were able to correctly identify their supervisors.
- 100% of supervisors able to correctly identify their supervisees.
- All contact methods were valid.
- Trainees were aware of other contact methods (e.g. bleep number to contact the duty consultant) should they be required.

Areas requiring improvement:

- 25% of supervisors did not give sufficient detail when asked about the type of work being carried out by their supervisees.

However, we understand that this may be a shortfall in the method of data collection, rather than a fault in the supervision pathway.

Local actions to be taken:

- Improve the audit method for the future use by using more thorough questioning when asking about the type of work the supervisee is doing.
  Including:
  - Questioning the supervisor more specifically i.e., which surgical specialty is involved? Is it emergency work or elective?
  - This will prompt a more detailed answer, which will retain the validity of the results and provide us with the full information required.

Trust Research Participation Overview 23/24

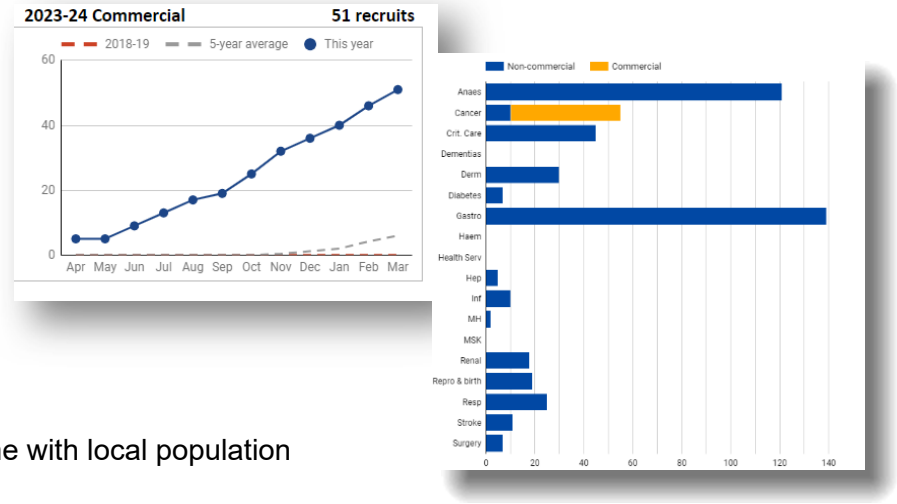
The Clinical Research and Development Strategy is one of the building blocks of our Trust vision to improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas. Being delivered in accordance with our Trust CARE values will contribute to our strategic objective to improving patient care through Research.

Our research participants will have the best experience of care, and we will ensure that our research team makes the best use of the resources we are provided with from the National Institute for Health and Care Research (NIHR), research funders and charitable funding. This strategy will raise awareness of and engagement with research and innovation at the Board and throughout the Trust and will result in:

- Increased staff participation in Clinical Research
- Patients will have increased opportunities to participate in research
- Prioritise participation in research which meets the needs of local, regional and national priorities of health and social care
- Research will be financially sustainable.

In 2023/24, we recruited 631 patients into 25 different trials across 14 different specialties:

- Commercial trials - 51 patients
- Non-commercial - 557 patients



We also opened 12 new trials across 9 specialties.

Our priorities for 2024/25 are:

- Aligning research trials in line with local population health needs
- Increasing number of research active Clinicians
- Increasing participation in Commercial research trials
- Building a stable and effective research team
- Promoting research with patients, nurses and clinicians across the Trust to increase our research profile

Once in the lifecycle of a trial, our patients are given the opportunity to provide us with feedback.

Here are some of the things our patients have said about us.

Safety Alerts

Safety alerts are issued when there is a specific issue that without immediate actions being taken could result in serious harm or death.

In 2023-24, the Trust continued to receive the patient safety alerts through the Central Alerting System (CAS) and Medicines & Healthcare products Regulatory Agency (MHRA). These were managed appropriately through the established process, which includes checking for relevancy, and recording completed actions.

All historic alerts have been actioned and completed.

The Trust have implemented a new management system which provides centralised oversight of all the alerts. The aim is to triangulate alerts with incidents and risks to provide a broader view of safety across the Trust and strengthen our safety profile.

Field Safety Notices (FSNs) are important communications about the safety of a medical device that are sent to customers by a device manufacturer or their representative.

The FSNs have continued to be reviewed, checked for relevancy to the Trust and actioned accordingly.

Best Practice Guidance

Since being first established in 1999, The National Institute for Health and Care Excellence (NICE) have been providing evidence-based recommendations for the health and social care sector; developed by independent committees of various professionals, consultants and lay members – to assisting us in providing the very best care for our patients.

The table below shows the guidance published by type for the year 2023-24

Type of Guidance	Total number
NICE Guidance	42
Clinical Guidance	39
Quality Standard	11
Diagnostic Guideline	10
Technical Appraisal Guidance	81
Medical Innovation Brief	6
Interventional Procedure Guidance	29
Medical Technologies Guidances	3
Health Technology Evaluation	13
Highly-Specialised Technology Guidance	8
TOTAL	**242**

NICE Guidance published for year 2023-24, broken down into type of guidance

Within the year we have seen increased engagement from divisions in allocation of a lead for managing guidance; enabling the NICE guidance team to effectively managing published guidance within Trust timeframes.

The Quality team has improved its links across its own work streams with the NICE Guidance and Clinical Audit Teams ensuring that the relevant guidance and recorded audits occurring within WVT are aligned. In addition, at the beginning of the CQUINS 2023/24 programme the teams met; reviewing the list of CQUINs, identifying related NICE guidance and taking appropriate action to align information, such as, re-review of the baseline assessment of published guidance documents.

Looking forward to 2024-25, the team are continuing to build on the work already undertaken within the Quality team by exploring how NICE sits with our Safety team and the triangulation of work under the newly introduced PSIRF model.

NICE have announced that they are exploring new ways of producing guidance; looking into the ways in which the organisation prioritise, maintain, review and update their guideline recommendations. We await the outcome of their review to see if we can adapt for our internal practices.

Information Governance

Information Governance is how an organisation handles patient and staff information, which may be of a sensitive nature. This includes ensuring all information, especially personal, is held legally, securely and confidentially.

The Data Security Protection Toolkit (DSPT) was introduced in 2018-19 and replaces the Information Governance Toolkit (IGT).

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

The Trust's year to date position is shown in the table below:

Progress Dashboard and Reports			
Mandatory Reporting – **87/108 mandatory evidence items provided.**		Baseline submission due (end of Feb) Current position - Approaching Standards **Final submission due – 30/06/23**	
Assertions 19/34		Confirmed	
Approaching Standards: **February 2024** **Target staff % pass rate for the data security and protection mandatory test have now been updated due to the new measurement.**	Current – (Feb 24) -84% Current – (Feb 24) – 90%	Target 85% - for majority of staff 90% - for higher risk staff/activities	Action to address: *Training Needs analysis updated as per DSPT evidence required and regularly monitored.*

Clinical Coding and Error Rate

Clinical coding is the translation of medical terminology (written by the clinicians) that describes a patient's complaint, problem, diagnosis, treatment or other reason for seeking medical attention into standard codes that can then be easily tabulated, aggregated and sorted for statistical and financial analysis, in an efficient and meaningful manner.

The figures for 23/24 show an improvement across the board for all areas of Clinical Coding, well exceeding Mandatory target.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip operation) so that indicators of quality can be produced to help improvement processes.

The Trust has a constant focus on data quality and the need to meet the organisation's reporting requirements against the National Data Security and Protection Toolkit.

Data Quality Standard 1. The Trust uses a variety of systems and processes to ensure poor data quality does not undermine the information being reported. Data quality (DQ) checks are performed on all main reporting domains (including quality, finance, operational performance, and workforce). The Trust makes use of internal and external benchmarks to highlight areas potentially requiring improvement to data quality.

As part of the Foundation Group, the Trust has developed some key principles for data quality and these will be adopted across all trusts within the group. Further work on developing Information strategy across the group is ongoing and projects and work streams being finalised. As part of these work streams, the previous work done around Data Quality Kite marks will be broadened out to include wider elements of data quality. The current plans around Kite Marks within our board KPIs is due for completion by end June 2024. These kite marks aim to give assurance, and highlight, the quality of the data which supports each indicator.

Illustration of the percentage coding accuracy at Wye Valley NHS Trust in 2023-24 of which all mandated standards were met as set by NHS Digital.

	WVT results	Mandatory	Advisory
Primary diagnosis	94%	90%	95%
Secondary diagnosis	90%	80%	90%
Primary procedure	93%	90%	95%
Secondary procedure	91%	80%	90%

The Trust is committed to ensuring staff are aware of their responsibility for data quality and the accurate recording of data on Trust electronic systems and paper held records. The Trust have included this responsibility in all job descriptions and regular audits are undertaken. We work closely with our partner IMS Maxims who are supporting with electronic patient record development. The Trust's commitment to data quality is demonstrated by implementing the following principles:

- The aim is that all staff should be fully trained in the use and recording of data on electronic systems – where possible access should not be given until training has taken place.
- All managers are responsible for data quality within their services.
- Staff are aware of the reporting mechanisms for data quality issues and complaints.
- The Trust has a dedicated team for each electronic system that come under CSG, for managing data quality issues, system management, system configuration in line with national standards and advising staff on managing data quality issues. For other systems used within specific departments there may be a single administrator providing support and advice.
- Regular reports are sent out for managers to ensure missing data and errors are actioned and regular meetings are held to discuss and report actions of the same.
- Summary data quality dashboard produced weekly and discussed at weekly Trust wide patient tracking list (PTL) meeting.
- Additional steps added to commissioning data sets processing to identify incorrectly recorded data and passed to the Electronic Patient Record Support Team to correct for the IMS MAXIMS system.

The Patient's NHS number

DA patient's NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients.

The Trust submitted records during 2023-24 to the Secondary Uses Service (SUS), for inclusion in the Hospital Episodes Statistics (HES), which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number for the period April 2023 to March 2024, is detailed below.

NHS Number 23/24				
	Has NHS	No Number	Total	%
IP	80629	96	80725	99.9%
OP	463482	244	463726	99.9%
AE	71187	585	71772	99.2%

The Patient's Registered GP Practice Code

Accurate recording of the patient's GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

The Trust submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records, which included the patients valid General Medical Practice Code, was highest at 99.3% for Outpatients.

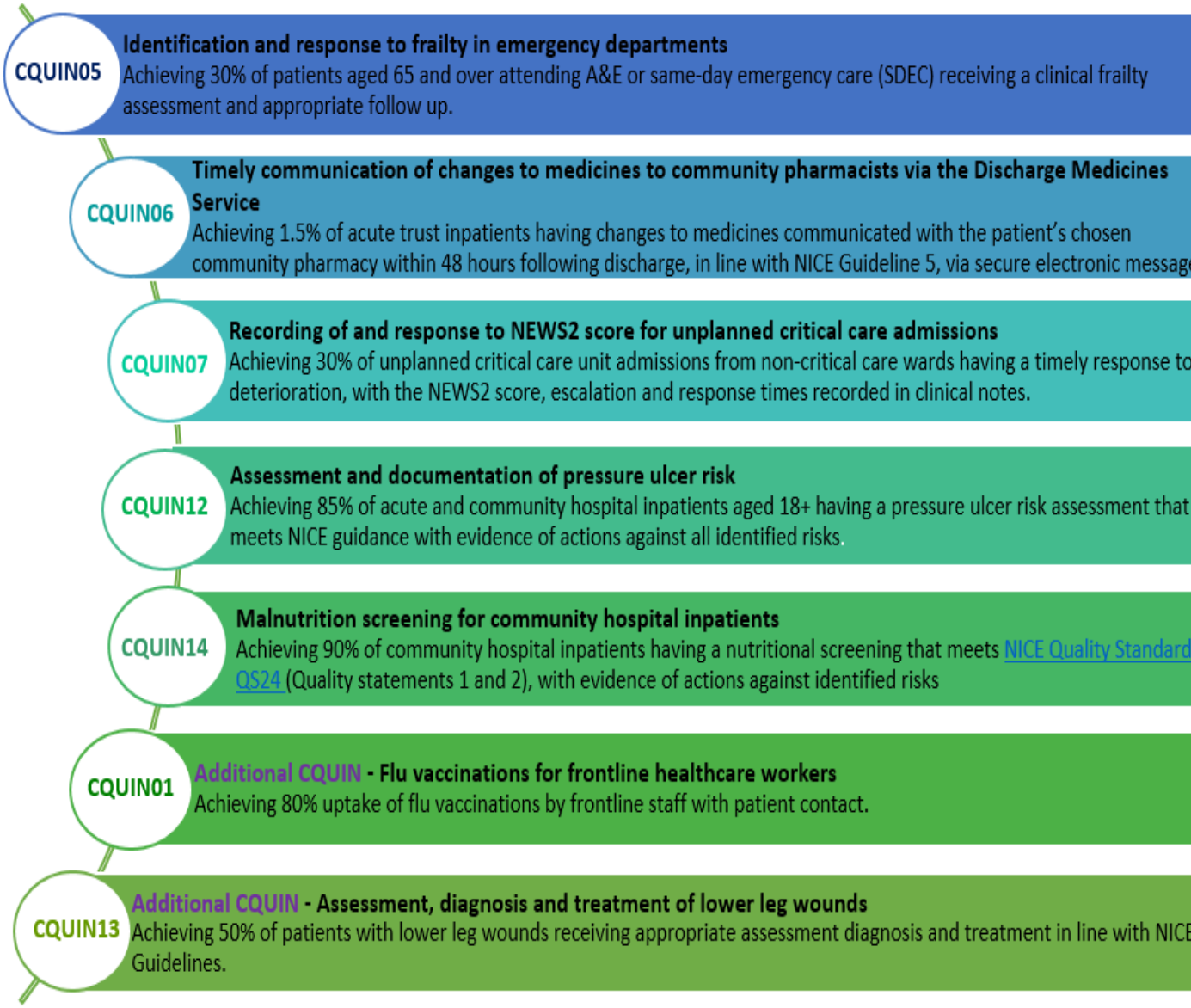
GP Code 23/24				
	Gp code	No Number	Total	%
IP	79456	1269	80725	98.4%
OP	460476	3250	463726	99.3%
AE	67786	2369	71772	94.4%

Commissioning for Quality and Innovations (CQUIN) 2023-24

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care including transformational change.

Each year a number of CQUIN schemes are identified across areas of care. This is linked to targets which may have a financial reward for achievement. With a proportion of the Trust's income provided by meeting these set CQUIN targets. These are nationally reported throughout the financial year.

For 2023-24 the Trust, in agreement with our Commissioners have selected five priority CQUIN projects that link directly to the Trust objectives or quality priorities, this year we have been able to report on two additional CQUINs, these are as follows:



Wye Valley NHS Trust have submitted the following results for the 2023-24 CQUIN programme

The five national indicators adopted by the Trust for 2023/24											
No	Area	CQUIN	Compliance Measure	Q1	% Q1	Q2	% Q2	Q3	% Q3	Q4	% Q4
CQUIN 05	Medical	Identification and response to frailty in emergency departments	10% - 30%	●	73%	●	80%	●	86%	●	89%
CQUIN 06	Clinical Support	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service.	0.5% - 1.5%	Whole period result - local result to be verified nationally						●	1.5%
CQUIN 07	Trustwide	Recording of and response to NEWS2 score for unplanned critical care admissions	10% - 30%	●	26%	●	45%	●	76%	●	62%
CQUIN 12	Trustwide	Assessment and documentation of pressure ulcer risk (acute & community)	70% - 85%	●	81%	●	89%	●	93%	●	86%
CQUIN 14	Integrated Care	Malnutrition screening for community hospital inpatients	70% - 90%	●	88%	●	86%	●	77%	●	86%
Additional CQUINs that will be reported on in 2023/24											
CQUIN 01	Trust wide	Flu vaccinations for frontline healthcare workers	75% - 80%	N/A	N/A	N/A	N/A	●	38%	●	38%
CQUIN 13	Integrated Care	Assessment, diagnosis and treatment of lower leg wounds	25% - 50%	●	54%	●	55%	●	61%	●	60%

The CQUIN scheme will be paused during 2024/25 pending the outcome of a wider review of quality incentives by NHS England. During this pause a list of non-mandatory indicators will be realised nationally to Trusts to enable a 'CQUIN-like' scheme to run locally throughout 2024-25.

Quality of Services - Key Areas

CELEBRATING CHANGE

Patient Safety Incident Reporting Framework (PSIRF)

Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The past 12 months

Has seen the ICB approve our plan and the Trust going live with PSIRF on the 1st November 2023. Our Serious Incident panel became Patient Safety Panel. This is a fundamental shift in the management of patient safety, with the key principles being:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

In order to implement PSIRF key colleagues across the Trust received the following training.

- Engagement and Involvement (improving engagement with persons affected by incidents)
- Systems approach to investigation
- Oversight (Exec and NED directors, senior managers leading on Patient safety)

The next 12 months

Wye Valley are continuing to embed the process and ensure learning generates improvement, this will involve

- Changing the format of Pressure Ulcer Panel
- Review the effectiveness of Falls Panel
- Changes to the format of Patient Safety Panel – focussing the discussion on emerging risks and assurance
- Introduction of an Assurance Panel (triangulation, sign off and monitoring improvement)
- Evaluate the training and develop a plan to roll out the Engagement and Involvement, and System Approach to Investigation training wider.

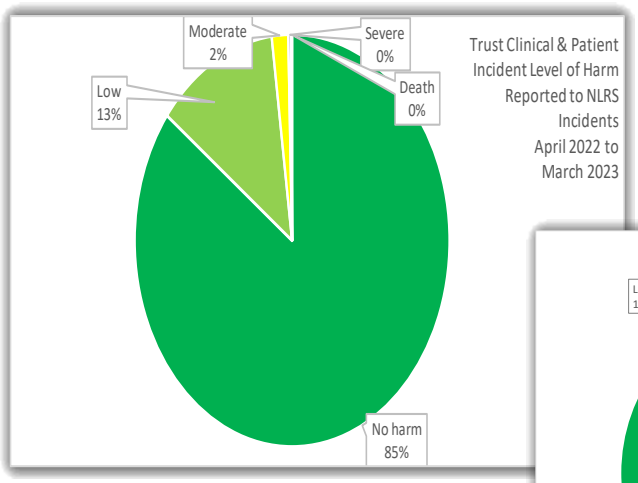

PSIRF Journey
1
2
3
4
November & December
Continue bringing moderate and above incidents to Patient Safety Panel.
Focus the discussion on identifying new learning.
Proportionate learning responses agreed.
January & February
Introduce broad thematic analysis of patient safety incidents and feedback related to patient safety priorities.
Focus the discussion on assurance that improvement responses addressing known issues.
March & April
Divisions to bring their thematic analysis of incidents and feedback irrespective of harm.
Focus the discussion on emerging risks and assurance.
April onwards
Assurance panel to sign off learning responses and PSII's.
Focus on assurance regarding ongoing monitoring and improvement.

Clinical Incident Reporting

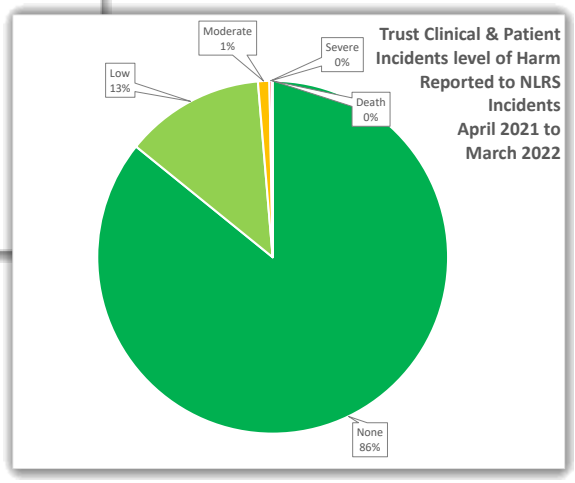
The Trust promotes a culture of safety where staff are encouraged to report actual or near miss incidents.

Comparison data as a rate per 1000 bed days is unavailable from NLRS due to the change to the new Patient Safety Incident Reporting Framework PSIRF.

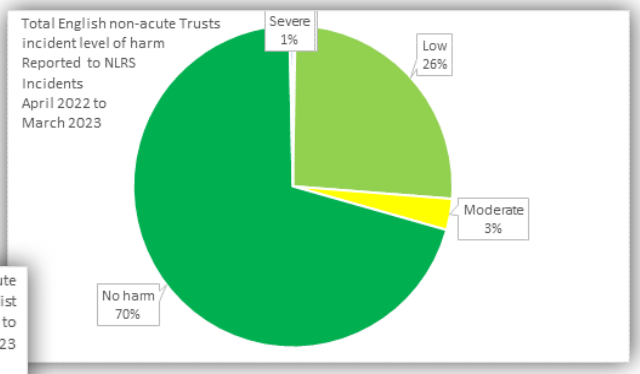
Incidents reported sent to NLRS have increased from 8,784(2020-21) to 10,309 (2022-23), therefore it is likely the Trust has maintained its place as one of the proportionately.

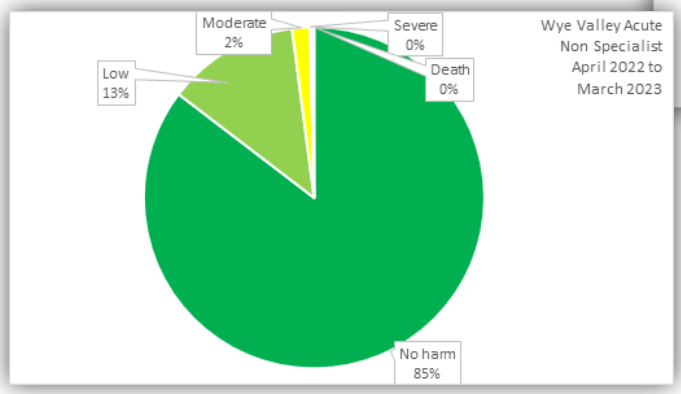


The chart adjacent provides a breakdown of the level of harm of incidents reported nationally to the NRLS April 2022 to March 2023. The chart below contains last year's data.



Levels of Harm are at a similar level to the previous reported year. The chart adjacent shows the Total English non-acute Trusts for comparison. Wye valley reports 2% with Moderate or more severe harm, see chart below comparted to the English total of 4%.

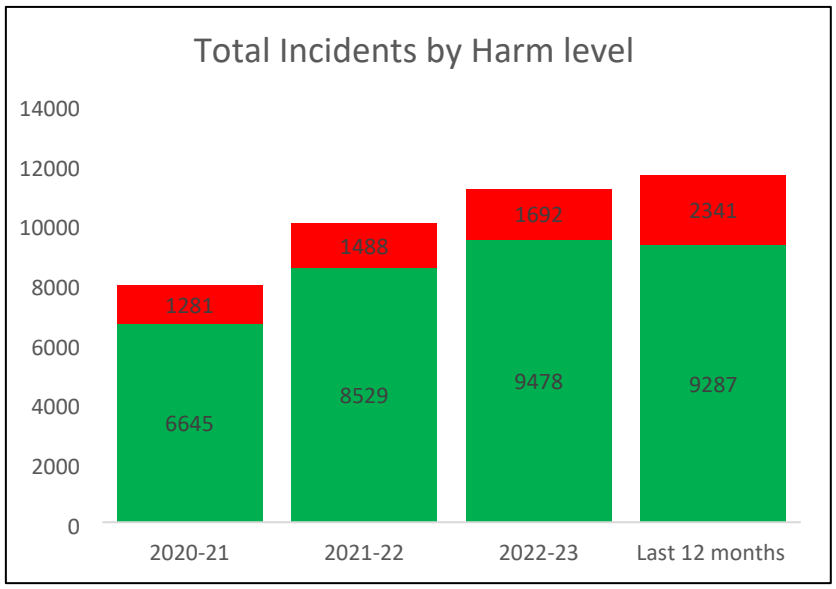




Current year comparisons are not available with the move to a new incident reporting framework, national comparisons are currently not available from NHS England.

The following chart shows all incidents reported by the Trust on the incident reporting system. The incidents reported increased during 2023-24 by 6.66%. This shows no harm incidents account for 80% of incidents.

The proportion of Harm incidents of total incidents has increased 7% now 19.67% as opposed to 12.66% seen last year. The volume of Harm incidents has increased by 66%, in 2023/24. The vast Majority of Harm incidents are low harm, with only 2.5% recorded as Moderate severity or greater harm. This compares to the 4% seen nationally in recent years (see Pie charts above).The volume of incidents rated as Moderate or greater severity has increased by 69.5% to 300 incidents in 2023/24. This may be a reflection of the new harm ratings in the National system which has seen the addition of a psychological harm category.



The top five categories of all incidents reported in 2022-23 on the incident reporting system are shown in the next table. The top five remain the same as the previous year.

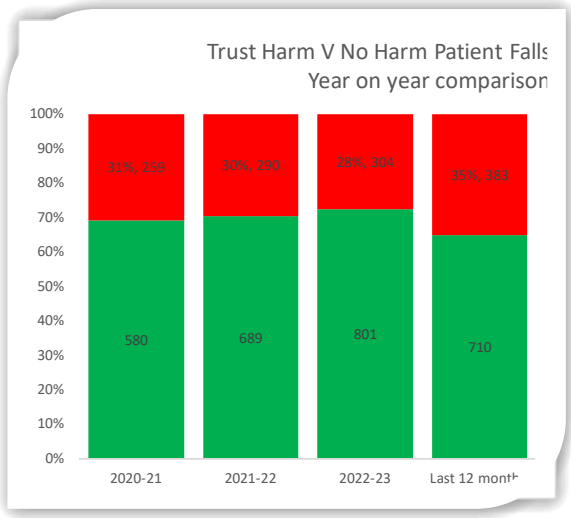
Category	2022-23	Last 12 months	%Total	% Change on 2022-23
Tissue Viability Incident	2396	2686	22.52%	10.18%
Falls	1135	1129	9.47%	-1.06%
Clinical assessment (inc scans, tests, assessment, treatment)	823	1120	9.39%	31.71%
Infrastructure (inc staff, facilities, environment)	1270	1048	8.79%	-18.66%
Admission, access, appointments, transfer, discharge	910	1043	8.75%	9.67%

Reducing Harm to Patients

Reduce patient falls

In 2023-24, we saw the following changes in comparison to 2022-23:

- Total falls decreased by 1.09%
- Falls resulting in harm increased by 26%
- Proportion of harmful falls as a percentage of total falls has increased to 35% from 28% in 2022/23.
- The vast majority of harmful falls are low harm, with 2.65% of total falls (29 falls) being of moderate severity or greater.



Never Events:

During 2023/24, two incident's that met the National criteria for a 'Never Event' occurred in Ophthalmology which were managed under the Serious Incident Framework and were subject to a full investigation using root cause analysis methodology.

Additionally one incident that met the National criteria for a 'Never Event' occurred in Dermatology. This was investigated under PSIRF with a full patient safety incident investigation with full engagement of the patient in the investigation process.

Duty of Candour

This is a statutory duty of all health and social care providers to be open and transparent with people using healthcare services. The Trust continues to provide an opportunity to patients and their families to be involved in providing input into reviews and investigations whether that is by sending questions in, face-to-face meetings or telephone calls.

For any incident that meets the statutory duty there is a prompt and a section to complete however staff are encouraged to be open and honest about any incident that occurs.

Duty of candour is monitored through monthly divisional and corporate reports and as part of the reporting to Quality Committee. In addition, collaboration occurs where a complaint has been received relating to the same incident. This is to provide one single point of contact for the patient and families and ensure they are included in the investigations if they choose to do so.

Adult Safeguarding

Adult Safeguarding means protecting a person's right to live in safety and free from abuse and neglect and is everybody's business. This remains a high priority for the Trust and we continue to work with partner agencies across Herefordshire and beyond to ensure best practice.

The Trust ensure the principles of empowerment, prevention, proportionality, protection; partnership working and accountability have been applied preserving the individual's wellbeing at its core. The outcomes being that people are:

- Safe and able to protect themselves from abuse and neglect.
- Treated fairly and with dignity and respect.
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

Making Safeguarding Person (MSP) continues to remain a high priority and the Trust have endeavoured to ensure the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible.

WVT now have a Lead for Domestic Abuse in post who works as part of the Adult Safeguarding team but also integrally with the Children's Safeguarding Team. The Lead is responsible for co-ordinating WVT's response to domestic abuse. The Domestic Abuse Act was passed in 2021 and puts clear responsibilities on all agencies to ensure that they are asking about domestic abuse and providing an effective response for all victim-survivors.

The Lead works very closely with the Hospital Independent Domestic Violence Advisor (HIDVA) (employed by West Mercia Women's Aid but working within WVT). The HIDVA provides independent advice and support for all patients and staff. The Lead for Domestic Abuse and HIDVA jointly deliver training across the Trust and a large focus of their roles is to raise awareness about domestic abuse and to build staff confidence so that more victims are identified and receive the support that they need.

The Trust maintains its commitment to Herefordshire Multiagency Risk Assessment Conference (MARAC) and Domestic Abuse Perpetrator Panel and is an active member of the Domestic Abuse Operational Group and MARAC Governance Group.

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests process in everyday practice. This has continued to be a quality priority for WVT. The Trust has an adult safeguarding performance dashboard, which is monitored and discussed at the Trust's Overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Quality Committee, with a report produced for the Trust Board annually.

The Trust has maintained their commitment to be an active member of the Herefordshire Safeguarding Adult Board and associated sub-groups, contributing to multi-agency audit, Safeguarding Adult Reviews and Domestic Homicide Reviews.

The Trust has equally maintained their commitment to work collaboratively with out of county Safeguarding Boards.

Children Safeguarding

A child and/or young person is defined as anyone who has not yet reached their 18th birthday.

Safeguarding children and young people is central to the quality of care provided to patients by the Trust. The Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2023. All NHS trusts are required to have effective arrangements in place to safeguard vulnerable children and to assure themselves, regulators and their commissioners that these are working. All health providers must be registered with the Care Quality Commission (CQC) and are expected to be compliant with the fundamental standards of quality and safety. The Chief Nursing Officer is the Trust's Executive Lead for Safeguarding Children and the Associate Chief Nursing Officer oversees the management of and the work undertaken by the Child Safeguarding team. The Trust has maintained a robust focus on Safeguarding Children through the governance arrangements depicted below.

The work of the safeguarding team is multi-faceted and relies heavily on partnership working, both internally and externally. The Trust strive to deliver a seamless integrated service to safeguard children from abuse and neglect. The Child Safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

The core functions of the team are to:

- Provide clinical leadership in respect of safeguarding to support high quality safeguarding practice.
- Offer support for practice development through:
  - Providing a robust training and development strategy utilising education forums, light bite sessions as well as formal training.
  - Supervision.
  - Coaching.
  - Share learning from safeguarding practice reviews.
  - Support and advise on case management, including attendance at complex meetings.

- Provide oversight and assurance regarding how the Trust is meeting its obligations in respect of Safeguarding Children.
- To provide oversight and development of policy and procedures.
- To provide challenge and scrutiny of safeguarding practice internally and externally.
- To support staff to provide high quality statements for court, the police and if attendance at court is required.
- To undertake internal management reviews and contribute to multi-agency practice learning / serious case reviews.
- Support the business of the multi-agency partnership.
- The Trust has an established safeguarding children quality framework, which includes a safeguarding children performance dashboard and an annual audit plan. The Trust's Overarching Safeguarding Committee monitors this framework. A report summarising activity and priorities is produced for the Trust Board annually. Learning from single and multi-agency audits, child safeguarding practice reviews and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

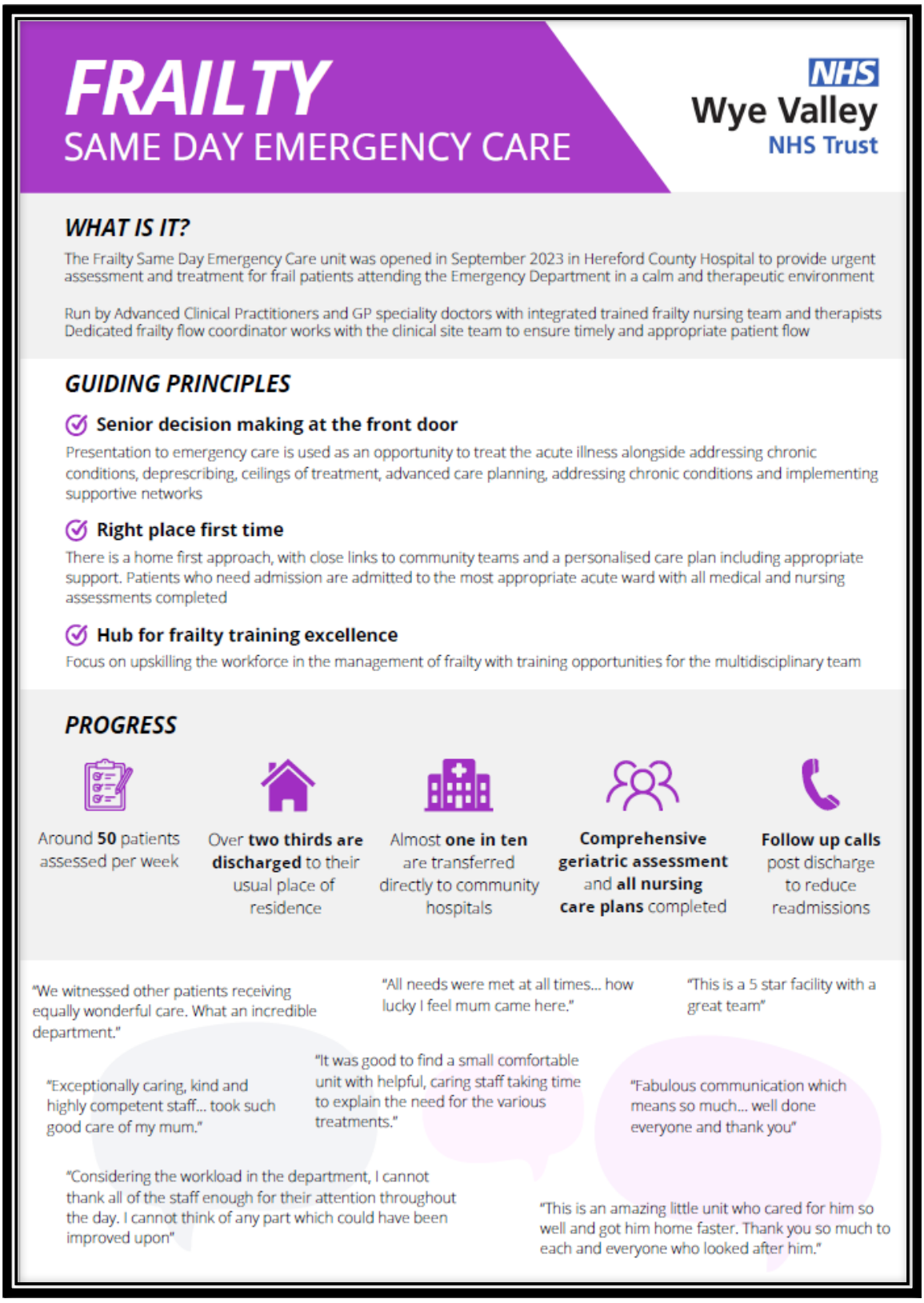
Ensuring staff receive the required safeguarding children training continues to be a priority and compliance rates for Levels 1, 2, 3, 4 and Board level, are shown in the table opposite

Training	At 29th Feb 2024	Target
% staff trained at level 1	88%	85%
% staff trained at level 2	88%	85%
% staff trained at level 3	86%	85%
% Staff trained to level 4	100%	85%
% Board Level	100%	85%

The Trust continues to support the business of the Herefordshire Safeguarding Children Partnership in a number of ways for example;

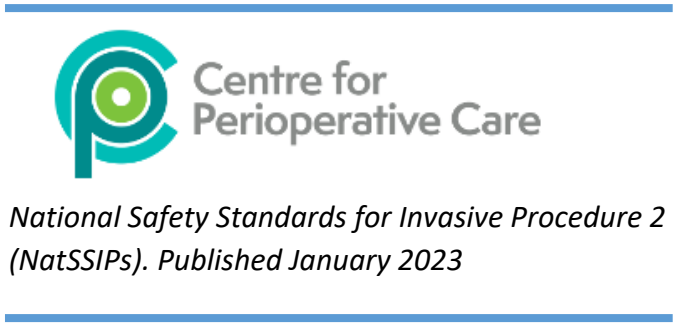
- By aligning safeguarding children priorities to those of the Partnership; contributing to the work of the various subgroups and task and finish groups and by providing trainers for various learning and educational events.
- The multi-agency work extends to contributing to the Local Authority Improvement Plan which is in response to the Ofsted inspections. To support this in response to looking to improve multi-agency working we have appointed a Specialist Safeguarding Children Practitioner within the MASH to strengthen collaborative working. The Trust already provides the health practitioner within the multi-agency safeguarding hub (MASH) which is often the first point of contact for professionals, family members or the public when they have concerns about a child's welfare or safety.
- Support the Children and Young Peoples partnership for Herefordshire☹CYPP)
  Keeping children and young people safe – BE SAFE FROM HARM
  (Supporting children and young people with our public health services discussing healthy relationships and professionals being trained to recognise safeguarding thresholds – the safeguarding team contributing to wider partnership training on this)
  The safeguarding team are key contributors to the Get Safe programme to prevent CE (child/criminal exploitation)
  Improving children and young people's health and wellbeing – BE HEALTHY
  (NHS services working on priorities of obesity, mental health support and access to dental health)
  Helping ALL children and young people succeed – BE AMAZING
  Ensuring that children and young people are influential in our communities – FEEL PART OF THE COMMUNITY
  As a safeguarding team we will support the mission of the CYPP to improve safeguarding in children's services.

CELEBRATING CHANGE
Frailty work/SDEC



National Safety Standards for Invasive Procedures and Local Safety Standards for Invasive Procedures (NatSSiPs and LocSSiPs)

The Centre for Perioperative Care (CPOC) published their guidance, National Safety Standards for Invasive Procedure 2 (NatSSIPs 2) in January 2023.



National Safety Standards for Invasive Procedure 2 (NatSSIPs). Published January 2023

This publication has seen NatSSIPs guidance evolve, containing less emphasis on tick boxes or rare 'Never Events', to now including cautions, priorities and a clear concept of proportionate checks based on risk with the focus being on implementation.

The Chief Medical Officer is the Trust's Executive lead for NatSSIPs/LocSSIPs, with the Deputy Chief Medical Officer overseeing the management of and implementation of the guidance across the Trust. The Trust witnessed a change in appointment to both roles in September 2023 and January 2024. The new Deputy Chief Medical Officer, over the next 12 months will focus on establishing what changes are required to be implemented to enable the Trust to meet the new guidance.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records for:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases
- certain 'dangerous occurrences' (near miss – incidents with a high potential to cause death or serious injury)

The Trust has a legal duty to report all RIDDOR reportable incidents in a timely manner. Work related accidents which lead to a member of staff unable to work, or are unable to perform their normal duties for a period of more than seven days need to be reported within 15 days of the incident. More serious incidents including deaths, fractures, need to be reported within 48hrs.

During 2023-24 there were a total of 10 RIDDOR reportable incidents, a decrease of four compared to 2023-24. Of these incidents, 6 were patient related and 4 were staff incidents. The detail below provides an outline of these incidents:

Patient incidents : Injuries included;	Staff incidents : Injuries included;
• Fracture pubic ramis. • Fatality due to cerebral contusions. • Fracture to ribs and T12. • Subarachnoid haemorrhage. • Hip fracture. • Fatality due to bilateral subdural haematomas.	• Fractured ankle. • Fractured tibia and fibia. • 7+day absence after anti-lig curtain rail fell on head. • L.O.C after bloods taken.

Patient Related Outcome Measures (PROMS)

What do we do? Participation in the national Patient Reported Outcomes (PROMs) programme is mandatory for Trusts in England where the relevant operative procedures are undertaken. The procedures included within the programme are:

- Hip replacements
- Knee replacements

Patients are asked to complete a questionnaire pre-operatively and then at 6 months post-surgery. The questionnaires include general quality of life measures and some condition specific measures. Comparison is then made of scores pre- and post-surgery to gauge the level of health gain following the operation. Results are usually publicly available through the NHS & Social Care Information Centre website.

How are we doing?

Participation rates are based on the completion of pre-operative questionnaires, which are measured nationally. Patient participation of questionnaires is voluntary.

England and Provider-level participation and coverage April 2021 to March 2022 (Published July 2023)

There were 396 eligible hospital episodes and 207 pre-operative questionnaires returned – a headline participation rate of 52.3% for Wye Valley NHS Trust (69.2% in England).

Of the 202 post-operative questionnaires sent out, 104 have been returned – a response rate of 51.5% (61.2% in England).

This publication covers a period where health services were still affected by the COVID-19 pandemic. The completion and return of questionnaires providing the data analysed in this publication will have occurred during a period where restrictions on movement and changes to behaviours may have affected patient response levels.

Outcomes

Results of outcomes, in terms of improvement, unchanged or worsening was published in July 2023.

The responses from the data outlined below are the patients' view of the changes to their wellbeing following their procedure.

April 2021 to March 2022 Finalised Data (published 13th July 2023)

Score	Procedure	Scores improved		Scores unchanged		Scores worsened	
		Wye Valley Trust	England	Wye Valley Trust	England	Wye Valley Trust	England
EQ-5D Index score (a combination of five key criteria concerning general health)	Hip replacements	95.3%	89.5%	4.3%	5%	0%	5.5%
	Knee replacements	81.8%	82%	9.1%	8.6%	9.1%	9.3%
EQ VAS (current state of the patients general health marked on a visual analogue scale)	Hip replacements	85%	69.8%	15%	8.5%	-	21.7%
	Knee replacements	53.1%	61.2%	15.6%	10.6%	31.3%	28.2%
Condition Specific Measures Oxford Hip/Knee Score	Hip replacements	100%	96.9%	-	0.5%	-	2.6%
	Knee replacements	86.5%	94.8%	-	0.8%	13.5%	4.4%

Improving Patient Engagement

The Trust receives feedback on its services through a number of different sources. This includes direct engagement and survey results as well as friends and family test (FFT), compliments, concerns and complaints data.

Within the Trust our engagement representatives, once again, supported the PLACE (patient led assessment of the care environment) audit. This saw service users joining staff to carry out the audit across both Acute and Community sites. To follow up on the results of PLACE, the Trust has planned a programme of regular, service user led audits utilising PLACE lite and the 15 steps audit tools.

The Trust patient engagement group undertook their first hybrid meeting this year, offering service users the opportunity to attend either face to face or virtually. This meeting was held in conjunction with Sodexo, part of our PFI partnership, to support the implementation of their new Experiencia system. This system will allow for near real time feedback in relation to food and cleanliness. Sodexo's new patient ambassador role will then work to resolve any issues as soon as they are raised.

Links have been established with the Chairs and Vice-Chairs of the patient engagement forums across the wider partnership group and regular meetings take place to share learning.
Service users also continue to support review of patient information resources as part of our virtual reader panel, to ensure patient information is understandable and accessible to end users.

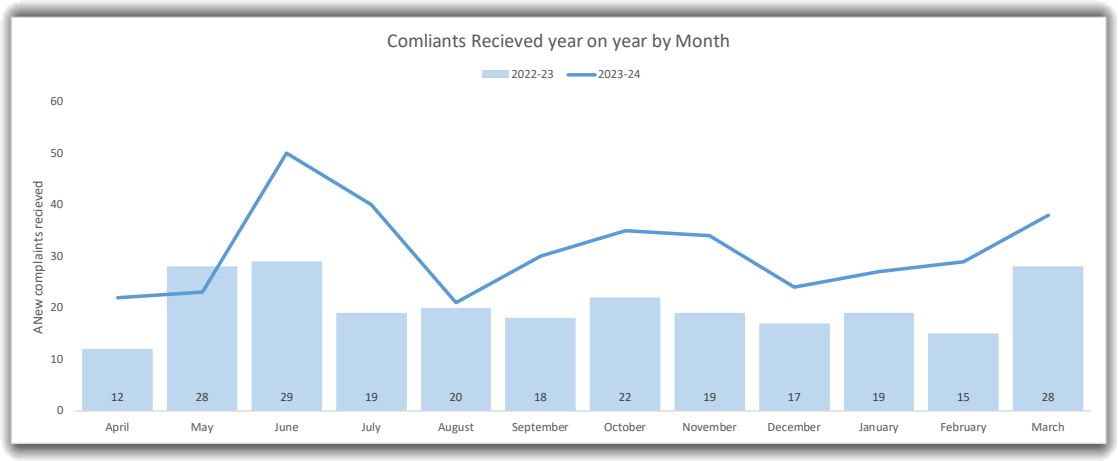
In addition, the Trust continues to work with both healthcare and voluntary sector partners, through the Maternity and Neonatal Voices Partnership (MNVP), Herefordshire Community Partnership and as part of the wider ICS Herefordshire Engagement Network to work collaboratively to identify areas for improvement, share learning and support the embedding patient engagement in all areas of service development.

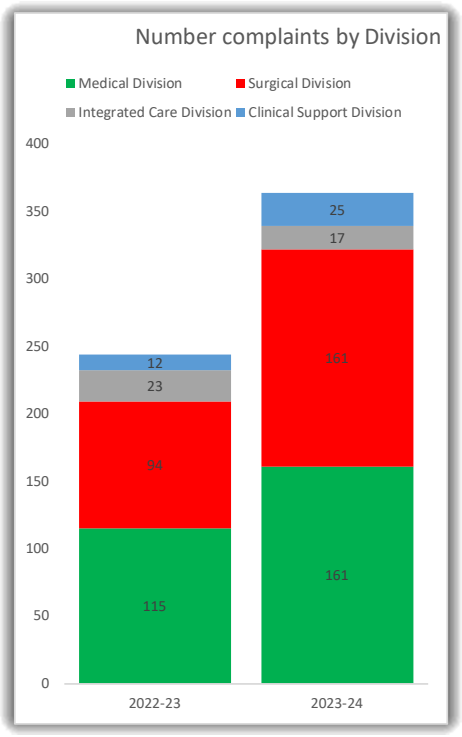
Complaints

The wider Quality, Safety and Experience team have restructured their management portfolios and the complaints team now sit within the patient safety work stream, rather than patient experience. This has multiple benefits including greater alignment with the patient safety strategy and has enabled effective oversight and triangulation of data, recognising that patient safety incidents are being raised by patients and families via the complaints route.

Following this restructure, and supported by the introduction of a new risk management system, the procedure for logging complaints has been reviewed. There is now a robust triage process to analyse complaints in more depth, identify themes and triangulate with multiple sources of patient safety information which improves our understanding of safety, and our patient safety culture as well as patient experience.

The overall number of complaints received during 2023-24 saw a 52% increase or 127 complaints.

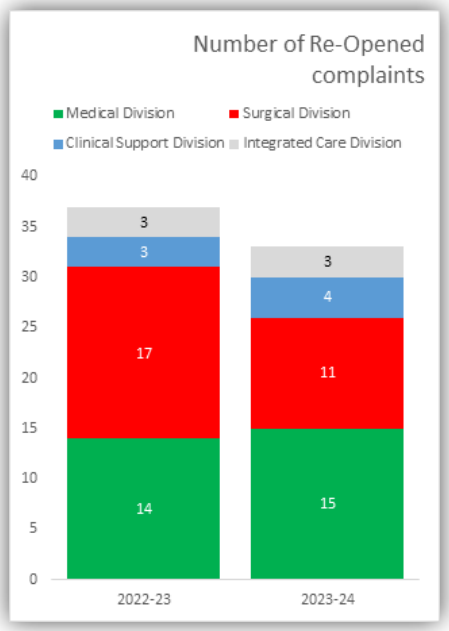




The surgical and medical division received the highest proportion of complaints, 43% each with numbers increasing in both Surgery up 42% (67) and Medical Divisions up 29% (46), compared to last year.

There has been a reduction of complaints that have been reopened, from 37 in 2022/23 to 31 in 2023/24.

There have been 4 preliminary enquiries made by the Parliamentary and Health Service Ombudsman (PHSO) in 2023/4, one decision made not to investigate further, awaiting outcome decisions for the remaining 3.



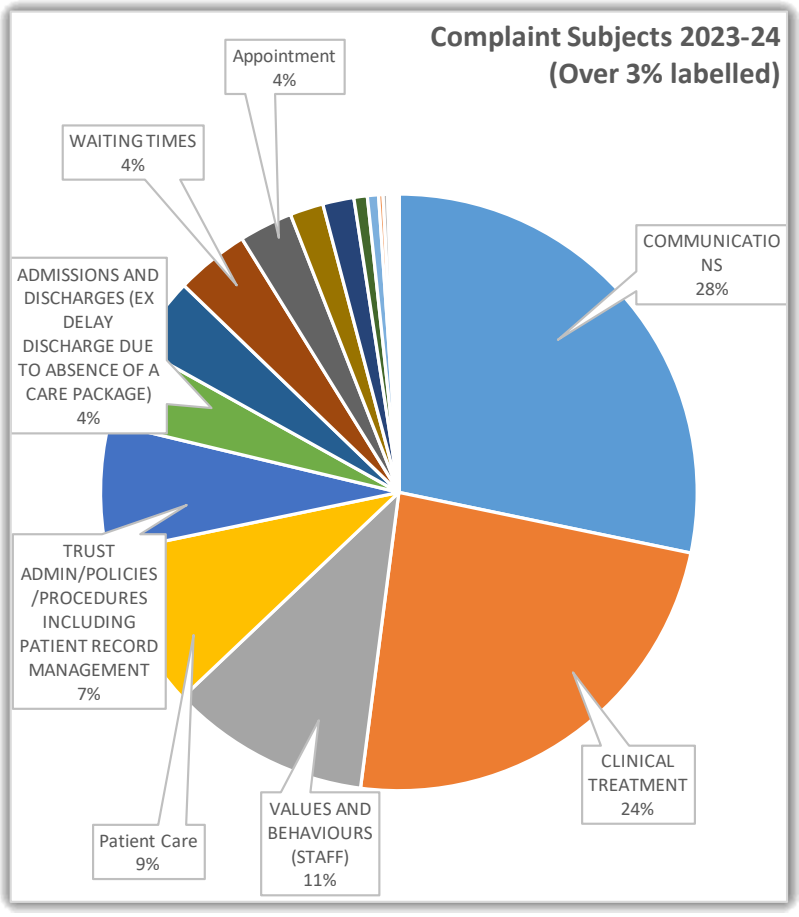
Complaint categories

63% of the complaints received related to perceived issues with the following categories by complainants:

- Communications
- Clinical treatment
- Values and behaviour

1. Communication:

There may be more than one communication issue identified within a single complaint e.g. communication with patient or carer, between departments or with the GP. Whilst we have seen an increase in the number of communication issues identified within a complaint, the number of complaints has decreased which reflects the more detailed complaint examination process. The main sub categories identified communication concern with patients, relatives and carers and patients not feeling listened to although this has improved 10% on last year's numbers.



2. Clinical Treatment:

A review of complaints shows the following sub categories accounted for 78% of complaints in this category.

- Delay or failure in treatment or procedure
- Delay or failure to diagnose (inc e.g. missed fracture)
- Lack of clinical assessment
- Post-treatment complications
- Inadequate pain management

3. Values and Behaviour:

There may be more than one issue identified relating to values and behaviour within a single complaint e.g. attitude of staff, rudeness or failure to act in a professional manner.

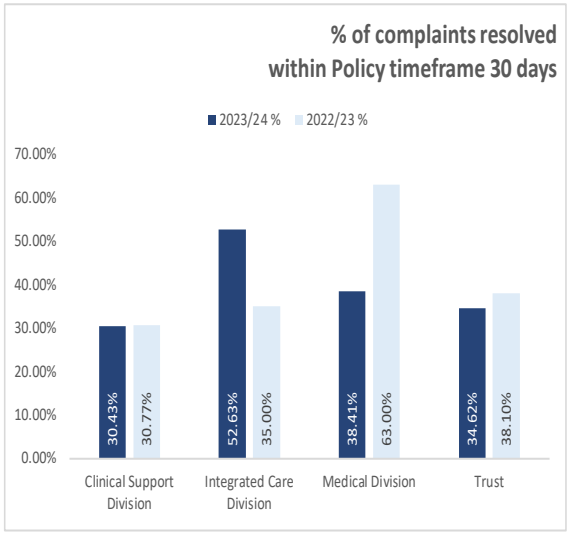
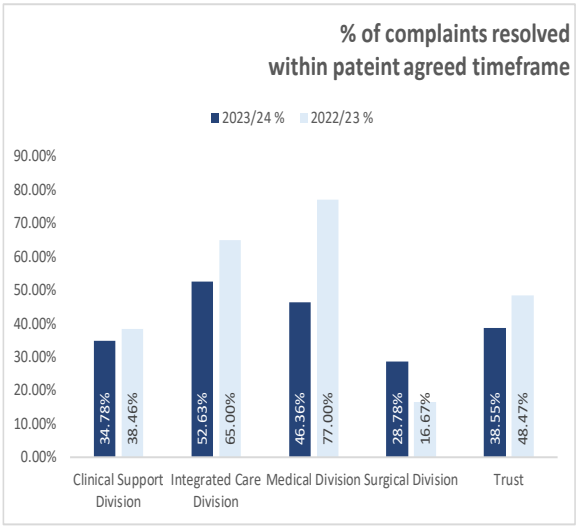
These are added to the complaint at the triage process and are based on the complainants perception of their experience.

Complaint response times:

There are two measures:

- Agree with the complainant
- The complaints policy timescale 30 working days

The chart compares closed complaints

Agree with the complainant	The complaints policy timescale 25 working days
	

Due to the increase in operational pressures experienced by the Trust at the beginning of 2023, complaint response times were increased from 30 days to 60* days for the months of January and February.

Over all, the number of complaint responses that are completed within the agreed 30 day timeframe is low at only 35%, this is down on last year's 38%. Within complainants timeframe shows slightly improved performance 38% but this is down on last year's 48%.

Inpatient and National Surveys

Three national survey reports were released by the CQC in 2023/24 for inpatients, maternity and urgent and emergency care. In addition, NHS England once again hosted the National Cancer Patient Experience Survey.

A brief overview of the survey results are outlined below. All results have been shared with the relevant teams for review and development of improvement plans and this year we have chosen to focus a spotlight on the National Cancer Patient Experience Survey results.

National Surveys 2023/24

- Four national surveys have been commissioned by Care Quality Commission (CQC), and carried out during 2023/24.
- The **annual inpatient survey, maternity survey and Adult and Emergency Care Survey** results will be received later in 2024.
- The **Children & Young Peoples survey** will be published in March 2025.
- NHS England are once again hosting the National Cancer Patient Experience Survey. The results of this are expected to be published later in 2024.

Inpatient Survey

A total of 1250 patients who had an overnight stay in an acute bed in the hospital during November 2022 were given the opportunity to participate in the survey. A total of 573 responses were received, representing a 47% response rate.

The Trust saw an improvement on the previous year's results, with work continuing in relation to specific areas for:

- Communication
- Food
- Seeking patient feedback whilst in hospital

Maternity Survey

Women and other pregnant people who gave birth between 1 and 28 February 2023 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey.

At WVT 207, participants were invited to complete the survey and 107 responded representing a 54% response rate.

Results placed us in the five top performing Trusts in the region for all the main categories, including start of your care during pregnancy, antenatal check-ups, during pregnancy, your labour and birth, staff caring for you, care in the ward after birth, feeding your baby, and care at home after birth.

Our score has significantly increased in eight areas compared to the previous year's results and the Trust is above the national average for the majority of areas in the survey.

The Trust has also scored in the top five Trusts nationally for:

- being able to speak to the midwife as much as the patient wanted
- being given appropriate information before induction or labour
- being taken seriously if raising an issue
- being able to access support and advice around the clock for feeding your baby
- receiving help and advice in the six weeks after the birth of your baby.

The maternity department are committed to working in partnership with the Maternity and Neonatal Voices Partnership (MNVP), co-producing an action plan to explore further service improvements.

Urgent and Emergency Care (UEC)

Patients were eligible for the survey if they were aged 16 years or older and had attended UEC services during September 2022.

1250 participants from WVT were invited to take part, with 363 responding representing a 30% response rate.

The results remained consistent to the previous year for the majority of questions, with positive scores for four questions resulting in the Trust sitting in the top 20% of scores in national benchmarking.
These four questions covered:

- waiting times from arrival to examination
- help with condition and symptoms whilst waiting
- Doctors and nurses talking to each other about you as if you weren't there
- Expected care and support available after leaving A&E

Areas identified for continuing improvement work includes some aspects of communication and dignity and respect.

Spotlight on cancer - National Cancer Patient Experience Survey (NCPES)

The National Cancer Patient Experience Survey 2022 was sent to adult (ages 16 and over) NHS patients with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May, June 2022. The 2022 survey involved 133 NHS Trusts. Out of 115,662 people, 61,268 people responded to the survey, yielding a response rate of 53%.

287 patients responded out of a total of 446 patients locally, resulting in a response rate of 64%. 263 reported their ethnicity as English / Welsh / Scottish / Northern Irish / British. 16 did not give their ethnicity.

The largest responses by tumour type was haematology, prostate, urological, breast and colorectal tumours.

Two questions fell above the expected range with four falling below the expected range.

Based on the findings of the NCPES Survey 2022 and follow up discussions with teams (where response rates had fallen below expected ranges) a comprehensive improvement plan was formulated, see diagram below. Further evaluation of age ranges was also carried out to better understand if there was any shortfall in service provision related to age at all and how that emerges.

NATIONAL CANCER PATIENT EXPERIENCE SURVEY ACTION PLAN		
Survey Question reference	**Survey Question asked**	**On-going action plan**
Q15	Patient was definitely told about their diagnosis in an appropriate place	• Ratify Breaking Bad News Guidance. • Continue to assess private space within WVT. • Increase informational support to inpatient areas.
Q52	Patient has had a review of cancer care by GP practice	• Continue to promote as part of One Herefordshire Cancer Committee.
Q17	Patient had a main point of contact within the care team	• Urology to review practice of 'named nurse'. • Haematology to review.
Q26	Care team reviewed the patient's care plan with them to ensure it was up to date.	• Haematology alerted and team to review.
Q41(3)	Beforehand patient completely had enough understandable information about radiotherapy.	• Radiotherapy – continue to audit, i.e. switch to online info, link to teams. • RT to build stronger links with MRU Information Centre. • Urology – holding a review with Radiotherapy; EBRT info and timeliness of information.
Q45	Patient was always offered practical advice on dealing with any immediate side effects from treatment.	• Haematology recognise discussion re: side effects needs to be repeated throughout care pathway by MDT. A more settled team and recruitment to ACP posts should assist. • Urology to review. • Info Centre to consider any barriers related to age re: how support offered.
Q58	Cancer research opportunities were discussed with patient	• Research – ongoing monitoring of situation re: capacity to take on research.

Substantial progress has been made with the actions identified above; some of the achievements are outlined below:

- Breaking Bad News Guidance has now been approved at committee and is awaiting final sign off at the Trust's Policy Review Group.
- An appropriate space has been identified in the Urology Centre for newly diagnosed cancer patients.
- Greater links have been developed between the Macmillan Information and Support Centre (MCISS) with primary care, wards, and other departments including radiotherapy to assess demand and improve provision of information.
- Radiotherapy continue to audit information provision and stronger links are being built between the MCISS at WVT and information team at Gloucester hospitals NHS Trust.
- MCISS continues to monitor any issues related to age and audit who attends the Info Centre for support.
- MCISS has also developed links to Shine Cancer Support aimed at 20-40 year olds.

- Haematology patients are now offered the contact details of the nursing team at several points during their journey and new Macmillan cards have been produced with the details of the Nursing team.
- Three ACP roles have been introduced to the haematology teams, which should help to support the review of care plans and to re-inform messaging regarding side effects.
- Cancer AHP team are introducing Cancer-related Fatigue Management Workshops and considering possibilities for on-line options.
- The Trust continues to monitor opportunities to take on more cancer-based research and several trials are being implemented or reviewed for feasibility.

Friends and Family Test (FFT) – National Data Collection

In July 2022, the Trust introduced a new system for receiving feedback from patients for the Friends and Family test. The Trust now sends a text message to patients to receive their feedback. Whilst Trusts are no longer monitored on response rate we know that the more feedback we receive the more opportunity we have to improve patient experience.

The benefits of the new system include live data dashboards, with staff having real time access to feedback specific to the service they provide which allows for meaningful, focused improvement initiatives. The Patient Experience Committee are overseeing how the feedback is used to improve service provision for patients.

The past 12 months has seen the service rolled out further across the Trust with the introduction for our Emergency Department, Maternity services and shortly for our community services.

From 1st April 2023 – 31st March 2024, the Trust received 44,699 responses from our patients and service users, representing an overall response rate of 19%. Over 90% of ratings being positive. Prior to using the text messaging service, the Trust response rate was between 1% and 6%.

Question 1	Ratings Received	Response Rate
SMS	44699	19.31%
Totals	**44699**	**19.31%**

Question 2	Comments Received	Response Rate
SMS	37507	16.20%
Totals	**37507**	**16.20%**

2024-25, will see the final stage of roll out completed with our Childrens services being able to access the system. In addition, the Trust is hoping to introduce an alternative way of leaving feedback with the creation of a portal accessed through our patient facing web page and the use of QR codes, further expanding the ability for anybody to leave feedback at any time, meeting our accessibility standards and the Friends and Family Test national guidance.

CELEBRATING CHANGE

Friends and Family Test – 'You said, We Did'

<u>OUTPATIENTS</u>

YOU SAID

'Long waits for x-ray in fracture clinic'

WE DID

Changed the pathway so that x-rays were requested for those patients needing them at the beginning of the clinic to reduce waiting times

<u>GARWAY WARD</u>

YOU SAID

'communication with family could be improved if unable to visit'.

WE DID

Daily call to relatives by Drs to families requesting

<u>ITU</u>

YOU SAID

"waiting room lacked comfortable seating for long stays"

WE DID

The department introduced additional reclining chairs and a sofa. In addition, the relatives' room was redecorated and made to feel as welcoming as possible.

<u>DINMORE WARD</u>

YOU SAID

'Increase visiting hours'

WE DID

Changed visiting to 10am – 7pm

Freedom to Speak Up (FTSU)

The requirement for Trusts to have a FTSU Guardian, as a mandated post in NHS Trusts continues as an outcome of the public enquiry in 2016 chaired by Sir Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust.

There are now over 1000 FTSU Guardians in over 500 NHS primary and secondary care, independent sector organisations and national bodies. FTSU guardians have now handled over 100,000 cases since the National Guardian's Office first started collecting data in 2017. In 2023-24, WVT had over 115 cases with each providing an opportunity to learn and improve to benefit the wellbeing of our colleagues and the care we provide to our service users. Research and data shows that an open culture in a Trust provides the safety needed for staff to speak up in the confidence that their voice will be heard.

FTSU and Civility Saves Lives

The Guardian alongside the team of FTSU Champions at the Trust continue to work together striving to meet the National Guardian's call to '*do as much as possible to push for positive change'.*

The Guarding leads on this by promoting FTSU, Civility Saves Lives (CSL) and the need for teams to create a space of physiological safety. This has all been promoted across the Trust in a number of ways both virtually and face to face:

- Mandated eLearning for Speaking Up for all WVT staff. This is one of the KPIs for measuring staff awareness of how to raise concerns and what they can expect.
- Listen Up Training is now part of all managers appraisal after feedback that managers do not listen.
- Expanded the FTSU Guardian role from part-time to full time.
- Delivering CSL sessions to 509 staff both Trust wide and bespoke to teams.
- Recruiting 60 more Champions taking us from 22 to 82 in the Trust. The aim is to have at least one Champion in each area.
- Creating a new way of speaking up via a QR code and confidential Survey

National Speaking Up Month

In the National Speaking up Month, October 2023, the FTSU team contributed to Staff Wellbeing week and attended the Foundation Group FTSU conference hosted by SWFT as well as promoting FTSU via the Trust's Safety Bites Bulletin within Trust Talk (the global weekly newsletter for staff). There was a stand in the staff canteen each week to both promote speaking up and recruit Champions. Several Executives attended to show their support for speaking up.

FTSU Quality Indicators

- Delivering awareness of FTSU and CSL at every Corporate Induction as well as other bespoke training. This includes timetabled sessions with foundation doctors, doctors in training, preceptorship and OSCE nurses.

FTSU quality indicators include the response to the question, "I feel safe to speak up about that concerns me in my Trust". This is calculated from the responses to the staff survey

Year of the Staff Survey	WVT Score	National/ Sector Score	Position Nationally
2022 Model Hospital/Staff Survey report	63%	62.5%	Quartile 3 - Mid-High
2023 Model Hospital/Staff Survey	Awaiting Publication	Awaiting Publication	Awaiting Publication

Totals for year 2023-24

(Note numbers will not match number of cases as some have more than one data point associated with the case and some have none)

Anonymous Reports	14		Suffered a Detriment	1
Bullying and Harassment	4		Worker Safety/Wellbeing	34
Patient Safety / experience	14		Inappropriate Attitudes and Behaviours	37

Six data points are included in the quarterly returns to the NGO by the FTSU Guardians that include Worker Safety (new in 2021-22) and Inappropriate Attitudes and Behaviours added for 2022 -23.

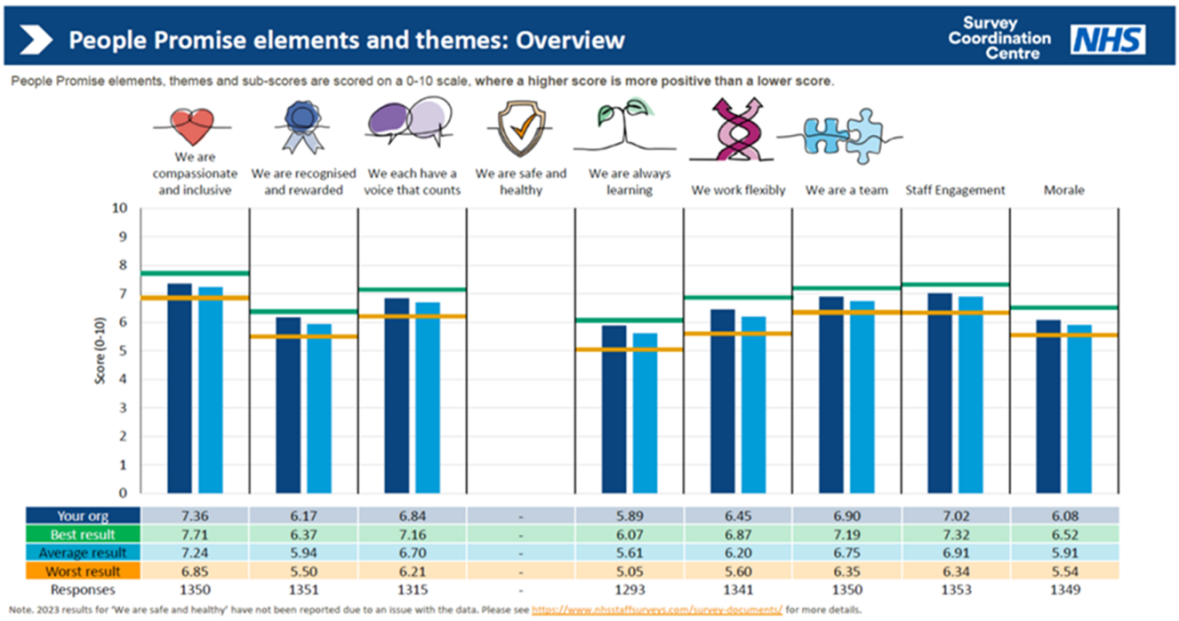
NHS Staff Survey 2023

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. Each year, the survey is conducted between October and November, with the results being published by March.

34% of our staff (1,356) participated in the 2023 survey.

Our results show good progress with above average results across all areas.

The following chart details the Trust's performance against the seven People Promise elements, benchmarking WVT results against the best and the worst performers within the benchmark group of Combined Acute and Community Trusts.



The 2023 data for WVT shows a **statistically significant higher change in five areas** highlighted below i.e. we are *recognised and rewarded, we are always learning, we work flexibly, staff engagement and morale*. This is reflective of the concerted efforts and investments we have made to improve these areas.

There is a reported increase in staff willing to recommend the NHS as a place to work. Similarly, the percentage of staff that would recommend their organisation as a place to receive treatment and care has also increased.

A summary of the 2023 results for WVT shows good progress with **above average scores in all areas of the survey** (*compassionate & inclusive, recognised & rewarded, voice that counts, safe & healthy, always learning, work flexibly, we are a team, staff engagement, morale*). This is attributable to a number of leadership, workforce & OD initiatives that have been implemented at the Trust over the past few years.

We will continue with the staff engagement work and initiatives across the Trust, divisions and directorates, that have proven to be successful over the last year, into 2024 and will be regularly monitoring and reporting on progress over the year.

Health & Wellbeing

Health and Wellbeing of our staff remains a high priority, and we have invested in trialling two roles to further support staff with their mental and physical health and wellbeing, i.e. a Staff Mental Health Wellbeing Nurse and a Staff Physiotherapy service. We continue to offer a range of support and initiatives accessible to all staff which include an Employee Assistance programme, access to NHS apps and support lines, face to face counselling and clinical psychology. We have built on Schwartz Rounds to support emotional and psychological wellbeing of staff and Halo Leisure instructors have further expanded their wellbeing programme offerings including walking groups and discounts to staff.

The Trust Board has now approved a Health & Wellbeing Strategy for the next 5 years which includes the key components shown in the diagram below:

Optimising Your Wellbeing is our Commitment / Helping You to Help Yourself

Appraisals and Mandatory Training

The table below shows the Trust's performance against statutory and mandatory training and appraisal as at end of March 2024. All areas are working to ensuring that appraisals are up to date by 30th June 2024.

	Target	Actual March 2024
Statutory and Mandatory Training	85%	88.4%
Appraisals	85%	70.8%

Recruitment and Retention

Recruitment and Retention continues to be one of the key areas of focus linked to the Trust's organisational strategic objectives and we have made good progress throughout the year. During 2023/24, we have seen improvements particularly in our workforce retention levels which are now at 10%. There have been a number of recruitment initiatives with a focus on reducing our vacancy gap, particularly in our healthcare

support worker, pharmacy and allied health professions and we have recruited to target our international nurses and midwives.

We support our International nurses with a 12 month preceptorship programme where we have been awarded the 'Gold' Standard Quality Mark. We have expanded our Band 6 ward leadership as well and we now have 59 international nurses who have been successful in gaining senior roles within the trust. We have been successful in our International nurse recruitment programme, where we have recruited over 300+ nurses and have a strong 95% retention rate with many nurses going on to leadership specialist roles.

We continue to be focussed on working with our partners across Herefordshire and Worcestershire ICS in recruitment events and promoting careers.

We are proud to have been awarded the Pastoral Care Quality Award this year, which demonstrates the organisation's good reputation for the strong pastoral care and onboarding process of our international staff.

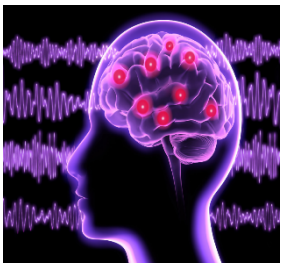
In addition, we have grown our collaborative working approach with the DWP with success stories of appointing staff to entry-level positions through our joint employment programme. The Trust has continued to show strong presence at a number of local, regional and national recruitment events.

CELEBRATING CHANGE

HOW WE WORK TOGETHER AT WYE VALLEY NHS TRUST

NG217: EPILEPSY IN CHILDREN, YOUNG PEOPLE AND ADULTS

Epilepsy is one of the most common long-term neurological conditions in the UK, affecting 0.8% of the population; defined as the tendency to have recurrent seizures. NICE guidance NG217: Epilepsy in children, young people and adults, was developed with wide multidisciplinary input, to provide national guidelines and standards on the care for patients with epilepsy.



An example of NICE guidance and clinical audit coming together to improve patient safety and care quality across the trust with the release of NICE guidance, NG217: Epilepsy in children, young people and adults; and, NCEPOD released national audit "Disordered Activity? - A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure".

Aim: Determine the Emergency Department's systems and responses for when a patient with epilepsy presents in the department with a seizure. Ensuring a core set of investigative evaluations are carried out, while developing a pathway protocol for both inpatients and those discharged to have a head CT (and EEG if not performed initially) for those adult patients with known epilepsy who meet criteria.

Aim 1: NCEPOD - Recommendation 5
NG217 – Recommendation 1.2: Specialist assessment and diagnosis

"*Develop a core set of investigations for all patients who present to the emergency department with a seizure*."

Aim 2: NCEPOD - Recommendation 6
NG217 – Recommendation 1.3: Neuroimaging

"*Develop a protocol that sets out the requirements for undertaking a EEG and CT scan of head in patients with known epilepsy*."

How was this achieved? Aim 1 – The protocol in place for patients presenting in ED with seizures was reviewed and updated to include carrying out a full detailed medical history, blood examination, 12-lead ECG to help identify cardiac-related conditions that could mimic an epileptic seizure; head scans - such as EEG, CT and MRIs.

Aim 2 – A review of the pathway and referral process from ED to radiology was undertaken, to develop a protocol that sets out the requirements for undertaking a head CT and EEG scan in patients with known epilepsy.

Both Aim 1 and 2 included the review and update of the epilepsy chart to ensure all tests performed met the advised criteria

Further and ongoing works: In Dec 2023, the Quality Standard QS211: Epilepsy was released – which will be reviewed over the next 12 months by the teams for comment; indicating whether any further clinical or quality improvement projects are needed to provide better service or to support potential business planning or expansion of service.

Who is involved?

- Emergency Department
- Neurology
- Clinical Epilepsy Team
- Radiology

Quality Priorities:

Review of the Previous Twelve Months

Quality Priorities for 2023-24

The Trust identified eight quality priorities for 2023-24, which are detailed below. This section explains the progress made for each priority over the previous 12 months.

Safe	Effective	Experience
1. Reduce the incidence of avoidable hospital and caseload acquired pressure damage. 2. Improve VTE risk assessment. 3. To reduce Clostridioide infection rates and deliver our cleanliness strategy. 4. Improve management of the deteriorating patient.	5. Ensure the Trust meets best practice requirements for nutrition. 6. Ensuring patients receive timely critical medications. 7. Embed the MCA and DOLS policies and process in practice.	8. Using local and national intelligence to improve patient experience.

Quality Priorities - Safe

1. Reduce the incidence of avoidable hospital and caseload acquired pressure damage.

Pressure ulcers are the highest category of incidents and serious incidents the Trust reports. This remains a priority for improvement and an area of concern in relation to patient safety. The Trust committed to drive improvement in reducing harm caused from acquiring pressure damage with this Trust Quality Priority.

Over the past 12 months' a huge amount of change has occurred to move this quality priority forward.

Patient Safety Incident Response Framework (PSIRF)

The introduction of PSIRF in late 2023, witnessed the Trust amend its response to investigation of pressure ulcer cases as serious incidents and narrowed down the criteria for incidents that require a learning response.

The principles of PSIRF have enabled a significant reduction in resource burden for the Trust, whilst ensuring that the Trust must provide assurance through clearly documented improvement action plans that address our known issues that prompted the development of the patient safety priority.

Trust-wide Improvement

Key areas of improvement were identified last year to tackle the themes emerging from investigations. The past 12 months have witnessed the following key areas of improvement:

- **Change in resource in the Tissue Viability Team**
  The Trust recruited a Band 4 Tissue Viability Nurse Assistant (TVNA). Their role focussed on pressure ulcer prevention through targeted improvement work with frontline staff. This has included understanding the specific issues (themes) in an area and developing focused education and practical support.

- **Education**
  The increased capacity within the team has allowed for the development of a variety of education opportunities for staff including;
  - Tissue Viability Link nurse day; highlighting the importance of wound assessment, education on the Wound Care Formulary; measuring wounds; various dressings techniques, therapy treatment in wound management, exudate management, lower limb bandage technique for inpatient settings.
  - The Tissue Viability team held a 'Coroners Court' study day. This covered the significance of documentation and the importance undertaking risk assessments. It was very well attended – 100 members of staff
  - Tissue Viability Link nurse day, 25th April 2024 is continuing with the theme wound assessment and management; highlighting the importance of nutrition to aid wound healing; interactive sessions on the categorisation of pressure ulcers; Active 2 mattress education.
  - There will be daily tissue viability training sessions for two weeks following National Nurses Day to continue to celebrate this national event and maintain a focus for staff on good nursing care.

- Participation in Clinical Practice Weeks.

In addition, issues were identified out of incident response findings or targeted improvements as planned, with evidence of quality improvement being made:

- **Failure to identify long periods of immobility (long lie) when it is not a patient who has had a fall**
  This issue predominantly emerged from long waits in ED. The past 12 months have seen management of pressure damage and prevention improve in ED where patients continue to experience delays.

- **No evidence of consideration of equipment to prevent skin damage/delay in providing appropriate pressure relieving equipment**
  The Trust now understands this issue, establishing this links to a lack of consistency in understanding equipment requirements in the acute setting. The tissue viability team have organised mattress education for acute staff, across all wards demonstrating how to use equipment. The team have received very good feedback regarding this education.
  To support the tissue viability team who are planning to audit every inpatient area and focus communication and education around equipment.

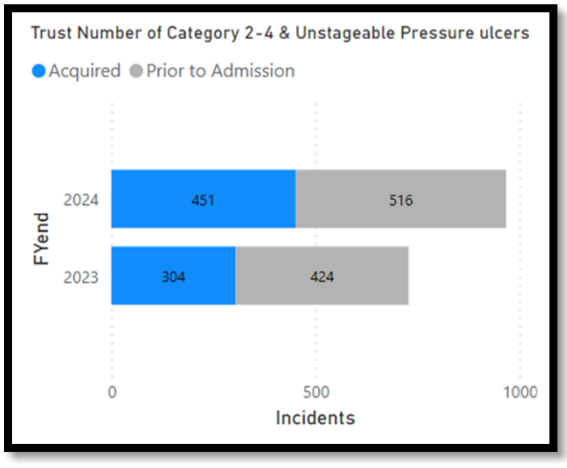
- **Failure in photographing the wound and no clear documentation of the wound**
  The Trust is now seeing improvements in wound documentation in noting and within incident reviews. The TV team have developed a presentation on 'how to take a photograph' on the TV page on WVT intranet for all staff to access.

- **Staff not recognising the various types of skin damage and sending inappropriate referrals to the Tissue Viability service**
  The team have witnessed referrals being received that should be directed to other specialist services. The tissue viability team have been engaging with those services to develop referral pathways to streamline the process and promote more timely and effective review of damage by the appropriate specialist service.

Despite the introduction of the above mentioned improvements, they have not yet generated demonstrable improvement with incidences of harm increasing, however The Trust is in a better position to analyse the level of harm and have a targeted, localised approach to improvement.

Our data for 23/24 in the chart opposite shows in category 2-4 and unstageable pressure ulcer incidents there was a:

- 48% increase in avoidable pressure care incidents (147 incidents)
- 33% increase in the total number of incidents reported
- 5% increase in the proportion of acquired pressure ulcers from 42% in 2022-23 to 47% in 2023-24.



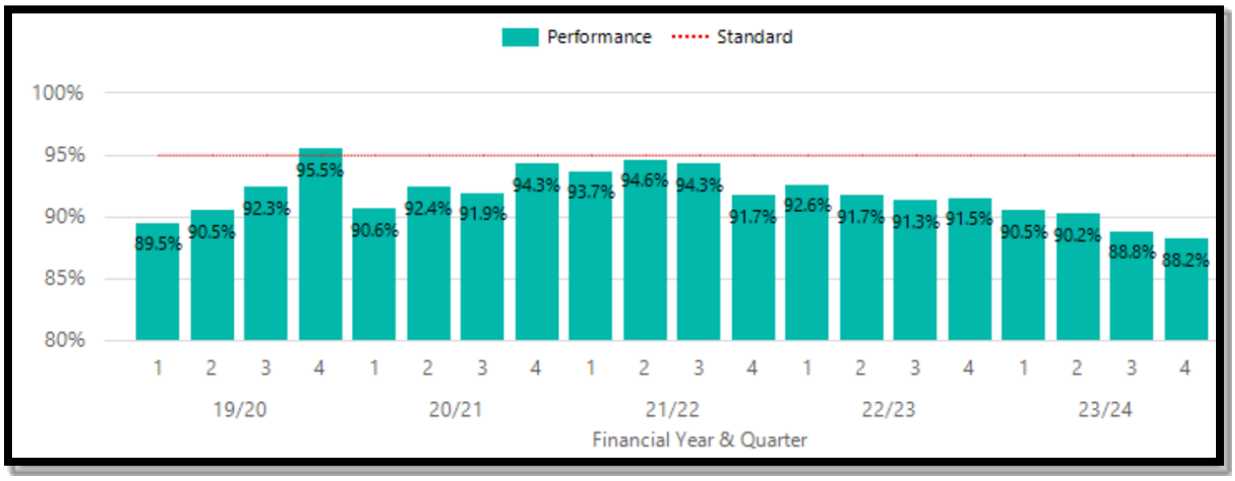
NB data includes 13 incidents in 2022-23 assumed category 2-4 as recorded as Device related pressure ulcer developed or worse in our care but no category given.

The next 12 months will see the Trust continue to focus on reducing pressure area damage and the improvement work already introduced. By refining the quality priority to focus on 'Reduction in cases of grade 2 pressure ulcers' in 2024-25 to support the patient safety priority 'Deterioration of moisture associated skin damage (MASD) to Category 3, 4 and Unstageable pressure ulcers.

2. Improve VTE risk assessment

Venous thromboembolism (VTE) consists of Deep Vein Thrombosis (DVT) and Pulmonary Emoblism (PE). Both DVT and PE are significant contributors to preventable in-hospital mortality. For prevention of VTE among patients being admitted to hospital, VTE risk assessments are required to be undertaken on admission followed by administration of thromboprophylaxis if required.

The national target for completion of VTE risk assessments on admission is 95%, the table below shows the Trust compliance for screening, which remains below national standard.



VTE Risk Assessment compliance – Trust Overall Quarterly

Next Steps : Improvement Plan

2023-24 enabled our newly appointed Chief Medical Officer and Deputy Medical Officer to understand the requirements needed to move this quality priority forward, the following improvements and actions have been identified:

- The Trust continues its aim to be an exemplar site and has approached the VTE Specialist Network to help achieve that via a recognised buddy system.
- The MAXIMS system undergoes an upgrade expected early Summer 2024 which will directly link the Risk assessment tool to our Electronic Prescribing & Medicines Administration (EPMA) system.
- Review of VTE status to be part of board ward round/post ward round huddle. Patient level status is available on whiteboard.
- Sharing the compliance data on a regular basis with the Divisions/Directorates. Clinical leaders to take ownership and accountability. In development is a live dashboard of compliance which centralises the real-time inpatient dashboards and includes more visual and targeted KPI content for many points including VTE.

- Conducting educational sessions to increase awareness and address concerns.
- Creating and communicating educational material on VTE risk assessment completion to frontline staff.
- Incorporating VTE risk assessment in induction of all new clinical staff.
- Explore process to screening all medical admissions daily and providing timely feedback to the physicians to complete the assessment.
- All (PE) deaths will be subject to Structured Judgement Review.
- Thrombosis committee to be reinvigorated, to lead on the improvement plan and continue to review all Hospital Acquired Venous Thromboembolism (HAVTE) to ensure lessons learned and disseminated.

To enable the above improvements to be implemented allowing the Trust to improve its VTE risk assessment compliance this quality priority will continue in 2024-25.

3. To reduce Clostridioide infection rates and deliver our cleanliness strategy.

1. Reducing Clostridioide infection rates

NHS Improvement (NHSI) released the official Clostridioide difficile infection (CDI) objective for 2023-24 for Wye Valley NHS Trust in April 2023. The total threshold for both Hospital and Community onset healthcare associated CDIs linked to Wye Valley NHS Trust has been set at 43 cases. This is a reduction of one case from last year's threshold.

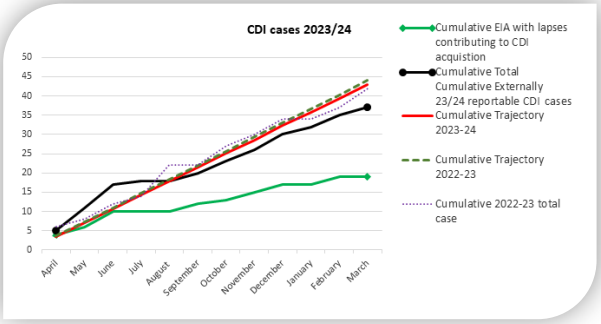
Progress made with CDI rates of infection

At the end of 2021-22, the Trust was an extreme outlier for CDI rates compared to other Trusts in the region and nationally.

NHSE report the Trusts CDI counts and 12 months rolling rates of hospital onset – healthcare associated cases as 38.13 per 100,000 bed days October - December 2023.

Apr to Jun 2020	Jul to Sep 2020	Oct to Dec 2020	Jan to Mar 2021	Apr to Jun 2021	Jul to Sep 2021	Oct to Dec 2021	Jan to Mar 2022	Apr to Jun 2022	July to Sept 2022	Oct to Dec 2022	Jan to March 2023	April to June 23	July-Sept 23	Oct-to Dec 2023
26.51	56.82	13.11	40.21	48.61	26.22	43.71	71.49	35.35	26.22	39.34	33.41	82.60	10.89	38.13

NB. Some of the high rate recorded over the last few years, may be explained by the fact that the denominator for the rate is taken from the KH03 occupied overnight bed data and does not include the community hospital beds.



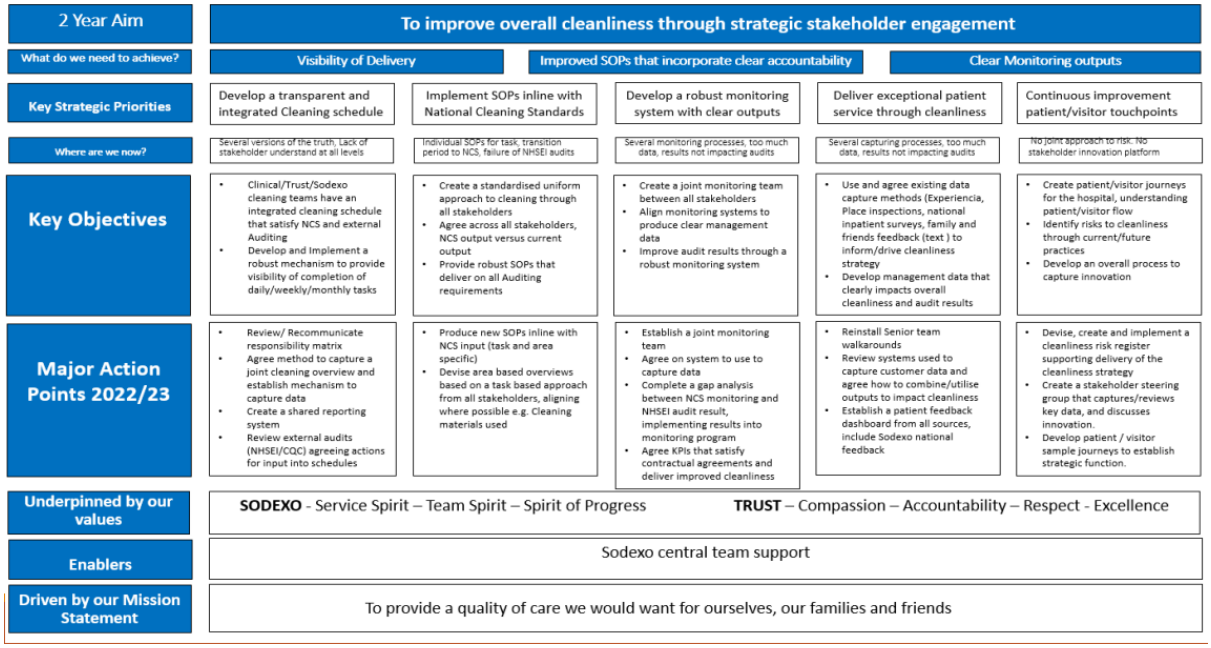
The Trusts year to date, overall Trust performance was 37 cases. This is under the Trust threshold for 2023/4.

To achieve this improved position, the Trust implemented the following actions:

- All CDI cases are reported via our incident reporting system.
- The Infections Prevention team (IP team) continue to undertake a post infection check of the clinical environment within 2 working days of CDI acquisition/reporting in order to identify and address any immediate concerns.
- The Informatics team continue to develop a formula and data set that will enable the trust to monitor the CDI rates of infection based on the entire bed base within the organisation.
- The Lead Infection Prevention Nurse participates in the NHSE Regional Task and Finish Groups focusing on CDI improvements.
- The Infection Prevention service has developed an Infection Prevention Improvement Plan which supports best practices for CDI management and prevention.

2. Delivering our Joint Cleanliness Strategy

The Joint Cleanliness Strategy was developed 2022-23.



2 Year Aim	To improve overall cleanliness through strategic stakeholder engagement				
What do we need to achieve?	Visibility of Delivery		Improved SOPs that incorporate clear accountability		Clear Monitoring outputs
Key Strategic Priorities	Develop a transparent and integrated Cleaning schedule	Implement SOPs inline with National Cleaning Standards	Develop a robust monitoring system with clear outputs	Deliver exceptional patient service through cleanliness	Continuous improvement patient/visitor touchpoints
Where are we now?	Several versions of the truth, Lack of stakeholder understand at all levels	Individual SOPs for task, transition period to NCS, failure of NHSEI audits	Several monitoring processes, too much data, results not impacting audits	Several capturing processes, too much data, results not impacting audits	No joint approach to risk. No stakeholder innovation platform
Key Objectives	• Clinical/Trust/Sodexo cleaning teams have an integrated cleaning schedule that satisfy NCS and external Auditing • Develop and Implement a robust mechanism to provide visibility of completion of daily/weekly/monthly tasks	• Create a standardised uniform approach to cleaning through all stakeholders • Agree across all stakeholders, NCS output versus current output • Provide robust SOPs that deliver on all Auditing requirements	• Create a joint monitoring team between all stakeholders • Align monitoring systems to produce clear management data • Improve audit results through a robust monitoring system	• Use and agree existing data capture methods (Experiencia, Place inspections, national inpatient surveys, family and friends feedback (text) to inform/drive cleanliness strategy • Develop management data that clearly impacts overall cleanliness and audit results	• Create patient/visitor journeys for the hospital, understanding patient/visitor flow • Identify risks to cleanliness through current/future practices • Develop an overall process to capture innovation
Major Action Points 2022/23	• Review/ Recommunicate responsibility matrix • Agree method to capture a joint cleaning overview and establish mechanism to capture data • Create a shared reporting system • Review external audits (NHSEI/CQC) agreeing actions for input into schedules	• Produce new SOPs inline with NCS input (task and area specific) • Devise area based overviews based on a task based approach from all stakeholders, aligning where possible e.g. Cleaning materials used	• Establish a joint monitoring team • Agree on system to use to capture data • Complete a gap analysis between NCS monitoring and NHSEI audit result, implementing results into monitoring program • Agree KPIs that satisfy contractual agreements and deliver improved cleanliness	• Reinstall Senior team walkarounds • Review systems used to capture customer data and agree how to combine/utilise outputs to impact cleanliness • Establish a patient feedback dashboard from all sources, include Sodexo national feedback	• Devise, create and implement a cleanliness risk register supporting delivery of the cleanliness strategy • Create a stakeholder steering group that captures/reviews key data, and discusses innovation. • Develop patient / visitor sample journeys to establish strategic function.
Underpinned by our values	**SODEXO** - Service Spirit – Team Spirit – Spirit of Progress			**TRUST** – Compassion – Accountability – Respect - Excellence	
Enablers	Sodexo central team support				
Driven by our Mission Statement	To provide a quality of care we would want for ourselves, our families and friends				

Progress against the strategy has been largely positive. NHSE have continued to provide ongoing support in the form of regular supervision to the lead IPC nurse, development sessions for the team and peer review visits. The Trust is still under enhanced support from the regional team and will continue to focus on cleanliness during 24/25. Monitoring of progress will be through the overarching improvement plan and enhanced local audit and surveillance with further embedding of joint monitoring with Sodexo colleagues.

4. Improve management of the deteriorating patient.

NICE guidance on acutely ill adults in hospital: recognising and responding to deterioration (2012) recommends that adult patients in acute hospitals should have physiological observations recorded at first assessment or admission and at regular intervals.
NEWS, (National Early Warning Score), which is the 'Track and Trigger system' endorsed by NHS England is a scoring system that measures 6 physiological parameters;

- Respiration rate
- Oxygen saturation
- Systolic blood pressure
- Pulse rate
- Level of consciousness or
- New-onset confusion and temperature.

NEW Score	Frequency of monitoring
0	Minimum 12 hourly
Total: 1- 4	Minimum 4 - 6 hourly
3 in single parameter	Minimum 1 hourly
Total: 5 or more Urgent response threshold	Increased frequency to minimum of 1 hourly
Total: 7 or more Emergency response threshold	Continuous monitoring of vital signs every 15 minutes

A score of 0, 1, 2 or 3 is given to each parameter. A higher score means the parameter is further from the normal range. Appropriate clinical responses are given for threshold – see diagram opposite.

In children, the PEWS (Paediatric Early Warning Score) chart is used whilst in Maternity; the MEWS chart is used to document the observations.

Progress to date

The Trust has focused the past twelve months on quality improvements that target the 3 key areas that affect outcome of deteriorating patients. These are:

1. Detection of deterioration
2. Escalation of deterioration
3. Quality of response to deterioration

The following has been achieved over the past 12 months:

1. Dashboard development

Focus has been on developing an information dashboard, which is now live in the Emergency Department. The intention is it is available to the wards in order to monitor their NEWS scores along with other key indicators to help highlight deterioration and potential deterioration so action can be taken, as well as provide statistics for performance across the Trust. The Trust is currently awaiting feedback following initial usage.

The dashboard will allow drill down to RLQ level, and further development is currently being undertaken in order to incorporate the new PEWS as well as MEOWS scores from the BadgerNet system.

2. Monitored beds

The Trust is currently assessing the available options regarding adding monitored beds, reviewing the pros and cons. Discussions have taken place with other Trusts to understand what approaches have been used elsewhere and how those approaches function in the day-to-day running of the Trust.

Next steps will be an options appraisal to aid decision making.

3. CQUIN

Alongside this quality priority for 23/24, the Trust selected the CQUIN 'Recording of and response to NEWS2 score for unplanned critical care admissions. The national compliance measure was 10%-30%.

The Trusts CQUIN results showed an increase each quarter except for Q4 where there was a decrease, however, still producing results in excess of the national compliance measure. The main failures occurring were in the recording of the time of escalation and the time of clinical response; proposed actions for improvements are discussed at the Deteriorating patient committee to take forward.

No	Area	CQUIN	Compliance Measure	Q1	% Q1	Q2	% Q2	Q3	% Q3	Q4	% Q4
CQUIN 07	Trustwide	Recording of and response to NEWS2 score for unplanned critical care admissions	10% - 30%		26%		45%		76%		62%

4. 24/7 Outreach Service

There is a national target for all hospitals to provide this service. The Trust has presented a business case for a 24/7 Outreach service to Trust Management Board.

The aim of this team is to take a proactive approach, visiting wards and monitoring NEWS scores to be able to make contact in circumstances where patients are deteriorating, in addition there is ongoing work to enhance how this service is utilised, for example to assist with NIV.

Work will continue into 2024-25, with the introduction of Martha's Rule, allowing next of kin to seek a second opinion if they feel their loved one is deteriorating.

5. Rolling out of SBAR as a communication tool

The SBAR tool is going to be built into Maxims from April 2024. Discussions are currently ongoing for the training strategy.

6. Education and Training

Compliance with NEWS2 Training by specialty will be monitored in future Deteriorating Patient Committee meetings as compliance to ALS/APLS/ATLS courses. The Acute Illness Management (AIMS) is being rolled out, though not compulsory.

Discussions continue as to how we ensure we link learning from incidents/complaints into training program of junior doctors. Case scenario training for ED doctors is due to start soon.

Quality Priorities - Effective

5. Ensure the Trust meets best practice requirements for nutrition

Nutrition was a quality priority for the Trust for 2022/23 and remained a quality priority for 2023/24. The scope of the priority for 2023/24 included the following 8 measures/projects, significance progress has been made in terms of developing the governance and oversight arrangements, some of these changes are detailed below against each measure.

1. Nasogastric (NG) Management

Current position – Nasogastric management (NG)
The Nutrition Specialist Practitioner (NSP) has worked across divisions to provide expert support and is leading on NG placement/management.
Work continues with the Education team to produce a theoretical training package around confirmation of nasogastric (NG) tube placement by chest x-ray.

An Enteral Feeding Care Plan is available as an ICP for nasogastric, nasojejunal, jejunostomy, PEG and RIG routes. This allows nurses to meet expectations to complete the safety checks and document in the care plan for all patients receiving enteral nutrition before accessing the tube.

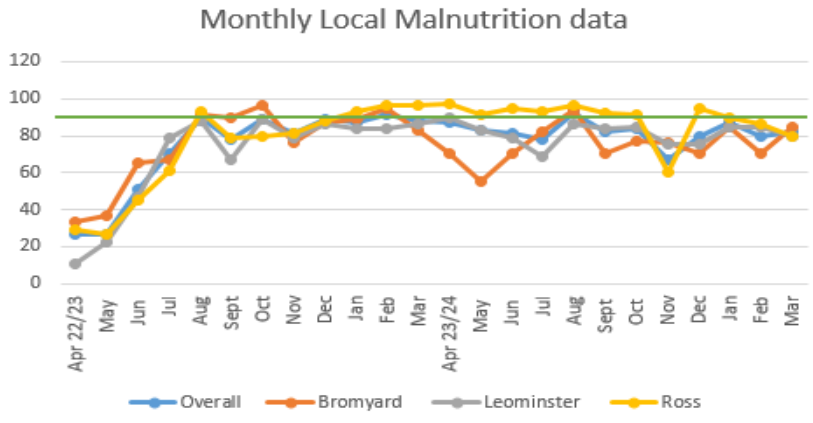
The revised Nasogastric (NG) Management policy is progressing through governance authorisation and will be available soon.

Current position – Parental Nutrition
The peripherally inserted central catheter (PICC) service has been extended to PN patients, allowing for improved patient experience, decreased infection risk and improved outcomes.

2. MUST CQUIN scores for community hospital and county site – to ensure sustained improvements in community hospitals and audit improvement on the county site.

Current position
This CQUIN was selected in order to identify correct application of the assessment tool and documentation thereof in our community hospitals.

Although the starting position was poor, the community hospitals showed great and largely sustained progress through 22/23. This CQUIN target remained for 23/24 and, although the scores at Bromyard have been more volatile, it has been pleasing to see these scores increasing again and largely being maintained at a higher level.



The County Hospital has an ongoing annual audit of MUST completion and assessment.

3. Development of a digital dashboard

Current positon
As part of Digital Nurse Noting, a ward dashboard has been developed, which will identify initial completion of patients' MUST scores. This innovation provides real time assurance/ oversight for ward managers and overall assurance to the Board and is superior to sample note audits in terms of data collection.

4. Ongoing audit of quality of MUST completion

Current position
The Lead Dietician continues to check the quality of MUST tool completion and associated actions on a rotational basis throughout the county hospital and community hospital wards.

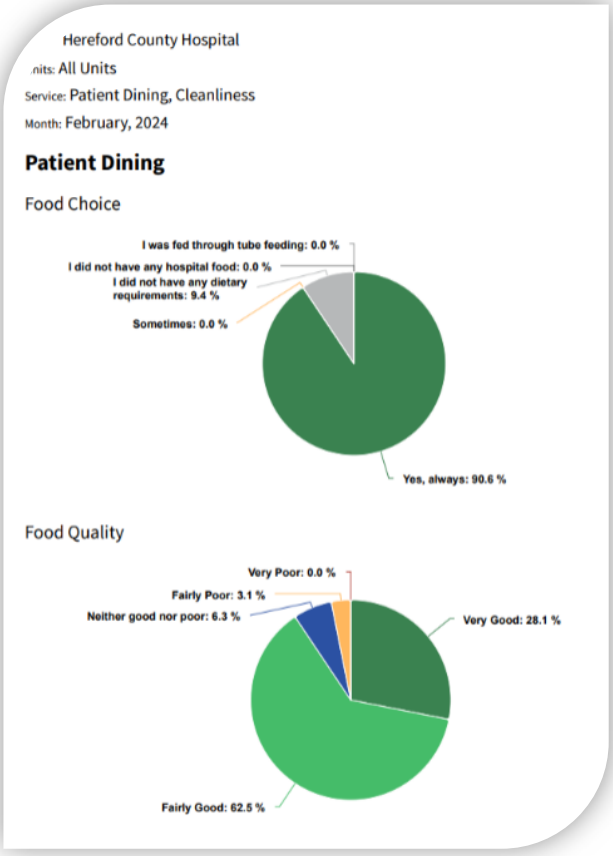
The annual WVT MUST audit was completed in December 2023, results have shown an improvement in the number of MUST tools being completed within 24 hours of admission and recoding a weight for each patient. Next steps are to focus education on accuracy and importance of completion of the tool.

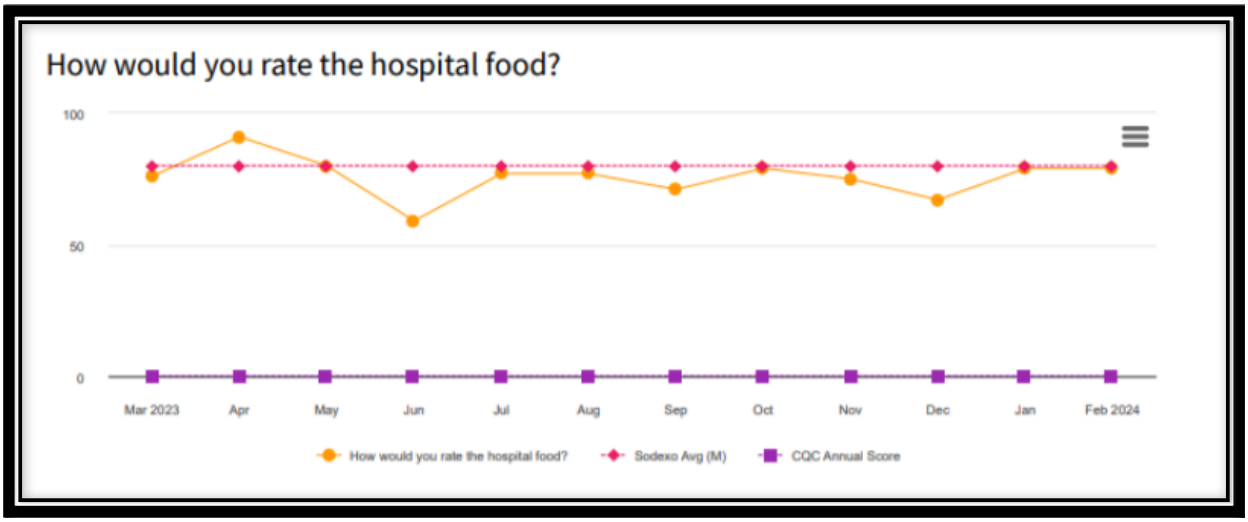
5. Improved food scores within in patient surveys

Current position
WVT Estates team and Sodexo are regularly auditing meal services/food provision. Opposite is an extract from the patient nutrition meal service audit for the County Hospital site for February 2024.
The adjacent chart indicates good results with sustained improvements.

Patient Led Assessments of the Care Environment (PLACE) are a further source of intelligence relating to patient feedback on food. PLACE audits were completed inthe latter part of 2023 and the results recently published. High level analysis of the latest PLACE data indicates lower combined food results than the national average. Additional analysis and action plan to address concerns is awaited.

The chart below indicates good results currently with sustained improvements.





6. **National Standards for healthcare food and drink**

   Current position
   A gap analysis has been undertaken against the eight key standards contained within the NHS England publication "National Standards for healthcare food and drink". Recommendations have been identified with actions required to meet these standards and a working group set up to compile our own WVT Food & Drink strategy. Progress will be monitored by the Nutritional Steering Group and escalated appropriately.

7. **Consider feedback and compliance following the launch of the mouth care guideline and national survey.**

   Current position
   The mouth care guideline is now established within WVT as best practice. There is ambition to include more information regarding mouth care and dysphagia within our Health Care Support Worker (HCSW) induction programme. Details of note audits and feedback from the national audit will feed into the Nutritional Steering group as part of business as usual governance for nutrition and hydration.

8. **Consider the development of bespoke surveys focussing on food provision.**

   Current position
   A bespoke survey is to be developed, in the interim food provision is analysed by the Nutritional Care Group who report into the Nutritional Steering Group. A bespoke survey is still to be considered due to the contradictory initial data from the National Patient Survey which indicates poorer results than the Sodexo survey results.

This past 12 months has seen quality improvement introduced at pace and the Trust is keen to continue this in 2024-25.

6. Ensure patients receive timely critical medications

Whilst the Trust acknowledges that there are a number of timely critical medications, the foundation group signed up to the national Parkinson's medication campaign to improve safety of patients with Parkinson's disease when in our care, this became the initial focus for the Trust and this priority.

The aim of the priority was:

- To reduce missed and delayed doses of critical medications.
- To work with Foundation Group colleagues to improve the care of Parkinson's patients by ensuring their medications are received on time every time.

Data so far

Data collation commenced in May 2023 and information distributed to divisions, sisters and matrons to enable targeting of good practice and areas to develop with the aim to reduce missed doses and drive forward awareness across the Trust for the importance of timely critical medication.

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total	1263			1293	1077	1182	817	988	1498
Administered 30 - 60 mins	14.17%			15.93%	10.68%	10.83%	17.26%	12.25%	10.55%
Administered 60 - 120 mins	5.54%			9.20%	6.50%	5.41%	7.22%	6.48%	4.67%
Administered 120+ mins	1.19%			4.49%	2.32%	3.64%	3.06%	2.53%	1.87%
Missed Dose*	1.35%			1.47%	0.84%	1.27%	1.84%	0.81%	1.47%
Other Omitted	3.80%			1.78%	1.86%	1.61%	1.84%	1.82%	2.54%

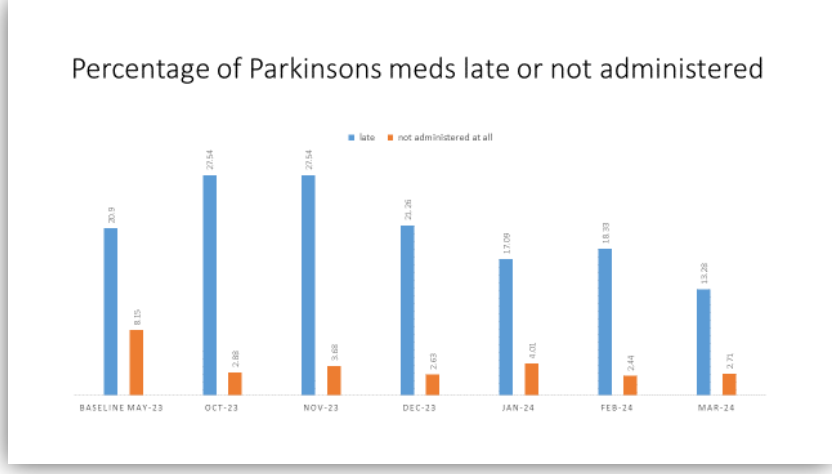
*True Missed (Combined - Deferred and not administered, Medicine

Jan-24	Administered	30-60 mins	60-120 mins	Over 120	Missed Dose*	Other Omitted
Medical	721	95	50	16	10	22
Surgical	166	20	11	3	4	5
Integrated Care	611	60	19	14	8	11
Surgical/Medical	2	1	0	0	0	0
Grand Total	1500	176	80	33	22	38

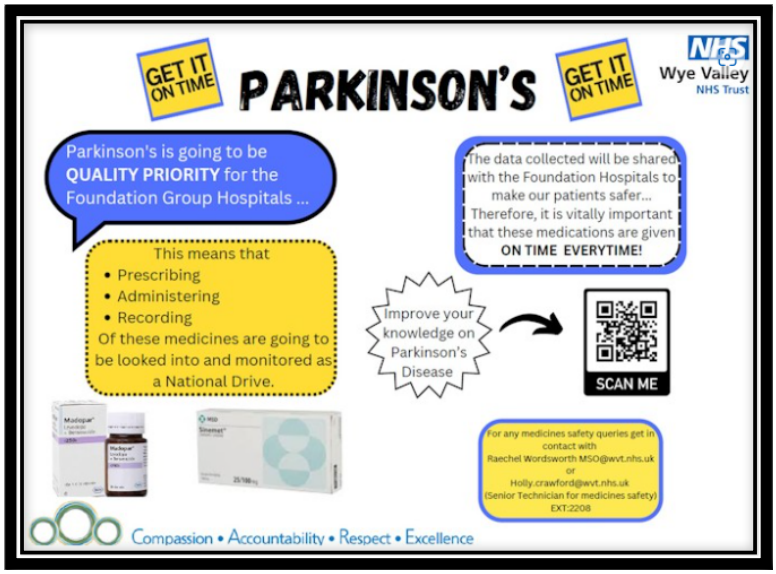
Dec-23	Administered	30-60 mins	60-120 mins	Over 120	Missed Dose*	Other Omitted
Medical	562	80	45	17	6	12
Surgical	150	16	14	6	1	4
Integrated Care	255	28	11	6	1	2
Surgical/Medical	9	2	0	0	0	0
Grand Total	976	126	70	29	8	18

For the period May 2023 to January 2024, our reporting system has been able to identify the following progress made, this includes:

- Doses delayed beyond 30 mins improved from 20.9% to 17.09%
- Omitted doses for specific reason (e.g. Nil By Mouth, Patient refused) improved from 3.8% to 2.54%.
- Since the Quality Priority commenced there has been a reduction in Parkinson's medication being administered late or not administered at all, see chart below:



In addition to the data shared, the Medicines Safety Officer (MSO) has conducted an extensive communication campaign via Trust Talk, screen savers, directed ward visits personally and via Medicines Champions. In addition, raising awareness at FY1/FY2 training sessions and the creation of a number of flyers and alerts which have been shared, see below flyer.



Whilst some progress has been made over 2023-2024, the Trust and our Pharmacy team continue to take our ability to ensure patients receive timely critical medications seriously. Therefore, we will see this priority continue in 2024-25.

7. Embed the MCA and DoLS policies and process in practice

This was a Trust Quality Priority for 2022-2023, being extended through to 2023-2024.

The Adult Safeguarding Team have experienced unexpected staff shortages during 2023-24, which has affected progress with this quality priority. Despite this, improvements have been introduced and future work has been identified in the following areas:

1. Training

There are three sources of training which are currently provided to staff:

- Online
  - Mental Capacity Act e-learning training
  - Deprivation of Liberty Safeguards e-learning
- Bespoke training sessions via Microsoft Teams or face to face
- Clinical practice weeks – bite sized training delivered in the clinical setting

MCA & DoLS eLearning is not mandatory training, yet 'badged' as essential to role where applicable. Uptake is reported through Finance & Performance Executive (F&PE) and data disseminated by HR Business Partners to all managers and divisions.

Attendance at monthly or bespoke training sessions has been mandated following any escalation of concerns or incidents where best practice was not followed when implementing the MCA or DoLS.

There has been a marked increase in the uptake of training in recent months and the clinical practice weeks are evaluating well.

2. Internal audit

An internal audit was carried out in December 2023 reviewing the policies related to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS); the audit also included a survey to evaluate staff understanding. The response rate to the survey was low and the internal audit recommends that this is repeated on an annual basis.

In addition, the specialist team plan to audit patient records in order to review how MCA and DOLs is applied in practice and the robustness of documentation.

The internal audit also recommended changes to the associated polices and these have been updated.

Given the complex nature and legal frameworks associated with the application of the MCA and DOLs in practice this work will be an area of focus on an ongoing basis. Moving forward the Trust's Quality Committee will receive updates on audit and survey findings and training uptake through the Safeguarding Adult Quarterly Reports.

Quality Priorities - Experience

3. Using local and national intelligence to improve patient experience

The Quality Account has detailed the use of the Friends and Family Test service to gather real time feedback, how we respond to complaints and results of national patient surveys.

In 2023-24, the Trust relaunched the Patient Experience Committee to provide oversight in all aspects of patient experience. The meetings provide the opportunity to triangulate the information we receive from all data sources to generate improvement projects.

A key area of concern and feedback from service users, and their families or carers related to missing patient property whilst an inpatient. This can cause a lot of distress to patients and families. The committee commissioned a project to review Trust processes for securing patient property and documenting decisions as to how patients would like to store their property during their stay. It was identified that the Trust policy, processes and records were out of date and did not align with the use of an electronic patient record to detail patient property and how it should be secured. Using quality improvement methodology a new property form and disclaimer is being trialled in the Emergency Department, where the majority of patients start their stay with in hospital. The project is ongoing but the Trust are committed to improving the storage of patient property.

This is one example of how the information we receive and seeking to improvement in our services.

Improvements to our complaints process have focussed on engaging with those who have had a poor experience at the earliest opportunity and offering to discuss the issues raised face to face or over the telephone to ensure we fully understand the concerns and the resolution the complainant it seeking. Taking this time to speak to service users and their families or carers makes a difference to their experience of resolving concerns but also ensures the Trust provides a detailed and open response to the complaint. The impact of this has meant the quality of responses have improved, which is seen in the reduction of complaints re-opened.

The committee recognises there is more the Trust can do to improve patient experience and going into the year ahead have refined and focussed the aims of our priority seeking to improve our responsiveness to all sources of patient feedback, providing a wealth of opportunity to develop quality improvement projects and maintain the momentum generated this year in engaging with services users and improving their experience of care and treatment at the Trust.

Quality Priorities:

The Year Ahead

Our objectives 2024/25

NHS Wye Valley NHS Trust

QUALITY

- **Develop a business case and implement our blueprint** for integrated urgent and emergency care with our One Herefordshire partners
- Work with partners to **ensure that patients can move to their chosen destination rapidly,** reducing discharge delays
- Work with partners to **deliver the improvement plan for Children's services**

WORKFORCE

- **Deliver plans for 'grow our own' career pathways** that provide attractive roles for applicants
- **Increasing the number and quality of green spaces for staff and improve the catering offer** at the County Hospital in order to improve the working environment for staff
- **Embed EDI objectives in our performance appraisals** in order to make a demonstrable improvement in EDI indicators for patients and staff

PRODUCTIVITY

- **Deliver our Elective Surgical Hub project** and associated productivity improvements in order to increase elective activity and reduce waiting times
- **Continue our Community Diagnostic Centre project, ready for Summer 2025** in order to improve access to diagnostics for our population
- **Create system productivity indicators** to understand the value of public sector spending in health and care

DIGITAL

- **Implement an electronic record into our Emergency Department** that integrates with other systems
- **Deliver the final elements of our paperless patient record plans** in order to improve efficiency and reduce duplication
- **Maximise the functionality of EMIS** with 1H partners and the shared care record

SUSTAINABILITY

- Work with Group partners to **identify fragile services and develop plans to make them more sustainable** utilising the scale of the group and existing networks
- **Redesign selected services to focus more on prevention** in order to reduce secondary care activity
- **Build our integrated energy solution** on the County Hospital site to reduce carbon emissions

RESEARCH

- **Increase both the number of staff that are research active and opportunities for patients to participate in research** through our academic programme in order to be known as a Research active Trust
- **Continue to progress our plans for an Education Centre** in order to develop our workforce and attract and retain staff

@WyeValleyNHS
@WVTNHS

QUALITY PRIORITIES 2024-25

PATIENT SAFETY PRIORITIES 2024-25

WVT Patient Safety Priorities				
Tissue Viability incidents – Deterioration of moisture associated skin damage to G3/4 or unstageable pressure damage	**Inpatient falls** In patients with dementia, delirium or a known high risk of falls	**Delays in assessment, diagnosis or treatment** Responding well to clinically changing conditions	**Admissions and discharges** Incidents relating to the movement of patients, particularly delays to follow up	**Medication incidents** Incidents relating to the failure of administration of critical medications

External Statements of Assurance

Herefordshire and Worcestershire

Statement of Assurance from NHS Herefordshire and Worcestershire ICB regarding Wye Valley Trust Quality Account for 2023-2024

To be completed

To be completed

Simon Trickett
Chief Executive, NHS Herefordshire and Worcestershire

Appendices

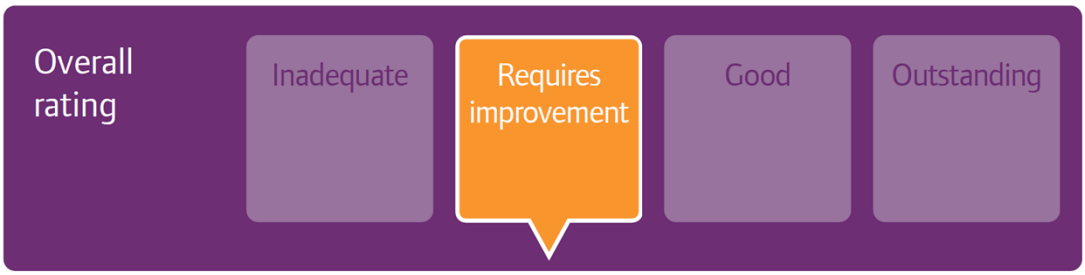
Appendix 1

CQC Ratings Tables

Acute Site ratings

Most recent inspection rating changes

The County Hospital



	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Community Services

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good → ← Mar 2020	Good → ← Mar 2020	Good ↓ Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Requires improvement → ← Mar 2020	Requires improvement → ← Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Requires improvement → ← Mar 2020
Community end of life care	Good ↑ Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020
Community dental services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good ↑ Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020

Appendix 2
National Audit & NCEPOD Compliance

Eligible National Audits	WVT participation in 2023-2024	Cases submitted (where applicable)	Comments
Royal College of Emergency Medicine (RCEM) Care of older people	✓	N/A	Report not yet due to be published
Royal College of Emergency Medicine (RCEM) Mental health (self-harm)	✓	N/A	Report not yet due to be published
Royal College of Emergency Medicine (RCEM) Infection Prevention	✓	All eligible cases submitted	RCEM National Quality Improvement Programme 2021/22 Infection Prevention and Control Year 2 Interim Report – Published April 2023 Infection Prevention and Control 2022-2023 RCEM National Quality Improvement Programme National Report – Published February 2024
Major Trauma Audit (TARN)	✓	All eligible cases submitted	Continuous data collections – all eligible cases submitted Data published quarterly
Case Mix Programme (CMP)	✓	All eligible cases submitted	Continuous data collections – all eligible cases submitted Data published quarterly
National Lung Cancer Audit (NLCA)	✓	All eligible cases submitted	National Lung Cancer Audit (NLCA) – State of the nation report 2023 – Published 12th April 2023

Oesophago-gastric Cancer (NAOGC)	✓	All eligible cases submitted	National Oesophago-Gastric Cancer Audit (NOGCA) Report - Published 11th January 2024 Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England (NOGCA) – Published 13th July 2023.
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	✓	N/A	Audit at planning stage nationally Wye Valley not required to enter data as yet but will be participating as required
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	✓	N/A	Audit at planning stage nationally Wye Valley not required to enter data as yet but will be participating as required
Bowel Cancer (NBOCAP)	✓	All eligible cases submitted	Bowel Cancer State of the Nation report - Published 8th February 2024
Prostate Cancer	✓	All eligible cases submitted	National Prostate Cancer Audit (NPCA) report - Published 11th January 2024
Cardiac Rhythm Management (CRM)	✓	All eligible cases submitted	National Audit of Cardiac Rhythm Management (NACRM)– Published 8th June 2023
National Audit of Cardiac Rehabilitation	✓	All eligible cases submitted	Continuous data collection – all eligible cases submitted National report - Published July 2023
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	25%	Management of Heart Attack: analyses from the Myocardial Ischaemia National Audit Project (MINAP) - Published 8th June 2023
National Heart Failure Audit	✓	33%	National Heart Failure Audit: Summary report – Published 8th June 2023

National Diabetes Audit - CORE	✓	All eligible cases submitted	National Diabetes Audit (adults) Young People with Type 2 Diabetes State of the Nation report (England and Wales) – Published 14th December 2023 National Diabetes Audit (adults) Diabetes Prevention Programme (DPP) Non-Diabetic Hyperglycaemia (NDH) State of the Nation report (England only) - Published 14th December 2023 National Diabetes Audit 2021-22, Type 1 Diabetes – Published 12th October 2023 National Diabetes Audit: Care Processes and Treatment Targets 2021-22 - Published 12th October 2023
National Pregnancy in Diabetes Audit	✓	All eligible cases submitted	National Pregnancy in Diabetes Audit 2021 and 2022, England and Wales – Published 12th October 2023
National Diabetes Foot Care Audit	✓	N/A	Report not yet due to be published
National Diabetes Inpatient Safety Audit	✓	N/A	Report not yet due to be published
National Audit of Dementia	✓	All eligible cases submitted	Dementia Care in General Hospitals Round 5 Audit 2022 (NAD) – Published 10th August 2023
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	All eligible cases submitted	Annual SHOT Report 2022 - Published July 2023
National Maternity and Perinatal Audit (NMPA)	✓	All eligible cases submitted	Report not yet due to be published
National Hip Fracture Database	✓	All eligible cases submitted	National Hip Fracture Database (NHFD): 15 years of quality improvement – Published 14th September 2023

Fracture Liaison Database	✓	N/A	Fracture Liaison Service Database Annual report – Published 8th February 2024
National Inpatient Falls Audit	✓	All eligible cases included	Inpatient falls and fractures – 2023 NAIF report on 2022 clinical data – Published 9th November 2023
National Joint Registry (NJR)	✓	All eligible cases included	National Joint Registry 20th Annual Report 2023 – Published 3rd October 2023
National PROMS Programme	✓	N/A	April 2021 to March 2022 Finalised Data - Published 13th July 2023
NPDA National Paediatric Diabetes	✓	All eligible cases included	National Paediatric Diabetes Audit Admissions report (NPDA) – Published 13th July 2023
National Neonatal Audit Programme (NNAP)	✓	All eligible cases included	National Neonatal Audit Programme Summary report on 2022 data – Published 12th October 2023
National Audit of Seizures and Epilepsies in Children and Young People	✓	All eligible cases included	Epilepsy12 organisational and clinical audits report, England and Wales (2020-22) – Published 13th July 2023
UK Cystic Fibrosis Registry (Adults & Children)	✓	Data only collected on Children	UK Cystic Fibrosis Registry 2022 Annual Data Report - published September 2023
National Paediatrics Asthma Audit	✓	All eligible cases included	Report not yet due to be published
National Child Mortality Database	✓	N/A	Infection related deaths of children and young people in England – Published 14th December 2023 Child Death Review Data Release: Year ending 31 March 2023 – Published 9th November 2023 Deaths of children and young people due to traumatic

			incidents (NCMD) – Published 13th July 2023
Cleft Registry and Audit NEtwork (CRANE)	✓	All eligible cases included	CRANE Database 2023 Summary of Findings for Patients and Parents/Carers - Published December 2023
National Chronic Obstructive Pulmonary Disease (COPD) Audit in Secondary Care	✓	N/A	Report not yet due to be published
National Adult Asthma Audit	✓	N/A	Report not yet due to be published
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehab Audit - Organisational & Clinical Audit	✓	N/A	Report not yet due to be published
British Thoracic Society - Adult Respiratory Support Audit	✓	N/A	Report not yet due to be published
National Early Inflammatory Arthritis Audit (NEIAA)	✓	All eligible cases included	National Early Inflammatory Arthritis Audit State of the Nation Report 2023– published 12th October 2023
Sentinel Stroke National Audit programme (SSNAP)	✓	All eligible cases included	Stroke: SSNAP State of the Nation 2023 report- published 9th November 2023
National Emergency Laparotomy Audit (NELA)	✓	All eligible cases included	Not yet due to be published
Perioperative Quality Improvement Programme (PQIP)	✓	All eligible cases included	Perioperative Quality Improvement Programme (PQIP) Report 4 July 2021-March 2023 – Published 11th July 2023
Breast and cosmetic implant registry	✓	All eligible cases included	Data published on NHS digital

British Hernia Society Registry	✓	N/A	Audit at planning stage nationally Wye Valley not required to enter data as yet but will be participating as required
Society for Acute Medicines Benchmarking Audit (SAMBA)	✓	All eligible cases included	Society for Acute Medicines Benchmarking Audit (SAMBA) National Audit of Acute Medical Care in the UK 2023 - published 10th January 2024
BAUS Urology Audits – Nephrostomy Audit	✓	N/A	Report not yet due to be published
National Audit of Care at the End of Life (NACEL)	✓	All eligible cases included	National Audit of Care at the End of Life (NACEL) 2022/23 report – Published 13th July 2023
National Acute Kidney Injury Audit	✓	All eligible cases included	UK Renal Registry- Acute Kidney Injury (AKI) in England 2022 Report – Published 20th December 2023
National Ophthalmology Database Audit	X	N/A	The Trust does not currently participate in this audit due to not having the electronic software required to upload the data
Improving Quality in Crohn's and Colitis (IQICC) Previously known as Inflammatory Bowel Disease (IBD) Registry	X	N/A	The Trust had temporarily withdrawn participation in this audit due to staff resources within the gastroenterology team, this audit came to a close at the end of March 2024
National Cardiac Arrest Audit (NCAA)	X	N/A	The Trust has temporarily withdrawn participation in this audit due staff resources within the resuscitation team but local data is being collected and reported

National Confidential Enquiries (NCEPOD)			
Eligible National Audits	**WVT participation in 2023-2024**	**Cases submitted**	**Eligible National Audits**
Maternal, Newborn and Infant Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes all maternal and child deaths to programme MBRRACE-UK Comparison of the care of Black and White women who have experienced a stillbirth or neonatal death – Published 14th December 2023 MBRRACE-UK Comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death - Published 14th December 2023 MBRRACE-UK: Saving Lives, Improving Mothers' Care State of the Nation Themed report (Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21) – Published 12th October 2023 MBRRACE-UK: Saving Lives, Improving Mothers' Care State of the Nation Themed report (Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth) – Published 12th October 2023 MBRRACE-UK: Saving Lives, Improving Mothers' Care State of the Nation Surveillance report – Published 12th October 2023 MBRRACE-UK: Perinatal Mortality Surveillance - Published 14th September 2023

Medical & Surgical Clinical Outcome Review Programme	NCEPOD	N/A	Contributed to the programme via Community Acquired Pneumonia – Consolidation Required – Published 14th December 2023 Making the cut? Review of care of patients undergoing surgery for Crohn's Disease (NCEPOD) – Published 13th July 2023 Endometriosis –Data collection completed and submitted, report due to be published Summer 2024 End of Life Care- Data collection completed and submitted, report due to be published Autumn 2024
Mental Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Mental Health Clinical Review Programme when required Suicide by people in contact with drug and alcohol services - published 8th February 2024 Suicide and safety in mental health: UK patient and general population data 2011-2021 - published 8th February 2024
Child Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Child Health Clinical Review Programme when required – This year the studies are as follows: Twist and Shout: Review of care provided to children and young people with testicular torsion – published 8th February 2024 The Inbetweeners – a review of the transition from CYP into adult health services – Published 8th June 2023 Juvenile idiopathic arthritis - Data collection completed and submitted, report due to be published Autumn 2024

Appendix 3

Comparable data summary from data available to the Trust from NHS Digital

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. Wye Valley NHS Trust considers that this data in the table below is as described for the following reasons:

https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Performance information is consistently gathered and reported on monthly to the Trust

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2021/22)	0	0	2.2	14	0	Hospital Onset cases. Latest 2022-2023 Previous 2021-22 (06/10/2023 release)
MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to reduce incidence of MRSA and so the quality of services, by ensuring its strict cleaning, hygiene, hand-washing regimes, and bare below the elbows practice is adhered to. The trust also has a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.						
qQNHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile	42	51	71.1	282	0	Hospital & Community onset, Healthcare associated. Latest 2022-23 Previous 2021-22 (06/10/2023 release)
Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and the quality of services, by learning lessons from these investigations, sharing with the clinical area and presenting at the Trust's Quality Committee meetings.						
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported						No new release of data due to the change to the new Patient Safety Incident Reporting framework
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported Severe or death						No new release of data due to the change to the new Patient Safety Incident Reporting framework
Note: No new release of data due to the change to the new Patient Safety Incident Reporting Framework.						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents and the outcome of investigations are shared throughout Divisional and Directorate governance meetings. Incident reviews that identify a new emerging risk or new learning are shared in a variety of forums and in the trust weekly Safety Bites newsletter.						
Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level. (Current Sept 22-Aug 2023) Band 2 (Previous Sept 22-Aug 2023) Band 1	1.0212	1.0335	1.0	1.2564	0.720	Data is banded 1-3 high to low Previous period Sept 2022 - Aug 2023
Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the (Current Sept 22-Aug 2023) Band 2 (Previous Sept 2021-Aug 2022) Band 1.	24%	42%	40%	65%	12%	Reported as a percentage of all deaths.
SHMI data at trust level, Dec22-Nov23 (xls).xls (live.com) SHMI data - NHS England Digital						
Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by maintaining the implementation of the Mortality strategy and supporting quality improvement work in relation to mortality alerts and learning from deaths.						
Limited submissions for current year . Numbers not sufficient for the benchmarking tool to use						
PROMS Total HIP Replacement (latest 2021-22) (Previous 2019-20 2020-21 not available	0.60	0.56	0.793	0.529	-0.35	Using EQ-5D Index score (a combination of five key criteria concerning general health) More info in link below
PROMS Total Knee Replacement Latest 2019-20 Previous 2018-19) 2020-21 not available	0.21	038	0.32	-0.034	0.74	
Patient Reported Outcome Measures (PROMs) - NHS Digital						
Wye Valley NHS Trust is taking the following actions to improve PROMs outcomes and so the quality of services, by continuing to look at the issues with the PROM outcome scores in greater detail, in particular those patients who have had a negative outcome and analysing patient level information to look at the outliers and their impact on the overall scores. This analysis is undertaken by the surgical teams to understand how we can improve.						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
National Inpatient Survey: Responsiveness to inpatients' personal needs. This is no longer in the survey Section 5 Your care & treatment NHS Outcomes Framework - Indicator 4b Patient experience of hospital care Statistic: verall how was you experience….in Hospital	**8.1** **8.0**	 7.9	8.2 8.12	9.1 9.28	7.7 7.35	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to 2022 survey Jan-March 2023 ***Published Sept 2023***
Adult inpatient survey 2022 - Care Quality Commission (cqc.org.uk)						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement						
d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d – 2022)	57	63	60	86	39	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2022 Previous December 2021
Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work (Q25c-2022)	60	61	56	75	41	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2022 survey latest available
Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.						
Friend and Family Inpatient services latest December 2023 previous(February 2020 sample)	84	99	94	100	73	Figures expressed as percentage who would recommend. Current Dec 2023 previous February 2020
Friend and Family Accident and Emergency services December 2023 previous(February 2020 sample)	72	76	78	100	54	
https://www.england.nhs.uk/fft/friends-and-family-test-data/ https://www.england.nhs.uk/publication/friends-and-family-test-data-february-2019/						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
VTE risk assessed						2019 latest published national data see VTE information on page 58 for latest quarterly data. There was a National data suspension during the Pandemic.

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/

Wye Valley NHS Trust is taking the following actions to improve the number of patients who are risk assessed for VTE and so the quality of services by maintaining a focus on achieving the national target through the quality priority set for 2020-21 and continued audit of practice.
2019 latest published national data see VTE section for latest quarterly data. There was a National data suspension during the Pandemic.

Appendix 4

Contracted Services 2023-24 - Contract Monitoring Services

SURGICAL	MEDICAL	INTEGRATED CARE	CLINICAL SUPPORT
General Surgery	Plastic Surgery	Physiotherapy	Palliative Medicine
Urology	Accident & Emergency	Occupational Therapy	Anti Coagulant
Breast Surgery	General Medicine	Dietetics	Chemical Pathology
Colorectal Surgery	Gastroenterology	Orthotics	Haematology
Upper GI	Endocrinology	Speech & Language	Radiology
Vascular Surgery	Hepatology	Podiatry	Audiology
Trauma & Orthopaedics	Diabetic Medicine	Medical Inpatients (Community Beds)	Pathology
ENT	Rehabilitation	Community Nursing Inc. Specialist Com.Nursing	
Ophthalmology	Cardiology		
Oral Surgery	Transient Ischaemic Attack		
Orthodontics	Dermatology		
Anaesthetics	Respiratory Medicine		
Paediatrics	Respiratory Physiology		
NeoNatology	Thoracic Surgery		
Gynaecology	Nephrology		
Obstetrics	Neurology		
Midwifery	Clinical Neurophysiology		
ITU	Rheumatology		
SCBU	Geriatric Medicine		
Community Child Health	Minor Injury Units		
Community Dental	High Dependancy Unit		
Podiatric Surgery			

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Operational Planning: Financial Plan 2024/25
Status of report:	☒**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Finance Officer**
Author:	Katie Osmond (CFO), Suzi Joberns (Deputy CFO)
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

This paper sets out the final draft financial plan for 2024/25, as part of the wider operational planning process.

Though described as final draft pending conclusion of the national process, the plan reflected in this paper necessarily forms the basis of the delegated budgets for divisions, directorates and departments.

2. Recommendation(s)

The Board is requested to:

- Note progress since the previous planning briefing in January 2024;
- Ratify the approval of the financial plan which was necessarily submitted under delegated authority due to timing; and
- Note that the plan may be subject to further change aligned to the national process

3. Executive Director Opinion[1]

This paper provides a final draft of the 2024/25 financial and operational plan. The challenge of meeting all of the requirements, across operational performance, workforce and finance should not be underestimated given our underlying exit deficit positon. There remains a significant level of financial risk associated with the plan, for which mitigations continue to be sought.

[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.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

2024/25 Financial Planning

Context

This paper sets out the final draft financial plan for 2024/25, as submitted through the national process on 2nd May 2024. Systems are expected to deliver a balanced financial plan alongside meeting the operational planning requirements for performance, activity levels and workforce.

The current plan, of a £34.4m deficit does not deliver a balanced financial position for the Trust or the Integrated Care Board (ICB). This is not unique to Herefordshire and Worcestershire and we envisage a further review process and potential resubmission exercise over the coming weeks.

The internal operational planning process has run alongside the delayed national process to ensure we are in a position to set a baseline budgetary and activity trajectory against which we can monitor divisional, corporate and Trust wide performance.

Activity and Operational Performance

The activity plan is based on achieving high productivity through core capacity, and only using additional capacity where it offers value for money and supports our ability to meet the required elective activity levels and thereby access to Elective Recovery Funding. Table 1 below sets out the planned activity volumes by point of delivery.

Core capacity is assumed to achieve 90% clinic utilisation, 85% theatre utilisation and a less than 5% clinic DNA rate. There is additionally a programme of work to reduce follow up activity, for example through proactive use of the Patient Initiated Follow Up (PIFU) pathways.

Table 1: Activity Plan

					24/25 Plan Vs 2019/20		24/25 Plan vs 2023/24	
Activity Type	Actual 19/20	Actual 22/23	23/24 Actual	Plan 24/25	Difference	Proportion	Difference	Proportion
New	59,545	62,430	66,976	72,893	13,348	122.4%	5,917	108.8%
Follow Up	132,696	141,561	143,122	143,749	11,053	108.3%	627	100.4%
IP/DC Admissions	22,814	21,594	23,499	27,398	4,584	120.1%	3,899	116.6%
Endoscopy Admissions	10,296	9,271	9,778	11,236	940	109.1%	1,458	114.9%
Trust Total	225,351	234,856	243,375	255,276	29,925	113.3%	11,901	104.9%
Excl. Follow Ups	92,655	93,295	100,253	111,527	18,872	120.4%	11,274	111.2%

*These numbers are from the Trust operational planning tool e.g. includes English and Welsh activity and only RTT specialties. This equates to 120% of 19/20 activity. This is slightly different to the national planning return which for example excludes Welsh activity and includes some non RTT specialties this is 117.5% of 19/20 activity.

The activity plan is projected to deliver performance against the national operational planning metrics as set out in table 2 below.

Table 2: ICB (inc WVT) Operational Performance Requirements

		21/03/2024 draft position Working Days Adjusted			
Planning requirement	**Target**	**ICS**	**WAHT**	**WVT**	**H&CT**
Elective Recovery - Value Weighted Activity (Working days adjusted)					
VWA - 24/25 vs 19/20 ind. pathways diverted through specialist advice	107%	120.8%	113.5%	117.5%	
VWA - 24/25 vs 19/20	107%	117.4%	108.8%	115.2%	
Elective care					
Eliminate elective waits of over 65 weeks by September 2024	0	0	0	0	
Reduce number if incomplete Referral to Treatment pathways by March 2025	reduce	-12353	-4498	-5798	
Cancer					
Meet the cancer 62 Day waiting time 24/25 standard by March 2025	70%	71.5%	70.1%	75.3%	
Meet the cancer 28 Day faster diagnosis standard by March 2025	77%	77.2%	77.2%	77.2%	
Increase those referred onto a non specific symptoms pathway	Increase	+176			
Meet the required % of lower GI referrals with a FIT result by March 2025	80%	83.8%			
Diagnostic Waits*					
Total	Progress towards 95% by March '25	90.02%			
Magnetic Resonance Imaging	Progress towards 95% by March '25	87.89%			
Computed Tomography	Progress towards 95% by March '25	99.09%			
Non-Obstetric Ultrasound	Progress towards 95% by March '25	95.66%			
Colonoscopy	Progress towards 95% by March '25	92.73%			
Flexi Sigmoidoscopy	Progress towards 95% by March '25	92.31%			
Gastroscopy	Progress towards 95% by March '25	94.20%			
Echocardiography	Progress towards 95% by March '25	79.40%			
DEXA	Progress towards 95% by March '25	95.89%			
Audiology	Progress towards 95% by March '25	81.49%			
Urgent Care					
Time in A&E Department by March 2025	78% by March 2025		77.0%	77.0%	
Improve ambulance cat 2 response times	30 mins across 2024/25	Part of Black Country Return			

Oversight of delivery of the activity plan and productivity levels will be undertaken through Productivity Board, Valuing Patient's Time Board and into Trust Management Board and Finance and Performance Executive meetings.

Workforce

The workforce plan has been developed alongside the activity and financial plans and maps anticipated changes in staff in post over the course of the year. There is significant scrutiny on our workforce growth Table 3 below sets out the staff in post from March 24, to March 25.

Table 3: Staff in Post Movement

	WTE as at 31/3/24 (Actual)	WTE as at 31/3/25 Plan	Movement
Substantive	3,573.10	3,727.79	154.69
Agency	174.39	55.74	-118.65
Bank	233.37	226.03	-7.37
Total	3,980.86	4,009.56	28.7

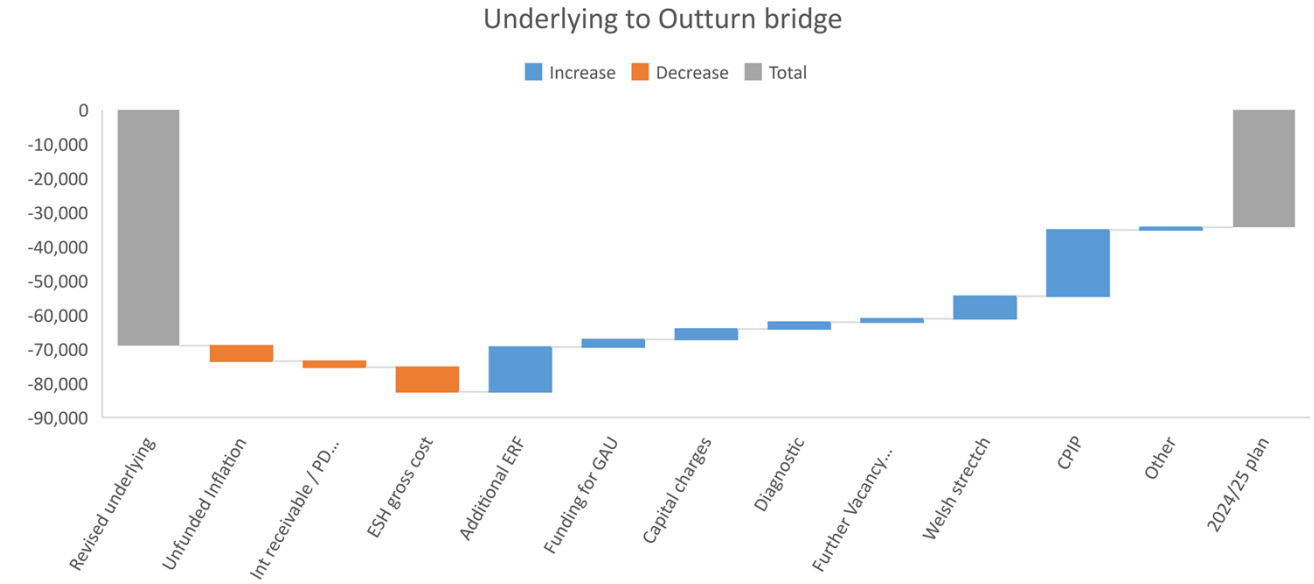
The table shows that overall our workforce remain largely flat with the growth areas being in known developments such as ESH and CDC.

Financial Plan (Income & Expenditure)

The Trusts outturn deficit in 2023/24 was £13.4m. It is recognised that financial year 2023/24 included reliance on non-recurrent income streams and benefits that reverse out into 2024/25 and put pressure on the overall position. The underlying deficit after adjusting for these one off items was initially assessed at £65m in January 2024, however due to further under delivery of recurrent CPIP increased to £69m.

The financial plan builds from this underlying exit position, recognising planning assumptions and outputs from the planning round including inflation, changes in activity and income, and efficiency and productivity. The plan has been developed using both a top down assessment and the bottom up operational planning outputs to ensure it remains ambitious yet credible. Table 4 sets out the movement from £69m underlying deficit to £34.4m plan.

Table 4: Underlying to Outturn



The financial plan reflects a deficit position of £34.4m as reflected in table 5. The overall system plan remains a net deficit which is unlikely to be accepted by NHSE given that it does not meet the planning requirement of break even. Work continues to explore further opportunities for mitigation ahead of an expected further plan submission in early June.

Table 5: Statement of Comprehensive Income (Income and Expenditure)

	Plan 30/4/24 £000	Plan 31/5/24 £000	Plan 30/6/24 £000	Plan 31/7/24 £000	Plan 31/8/24 £000	Plan 30/9/24 £000	Plan 31/10/24 £000	Plan 30/11/24 £000	Plan 31/12/24 £000	Plan 31/1/25 £000	Plan 28/2/25 £000	Plan 31/3/25 £000	Plan Total £000
Income	29,774	26,475	26,476	26,767	26,768	26,767	26,768	26,767	26,768	26,768	26,770	26,759	323,627
Pay	-17,796	-17,821	-17,806	-17,841	-17,757	-17,714	-17,614	-17,614	-17,605	-17,494	-17,494	-17,479	-212,035
Non Pay	-10,733	-10,734	-10,683	-10,800	-10,805	-10,803	-15,893	-10,754	-10,756	-10,705	-10,709	-10,707	-134,082
Operating Surplus/(Deficit)	**1,245**	**-2,080**	**-2,013**	**-1,874**	**-1,794**	**-1,750**	**-6,739**	**-1,601**	**-1,593**	**-1,431**	**-1,433**	**-1,427**	**-22,490**
Finance Costs	-462	-462	-461	-462	-462	-461	-462	-462	-461	-462	-462	-2954	-8,033
Surplus/(Deficit) for the perios/y	**783**	**-2,542**	**-2,474**	**-2,336**	**-2,256**	**-2,211**	**-7,201**	**-2,063**	**-2,054**	**-1,893**	**-1,895**	**-4,381**	**-30,523**
Add back I&E impairments				5,141									5,141
Remove Capital Donations	-3,301	-3	-4	-3	-3	-4	-3	-4	-3	-4	-4	-8	-3,344
Adjust for PFI	-636	-636	-636	-699	-699	-699	-699	-699	-699	-699	-699	1,786	-5,714
Adjusted Financial performance Surplus/(Deficit)	**-3,154**	**-3,181**	**-3,114**	**2,103**	**-2,958**	**-2,914**	**-7,903**	**-2,766**	**-2,756**	**-2,596**	**-2,598**	**-2,603**	**-34,440**

The following section sets out assumptions in relation to core components of the financial plan and drivers of the deficit position:

- Cost Improvement and Productivity (CPIP): The plan recognises £19.4m / 5.5% efficiencies, going further than the national efficiency expectation of 2.2%. At this stage the CPIP is underpinned by a broad plan for delivery, primarily weighted towards agency reduction schemes, transformation and productivity opportunities and procurement / contract management.

Governance arrangements are in place to oversee identification and delivery of the programme. There is a workshop planned for 22nd May which will explore plans in more detail and to refine the strategic delivery of our CPIP programme. Additionally, the activity plan assumes a level of productivity improvement within core capacity. Ultimately the Board will need to assure itself that the level of cost improvement is stretching yet credible in the context of the overall financial position and performance and quality priorities.

Table 5 below summarises the distribution of the planned efficiencies and the stretch target across divisions. Medical and Nursing Agency Reduction Programmes (MARP/NARP) have a specific target which is shown separately below and in practice is devolved across the divisions for delivery. Divisions will retain autonomy to vire cost improvement targets across their directorates and departments and between pay and non-pay as they see fit and as opportunities present.

Table 5: Efficiency (£000)

Division	Nurse Agency CPIP Target	Medical Agency CPIP Target	Other CPIP Target	24/25 CPIP Target
Surgical	720		2,389	3,109
Medical	2,600		2,522	5,122
Integrated Care	652		935	1,587
Clinical Support	28		1,491	1,519
Corporate (inc. estates, HR etc)			655	655
Corporate Plan		4,000		
ESH			3,363	
Total	4,000	4,000	11,355	19,355

- **Excess Inflation**: the plan recognises approximately £4.5m of inflationary pressure over and above the level funded. The main drivers are pay, drugs and utilities.

- **Capacity & Elective Recovery**: the plan recognises £7m of Elective Recovery Fund (ERF) income based on achieving the target of 106% of 2019/20 value weighted activity (VWA) and a further £6.1m in recognition of the plan to achieve 120% of 19/20 VWA. Delivery of this level of activity is not achievable solely within core capacity, despite the high productivity assumption. Where additional capacity is required to deliver the plan, a value for money assessment has been undertaken. This includes the continued use of the mobile theatre in quarter one in advance of the Elective Surgical Hub opening in July 2024 and retaining access to a mobile MRI scanner to maintain diagnostic waiting times.

- **Welsh Stretch Income**: The plan includes £5m of income from achieving parity of funding mechanism between English and Welsh commissioners. For example English commissioners pay towards rurality and additional income to achieve operational targets which we do not received from Welsh Commissioners. There is also a further £1m of income or cost reduction to reflect the level of delayed discharges due to adult social care delays. This is being taken forward at a national and regional levels and remain high risk assumptions.

Financial Risk and Opportunity:

- **Elective Recovery Funding:** The plan assumes a level of elective activity to secure access to ERF. There is a financial risk if we under achieve on delivery of elective activity. Delivery of the additional capacity and improved productivity is key for achieving the 120% included in the plan.

- **Delivery of CPIP:** Development of the full programme is behind where we would want to be at this stage of the planning cycle. Significant focus is currently on supporting divisions to convert opportunities to credible schemes and into delivery, and on identifying further mitigation.

- **Variability of Additional Capacity Cost –** the plan is fully triangulated between activity and cost of delivery. Any variability in planned care levels against the monthly activity plan would be expected to result in associated variability in financial non recurrent capacity budgets.

- **Contract Status**: significant progress has been made with all commissioners however none of these are finalised at the time of writing: the latest position has been included within this version of the income plan. There is a risk that some of our income assumptions may not ultimately be reflected within signed contracts.

- **Pay Settlement**: planning guidance assumes that the final pay award will not adversely impact the Trust's financial position. There is a risk that the national mechanism to mitigate the impact will not fully recognise local costs, for example linked to our PFI contract responsibilities which would impact our financial performance.

- **Developments**: Other than where investment directly relates to the provision of additional capacity (such as for elective recovery), no provision has been made within the financial plan for new developments. Existing approved developments in their implementation phase have been included within the plan in line with the approved case, and will be subject to a structured review of benefits realisation in line with our business case process.

Delegated Budgets

In line with the budget setting process and the Standing Orders and Standing Financial Instructions, responsibility for delivery of the financial plan is delegated to named budget holders across our divisions, directorates and departments. This delegation of responsibility for budgets is important for ownership and accountability of effective use of resources. A small number of items are held centrally at the initial budget issue to ensure the relevant governance process is followed before the funding is devolved.

As part of the routine governance process, budgets are issued to respective budget holders and a sign off process undertaken to ensure responsibility has been accepted for the delegated budgets, and associated financial, activity and workforce plans. This process is underway. Table 6 below sets out the delegated financial budgets by division, and table 7 sets out the associated funded establishments.

Table 6: Delegated Budgets

Divisional Budgets	Clinical Support £000s	Integrated Care £000s	Medical £000s	Surgical £000s	Estates, Facilities & PFI £000s	Corporate £000s	Other Management £000s	Total £000s
Income								
SL Income	1,201	1,057	277	731	1,805	3,205		**8,275**
Other Income							316,050	**316,050**
Total Income	**1,201**	**1,057**	**277**	**731**	**1,805**	**3,205**	**316,050**	**324,325**
Expenditure								
Pay	(25,232)	(27,230)	(50,192)	(68,256)	(2,719)	(20,204)	(18,215)	**(212,048)**
Non Pay	(22,324)	(2,999)	(13,582)	(16,700)	(28,211)	(36,091)	(22,896)	**(142,803)**
Total Expenditure	**(47,556)**	**(30,229)**	**(63,774)**	**(84,956)**	**(30,930)**	**(56,295)**	**(41,111)**	**(354,851)**
Remove capital donations/grants							(3,914)	**(3,914)**
Surplus / (Deficit)	**(46,355)**	**(29,173)**	**(63,497)**	**(84,225)**	**(29,126)**	**(53,090)**	**271,026**	**(34,440)**

Table 7: Funded Establishments

Divisional Budgets	Clinical Support WTE	Integrated Care WTE	Medical WTE	Surgical WTE	Estates, Facilities & PFI WTE	Corporate WTE	Other Management WTE	Total WTE
Establishment								
AHPs	88.50	259.46	0.74	17.13	-	1.63	2.25	**369.71**
Clerical <=Band 5	109.99	57.36	122.75	167.53	27.44	188.05	1.40	**674.52**
Directors & Sen. Managers =>B8	5.96	6.18	4.00	6.04	4.00	50.59	0.30	**77.07**
Managers/Technical >Band 5	3.50	1.96	4.60	5.46	5.64	64.53	2.50	**88.19**
Medical & Dental	34.65	0.80	166.17	240.60	-	9.84	14.17	**466.23**
Nurses & Midwives	93.72	261.75	549.12	687.24	34.41	41.81	71.99	**1,740.04**
Other Pay	-	-	0.67	-	4.00	-	-	**4.67**
Pharmacists	23.19	0.30	1.00	-	-	2.00	-	**26.49**
Professional, Technical, Scien	181.04	4.12	26.29	41.38	-	1.73	0.50	**255.06**
Establishment (WTE)	**540.55**	**591.93**	**875.34**	**1,165.38**	**75.49**	**360.18**	**93.11**	**3,701.98**

**Budgeted establishments issued on the 30th April2024. Some budgets remain in reserves and are therefore not issued, such as CDC, until WTE have been confirmed. Hence slight difference with table 3.*

Capital and Cash

- **Capital Planning**: Our headline allocation remains consistent with last year at £4.5m which is both significantly below the level we have been able to invest over recent years, and our anticipated requirement. Our allocation is also now lagging behind the level of depreciation that we are charging to revenue, effectively meaning cash designed to be available for replacement of assets cannot be fully utilised as there is insufficient resource limit cover. This has been flagged to NHSE by the ICS.

  There remains limited availability of capital outside of these allocations, other than for targeted national programmes such as Community Diagnostics Centre and Frontline Digitalisation. An initial prioritisation process was undertaken to develop the planned capital programme. This will now be refined through the existing internal processes to allow the programmes to commence. Table 8 shows the summarised capital programme for 2024/25. In addition the Trust anticipates the receipt of further PDC and CDEL of £2m due to delivery of Urgent Care operational targets in 2023/24. This will contribute towards the £2.9m gap in funding for ESH which was identified in the business case.

Table 8: Capital Programme

Scheme Type	System CDEL allocation £k	National Schemes - PDC £k	Donated/ grant funded £k	IFRS 16 £k	Total £k
Elective Surgical Hub	615	2,161			**2,776**
Estates Works	654			400	**1,054**
Clinical Equipment	529				**529**
ICT - Clinical Systems	415	750			**1,165**
ICT - Hardware	800				**800**
ICT - Software	52				**52**
Clinical Diagnostics Centre	1,408	11,352			**12,760**
Donated assets			273		**273**
Integrated Energy Scheme			10,972		**10,972**
Vehicles and Transport				10	**10**
Total	**4,473**	**14,263**	**11,245**	**410**	**30,391**

- **Cash - revenue**: During 2023/24 we have required revenue cash support due to the deficit position. Given the projected deficit position for 2024/25, availability of cash will clearly present an increased risk which will require close management. To date there has been a national process to facilitate access to revenue cash for organisations with a cash shortfall, which is expected to continue into 2024/25. Our plans show a revenue cash support requirement of £28m this year, based on delivery of the £34.4m deficit. We have already made the first application for 2024/25 to draw down cash support in June. We will continue to ensure the relevant documentation and evidence is in place to support further applications throughout the year.

- **Cash – capital:** The planned sources of capital cash as set out in table 9.

Table 9 - Capital funding sources

Funding Source	System CDEL allocation £k	National Schemes - PDC £k	Donated/ grant funded £k	IFRS 16 £k	Total £k
Internal funding (depreciation less liability repayments)	255				255
Cash - Other	274				274
PDC - system capital support	1,921				1,921
PDC cash unspent from 23/24	2,023				2,023
PDC - Central Programmes		14,263			14,263
Income from grants/ donations			4,275		4,275
Carry forward of Grant income received in 23/24			6,970		6,970
Total	4,473	14,263	11,245	0	29,981
IFRS16 lease additions (non-cash)				410	410
Total Capital Funding Sources	**4,473**	**14,263**	**11,245**	**410**	**30,391**

The Trust's first call on its internal funding (depreciation) is capital liability repayments for the PFI and leases. In line with all NHS bodies, the Trust adopted IFRS16 liability re-measurements in 2023/24 which significantly increased both the PFI liability value and the associated liability repayments. The internal funding left to support the capital programme has therefore significantly decreased. The amount available in 2024/25 is shown in table 10.

Table 10 - Capital internal funding

Internal funding calculation	**£k**
Depreciation	14,030
Less: PFI liability repayments	(11,979)
Less: lease liability repayments	(1,796)
Internal funding (depreciation less liability repayments)	**255**

Next Steps

The plan reflects an ambitious yet credible position based on the assumptions made, and as has been set out above is not without risk. Given the system deficit, we are anticipating a further review and resubmission exercise, and continue to seek potential mitigations. Any subsequent updates will be provided to future Board meetings.

Recommendations

The Board are asked to:

- Note progress since the previous planning briefing in January 2024;
- Ratify the approval of the financial plan which was necessarily submitted under delegated authority due to timing; and
- Note that the plan may be subject to further change aligned to the national process.

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Herefordshire and Worcestershire - NHS Five Year Joint Forward Plan update for 2024/25
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	ICB Board
Lead Executive Director:	**Chief Strategy Officer**
Author:	Ali Roberts, Associate Director, System Development & Strategy, H&W ICB
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

Mandatory national NHS guidance requires NHS Partners to produce a Five Year Joint Forward Plan (JFP) to outline how NHS Partners will contribute to the delivery of the ICS Strategy and the JLHWS. The JFP must also outline how NHS Partners plan to meet mandatory national requirements in the NHS Long Term Plan and any other operational priorities determined which are determined annually. In July 2023 NHS Partners in H&W developed and agreed the first NHS Joint Forward Plan (JFP), this can be found here https://www.hwics.org.uk/priorities/nhs-joint-forward-plan The development process has enabled local partners to create a document that is jointly and equally owned by all six of the major NHS bodies across the ICS area.

The refreshed JFP focuses on developments priorities based on delivery during 2023/24. There are no significant revisions or changes of direction. The plan has been developed with system partners and is aligned with 2024/25 operational planning priorities.

Original NHS England guidance on updating JFPs required ICSs to publish refreshed plans by 31 March each year. However, due to the delay in the publication of the operational planning guidance for 2024/25, the publication timeline has been delayed to the end of June 2024. This allows for formal board endorsement for the updated JFP.

Structure of the Joint Forward Plan

Effectively the plan should addresses all services within the scope of the ICB's statutory duties and system priorities for NHS partners. This results in a very comprehensive document. To make the plan easily navigable for readers, it has been structured in the following way:

Section	Pages	Focus
Main document	30	The main drive of the plan is about outlining the NHS intention to drive a shift toward more focus on prevention and, when treatment/care is required, it is provided in the best value care setting. Best value care is defined within the plan as the setting that achieves the right balance between clinical need and optimal cost.
Appendix 1	35	This outlines the detailed plans for individual NHS service areas such as urgent care, cancer services, stroke, primary care, mental health etc.
Appendix 2	21	This covers cross cutting themes (such as digital, personalised care, prevention etc) that impact on all NHS service areas and strategic developments such as place-based working and collaboration between NHS providers.

Appendix 3	5	This covers a number of checklists to demonstrate how the JFP addresses specific areas. This includes a specific page cross referencing JFP actions to the priority areas set out in the JLWHS for Worcestershire.

Development of the 2024 draft JFP

A working group of the strategy directors across NHS and Primary Care organisations has overseen the approach to developing the JFP for 2024, in line with the group overseeing operational planning, due to the integrated nature of strategic and operational planning.

The ICB Board for H&W approved this version at their public board meeting on the 15th May 2024. The main changes between the original publication in June 2023 and this refresh are:

Main document:

- Updates to leadership including the Foundation Group model.
- Latest statistics and updated priorities in workforce section.
- Addition of 2024/25 programme Best Use of Resources and Benefits Realisation.
- Update to 2023/24 Point Prevalence Audit results and incorporation of the Demand and Capacity modelling work.
- Updated section on Population Health Management approach added to main section, noting role in delivering left shift.
- Finalised summary of overall delivery during 2023/24.
- Updates to 2024/25 performance trajectories in line with national operational planning guidance when published.

Appendix 1,2 and 3:

- Summary of 2023/24 delivery added to each section.
- Priorities and actions updated to reflect the rolling 5-year period.
- Governance and ownership updated, including additional delegated services.

The 2024/25 NHS financial plan is still draft and therefore the finance section will be updated in due course.
Whilst a draft plan has been submitted to NHS England as part of the operational planning process, it has not yet been accepted and further amendments are required. The Joint Forward Plan will be updated to reflect the final accepted plan in due course. Any other section of the JFP that is materially affected by the final financial plan will also be reviewed and refreshed in line with the final submission. It is anticipated that this may result in new risks being identified regarding performance standards and delivery trajectories.

2. Recommendation(s)

The Board is asked to approve the updated JFP (attached as Appendix 1), ahead of its publication in June subject to approval of the finance section, under delegated authority of the Board, by the Chief Executive.

3. Executive Director Opinion[1]
The JFP has been refreshed by strategy teams across the ICS and reflects the work of system, Group and the One Herefordshire Partnership at Place. The following actions will be taken in advance of publication by the 30th June 2024: • Updates to the financial trajectories in the main document when agreed. • Public and workforce focused summary developed.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☒ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☒ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☒ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☒ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☒ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☒ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☒ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☒ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☒ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☒ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☒ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☒ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☒ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☒ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☒ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☒ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

[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.

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice

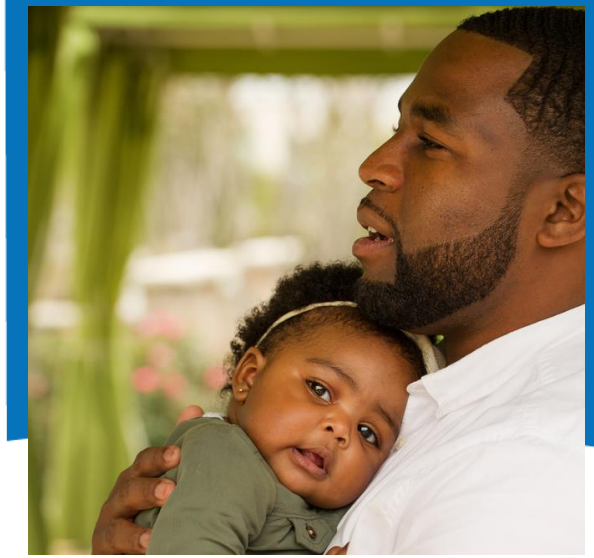
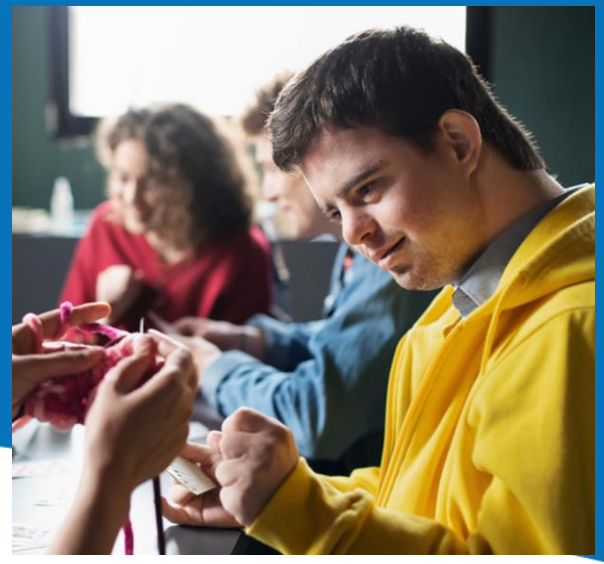
GENERAL PRACTICE WORCESTERSHIRE

NHS Wye Valley NHS Trust

NHS Herefordshire and Worcestershire Health and Care NHS Trust

NHS Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire and Worcestershire

Driving the shift upstream to more prevention and best value care in the right setting

NHS Five Year Joint Forward Plan 2024/25 – 2028/29

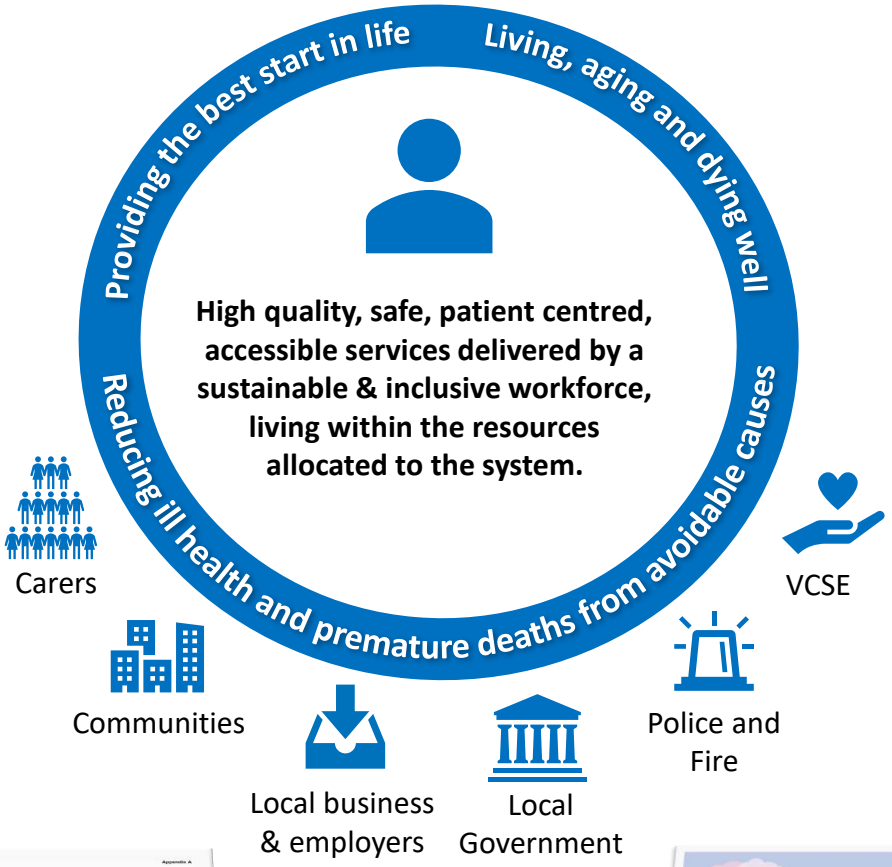
Final draft: 22ND May 2024

The strategic intent of the Joint Forward Plan……..on a single page.

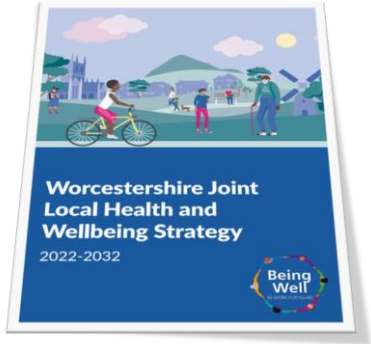
Driving the shift upstream to more prevention and best value care in the right setting

More focus on:

- **Self-care and independence**, enabling all people to look after their own health
- Promoting healthy behaviours which **reduce, delay and prevent** ill health
- **Co-production, personalised care and support**, meeting the needs of individuals
- **Population health management** and better use of data to target efforts
- **Sustainability of services,** and delivery of the right care models



Outlining the NHS contribution to the two Joint Local Health and Wellbeing Strategies.



Enabling reduction in:

- **Healthcare inequalities** – unequal access, outcomes and experience
- Days people spend in the **wrong care setting**
- The time spent **waiting** to access healthcare
- **Inefficient use of resources** and financial deficits
- **Avoidable pressures** on services
- People experiencing **digital exclusion**

Contents and navigating the Joint Forward Plan

Introduction to the Joint Forward Plan

This, the second Joint Forward Plan for Herefordshire and Worcestershire has been produced by NHS Partners across Herefordshire and Worcestershire. It describes the shared priorities that partners will collectively work on over the next five years. in response to the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies. The strategic intent is to collectively drive the shift upstream to more prevention and achieve best value care in the right setting.

We would like to thank the two Health and wellbeing boards for supporting the plan and recognising its contribution to delivering the two Joint Local Health and Wellbeing strategies. We will continue to work together to enable good health and wellbeing for the people of Herefordshire and Worcestershire.

As representatives of NHS partners in Herefordshire and Worcestershire we endorse the plan on behalf of our organisations, recognising our role in delivering the priorities within it.

Russell Hardy - Chair
Foundation group partner organisations

Crishni Waring - Chair
NHS H&W ICB

Mark Yates - Chair
H & W Health and Care NHS Trust

Dr Nikki Burger
On behalf of Worcestershire General Practice

Dr Nigel Fraser
On behalf of Herefordshire General Practice

Opinion of Herefordshire Health and Wellbeing Board

The Herefordshire Health and Wellbeing Board are committed to improving the health of our local communities and tackling health inequalities. We recognise the value of working with all our partners, and that our communities need to be at the heart of how we work differently to empower individuals and reduce demand across health and social care.

The NHS Five Year Joint Forward Plan provides a key delivery mechanism for achieving our ambitions as set out in the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategy, recognising the importance of prevention and the wider factors that affect the health and wellbeing of our residents.

Councillor Carole Gandy
Chair of Herefordshire Health and Wellbeing Board

Opinion of Worcestershire Health and Wellbeing Board

As partners we are engaged on a common mission. As such, the Integrated Care Strategy, Worcestershire's Joint Local Health and Wellbeing Strategy and this NHS Five Year Joint Forward Plan are well aligned to drive greater integrated working, address health inequalities and importantly, focus on prevention. Promoting good health and preventing people becoming unwell, or escalation where illness occurs, is key to reducing dependency on our health and social care system.

The Health and Wellbeing Board has focused its strategy on good mental health and wellbeing, supported by action on the wider determinants of health. The Joint Forward Plan clearly demonstrates intent to address this priority, through partnership working at county and district collaborative level. NHS partners recognise the inextricable links between the diverse range of social, economic and environmental factors influencing our health, and commit to work together across our system to address these in order to improve health outcomes.

Councillor David Ross,
Chair of Worcestershire Health and Wellbeing Board

Introduction to the Joint Forward Plan

The mandatory requirements for the JFP

- The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP).
- As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the Integrated Care Strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments.
- As such, the JFP provides a bridge between the ambitions described in the Integrated Care Strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions.
- Systems have the flexibility to determine the scope of their JFP, as well as how it is developed and structured. Systems are encouraged to use the JFP to develop a delivery plan for the Integrated Care Strategy that is owned by the whole system, including Local Authorities and Voluntary Community and Social Enterprise partners.
- As a minimum though, it should describe how the ICB, its partner NHS trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services.
- This should include delivery of universal NHS commitments and address the four core purposes of ICS.
- The guidance that systems are required to follow sets out 3 principles for Joint Forward Plans:

Principle 1	Principle 2	Principle 3
Fully aligned with the wider system partnership's ambitions.	Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.	Delivery focused, including specific objectives, trajectories and milestones as appropriate.

Appendix 3 sets out the detailed requirements and the system response to those.

The planning framework within which the JFP is set

The Health and Care Act 2022 put **Integrated Care Systems (ICS)** on a statutory footing and has provided the opportunity for local partners across the NHS, Local Government and the Voluntary Community and Social Enterprise to work in a more integrated way in the pursuit of better outcomes for local people.

The act established **Integrated Care Boards (ICB)** and required ICBs to come together with Local Authorities that provide public health and social care functions to form an **Integrated Care Partnership (ICP)**. The core purpose of the ICP is to provide a platform for local partners to come together to agree and **Integrated Care Strategy** for the whole ICS area, addressing the 4 core purposes of ICSs:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The **Integrated Care Strategy** aligns to the two **Joint Local Health and Wellbeing Strategies (JLHWS)** in the ICS area, and identifies three shared priority areas, which address issues identified in the respective **Joint Strategic Needs Assessments**:

Integrated Care Strategy Shared Priorities across Herefordshire and Worcestershire		
Providing the best start in life	Living, ageing and dying well	Preventing ill health and premature death from avoidable causes

This **Joint Forward Plan (JPF)** sets out how NHS Partners will contribute to the delivery of:

- The shared priorities set out in the Integrated Care Strategy
- The priorities identified in the two Joint Local Health and Wellbeing Strategies
- National priorities for the NHS set out in the NHS Long Term Plan and mandatory national planning requirements.

The JFP will not set out new priorities; instead it will describe actions, timelines, targets and performance measures that will demonstrate the core areas of focus that NHS partners will focus on over the coming 5 years.

The JFP is the NHS contribution to ….. The Integrated Care Strategy and ……

The Integrated Care Partnership approved the system Integrated Care Strategy in April 2023. The strategy sets out the shared ambition of system partners for achieving ***Good Health and Wellbeing for Everyone*****.**

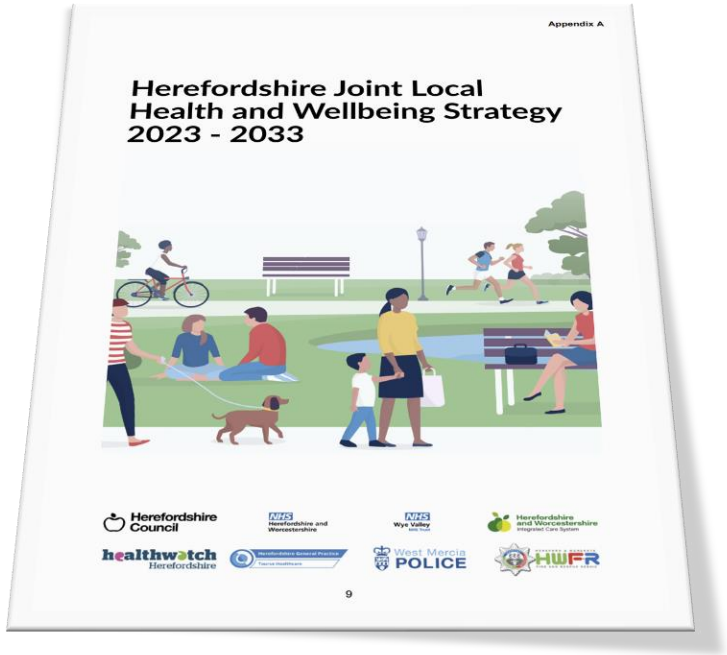
The ambition outlined in the strategy is for ***working together with people and communities to enable everybody to enjoy good physical and mental health and live independently for longer***.

Underpinning the strategy are 8 commitments that partners across the ICS have agreed as being fundamental to delivering integrated care.

The three shared priority themes and underpinning performance measures have been developed directly in response to the Joint Strategic Needs Assessments for each county and the priorities that are reflected in **Joint Local Health and Wellbeing Strategies**.

The strategic enablers bring partners together to work collectively in those areas that provide the essential platform for collaboration and working in a different way.

The JFP is the NHS contribution to ….. The two Health and Wellbeing Strategies



Herefordshire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in April 2023 and covers a 10-year period.

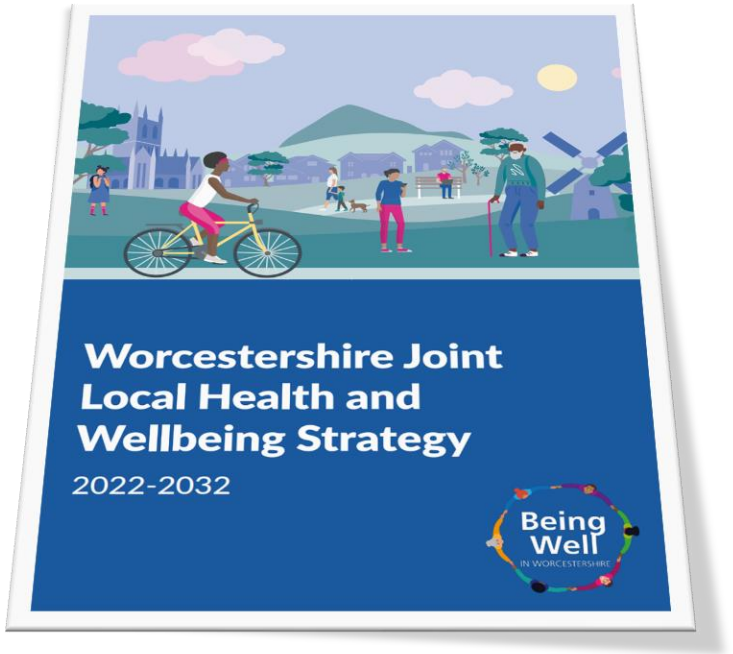
It was developed collectively by partners working together to agree a common ambition and set of priorities that were clearly identified through an extensive engagement exercise.

There is very strong alignment between the JLHWS and the Integrated Care Strategy, with both documents sharing a common vision and complementing priority areas of focus.

Worcestershire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in November 2022 and also covers a 10-year period.

Development of the strategy occurred in parallel with early work on developing the Integrated Care Strategy, which enabled strong alignment in some key areas.

Mental health runs through all three of the Integrated Care Strategy themes, mental health for children as part of the best start in life priority; good mental health through living ageing and dying well particularly focused on therapies and dementia care and reducing suicides as part of the third priority.



Herefordshire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Best start in life for children	●	●	
Good mental wellbeing throughout life	●	●	●

Worcestershire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Good mental health and wellbeing	●	●	●

● Directly aligned priorities where work led and undertaken at county level will directly deliver the Integrated Care Strategy priorities at System level

The key steps to deliver our JFP in 2024/25…

Building on what we have delivered together in the first year of our JFP there are some specific pieces of work that will drive forward the delivery of our strategic intent during 2024/25:

Driving the shift upstream to more prevention and best value care in the right setting

Developing a renewed focus on the 4th pillar of integrated care systems, **supporting broader social and economic development of the system** by developing a strategy for Social and Economic development, with a strong role in reducing health inequalities. This will take the same type of strengths-based approach as we have done in targeting recruitment into health and social care from communities where access to employment opportunities are limited by existing barriers.

Herefordshire and Worcestershire have been one of 15 systems across England to have been successful in bidding for a **grant of £2.4 million to deliver Workwell over 2 years.** This will be a service to help people with health conditions to stay in or to return to work. This will personify our commitment to help address the wider determinants of health and to support vulnerable people in our communities by using existing partnerships across the NHS and Local Authorities.

Reducing health and healthcare inequalities remains a strong focus, with the start of 2024/25 seeing the launch of our local **Health Inequalities Ambassadors programme.** This will ensure that there are named individuals shining a light on health inequalities through all programmes of work, as set out in appendix 1. A key enabler will be the development of a **Population Health Management Framework,** which will define a clear vision to engage our leadership and build a community of practice to enable us to provide access to the right data and insights and put it into the hands of those that can make a difference. A core facet of PHM is **engaging patients, service users and citizens** to understand their needs and look at how we can design services to effectively meet these needs within the resources available, improving access, outcomes, experience and reducing health inequalities.

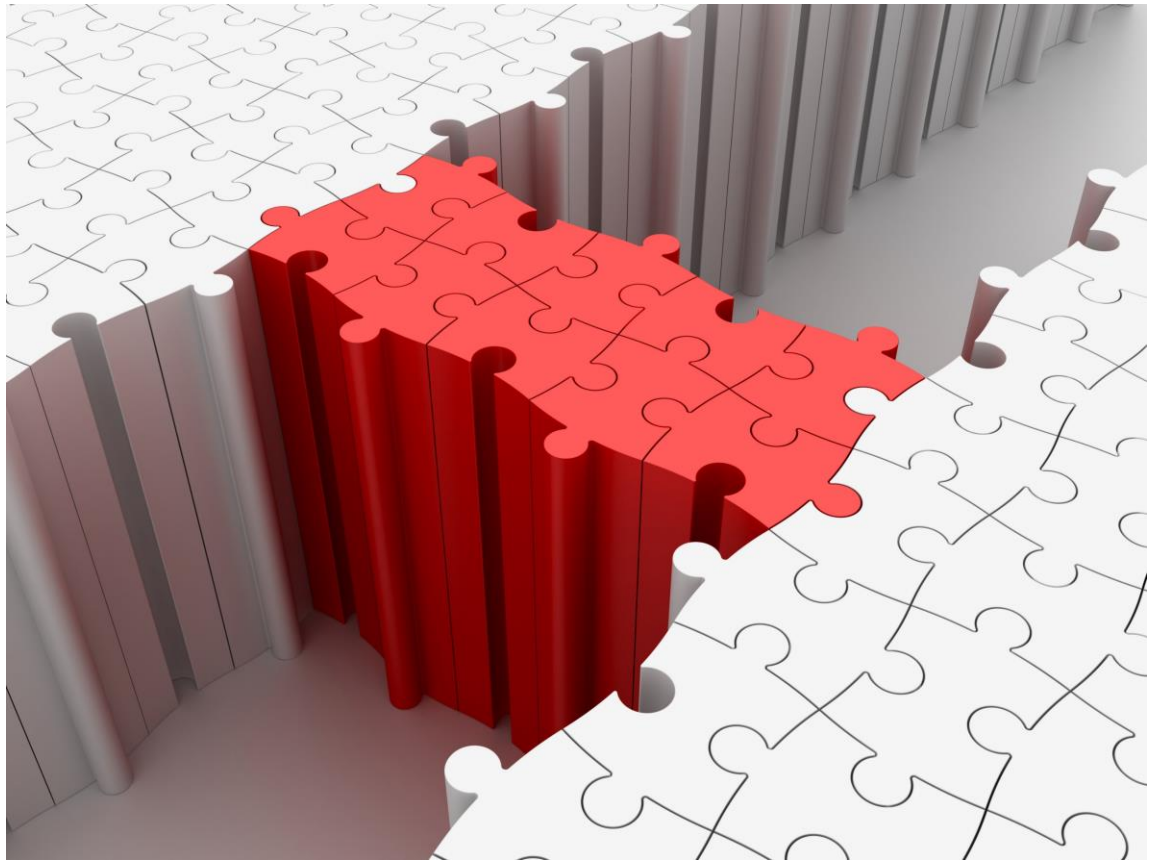
Delivering **best value care in the right setting** has been predicated on a review of demand and capacity modelling and our annual Point Prevalence Audit. This work allows us to see the progress we are making in ensuring that care is received in the best setting for local people, based on health and care needs at that point in time. We will be conducting the Point Prevalence audit again in Q3, to build our evidence base.

A significant focus for 2024/25 will be to develop an **ICS Infrastructure Strategy.** As part of an NHS Midlands pilot, health planners has been commissioned to enhance the **demand and capacity work** we have already undertaken on bed modelling by extending into the broader community estate needed to deliver health and care services to local people. To do this we will be using an Activity, Demand and Estates Planning Tool (ADEPT) to model out future estate needs based on our current estate and existing strategies and clinical priorities, as outlined in this document.

The voice of our clinical and care professionals is fundamental in delivering the commitments outlined in our plan. As we go into the second year of delivery, we will build on initiatives, such as work undertaken during 2023/24 to identify and **mitigate fragile services** earlier through provider collaboration. The next phase of this work will look more broadly at the development of clinical services across and within the ICS and developing a **Clinical Services Framework** to inform the development of the Infrastructure Strategy. This will ensure that clinical services evolve in line with our overall priorities and strategy and are high quality, sustainable in the short and long term.

Our **Best Use of Resources (BUR)** programme underpins all of this work. A three-year programme, in our operational planning, BUR will reduce demand for services, optimise cost of provision and support sustainable care models and workforce. The programme maps out the detailed work to translate commitments into operational delivery. Each initiative is reviewed through a **Benefits Realisation Frramework** to ensure delivery of expected benefits. Understanding these impacts is critical in ensuring that the right services are in place and to help improve the financial position, deliver our performance ambitions and support high quality of care is delivered through a sustainable workforce model.

The Strategic Context for the Joint Forward Plan



Strategic Context - What is working well – The first year of our joint forward plan, 2023/24

Some of the best access to GP service in England

- 76% of our patients rated their experience with general practice as 'good' – The 6th highest in the country.
- During 2023 we offered a record number of general practice appointments 5,523,033 appointments delivered, 861,000 appointments (18.5%) more than before the pandemic (GPAD 2023).
- There has been expansion of services in pharmacy, making it easier for patients to access treatment for common conditions through their local pharmacy. As it stands, 115 (98%) of our pharmacies have signed up to deliver these services via Pharmacy First Service.

Reduced waits for patients awaiting cancer diagnosis

- We achieved 75% for 28-days Faster Diagnosis in March 2024.
- We reduced 62-day backlog of patients by 39% during 2023/24 and delivered the Operational Planning target of less than 261.
- Started to implement and fully embed Best Practice Timed Pathways across all cancer pathways;
- Introduced robotic prostate surgery across the ICS reducing waiting times for surgery.
- More than 80% urgent suspected colorectal referrals are now accompanied with a FIT test to stratify higher risk referrals.

Better adult learning disability care in the community

- Learning disability annual health checks – Over 75% of 14 – 24-year-olds have had an annual health check for the first time; for the second year running, over 85% of total eligible population had an AHC (exceeding the national target by 10%), of whom 99% had a recorded health action plan.
- Reduced the use of Tier 4 beds for autistic children and Young people by 62%

Positive impact on reducing health inequalities

- Over 75% of adults with severe mental illness have had a full health check over the last 12 months, compared to (insert figure) the previous year.
- Increased awareness of bowel screening and increased uptake in bowel screening for people with a learning disability
- Reducing the number of pregnant women and inpatients in acute hospitals who smoke, with the highest proportion of people successfully quitting coming from the most deprived communities.
- development of Women's Health Hub, with a focus on reducing health inequalities

Recovering diagnostic and elective services*

- Reduced the volume of people waiting longer than 52 weeks for referral-to-treatment by 40% between April 2023 to February 2024.
- Improved day case rates to at least 85%, achieving second performing ICB nationally.
- GPs continued to effectively use Specialist Advice, with an ICS utilisation of 41%.
- Waiting times for diagnostics has remained good with the exemption of some tests and investigations, with majority of people seen within 6-weeks.

Better access to urgent and emergency care*

- Improved hospital and system flow occurred towards the end of the year, with a reduction in ambulance handover delays, improving emergency access standard for people attending emergency departments and improving category 2 average response times.

*awaiting updated March data

Strategic Context - The biggest strategic challenges that NHS partners need to address

Tackling increasing demand for health and care services

The national challenges for health and social care providers are well documented. Delayed and reduced services during the Covid-19 pandemic increased the backlog for people waiting for urgent and elective services. Overall, there has been an increase in demand and complexity of need and services are struggling to provide a positive experience with good outcomes for individuals.

At the same time the population is ageing, with over 44,000 more over 65 years olds living in Herefordshire and Worcestershire by 2031, over a quarter of the increase being over 85 years old. By 2033 there will have been a 50% increase in the number of people who are over the age of 80. Alongside this demographic growth, there will be an increase in frailty, with projections indicating that people living with the highest levels of frailty will increase by around 28% over the next 10 years.

Securing sustainable workforce and clinical models for all services

There are around 39,000 people working in health and care services across the system. Around 18,500 work in Primary and Secondary Care and 20,000 in Social Care. Turnover is slowly reducing in the sector from an all-time high post COVID. In recent years, turnover has been at 15% for staff in the NHS and 30% of staff in social care. Vacancy rates range between 8% -10%. Recruitment activity to bring more people into Healthcare and care worker roles has had a positive effect but there remain critical areas of workforce shortages in nursing, some medical specialities and social workers There are around 500 nurse vacancies across the system (400 in the NHS and 100 in Social Care) and a reliance upon international recruitment. There is also a lack of pharmacy professionals across the system, with increased numbers moving to community pharmacies.

Sickness rates are at around 5.5-6%, likely impacted by poor morale and increased workload as well as ongoing pressures from industrial action. Staff engagement remains average compared to other systems.

Workforce shortages in some specialties have resulted in increased levels of service fragility, particularly in cancer and stroke pathways. In the most extreme examples, such as haematology, emergency service changes have been needed whilst sustainable options were identified. In other instances, to fill gaps in substantive rotas and minimise risks to patients, health and care services have relied heavily on bank and agency staff.

However, with agency spend in 2023/24 being in the region of £70m and accounting for around 8% of the total workforce budget, this is not a financially sustainable solution. As well as the financial pressure it creates, it can also lead to inconsistency in care provision and poorer experiences. Partners across NHS services are working together to reduce the reliance on agency staff to reduce these risks going forward.

Demand and workforce challenges can impact the effectiveness of services to see and treat patients in a timely and clinically safe manner, negatively impacting on healthcare outcomes. Addressing the signs of vulnerability requires early identification and solution-planning with the engagement of clinicians. Subsequently proactive work to pre-emptively identify vulnerabilities has led to the system developing a fragile services framework.

Financial sustainability and optimising use of services

As a deficit financial system, there is a requirement imposed on all system partners to implement stringent productivity, efficiency and savings programmes. This requires partners to introduce rigorous cost control measures and explore options for reducing service levels to bring spending into line with financial allocations. This includes freezing any new income and halting any service developments or business cases that do not identify lower cost delivery models or have clearly identified funding streams. This downward pressure needs to be understood in the context of the system being overfunded using the national formula

In September 2023, partners replicated the study undertaken a year earlier to audit whether people were being cared for in the most appropriate care setting for their needs at the time. The study showed that just under 25% of the 1,660 people reviewed could have been cared for in a more appropriate care settings – if an optimal balance between capacity, demand and flow efficiency was achieved. There was significant variation between the two counties however, with Herefordshire's percentage being 32.6% and Worcestershire's being 21.5%.

Alongside this, the strategic demand and capacity model work suggest that without change, the system will require between an additional 365 acute beds by 2033. The upper end of this range is comparable to building new wards that are equivalent in scale to about 2/3rds the size of Hereford County Hospital. Even if the finances were available to fund such expansion, the workforce would not exist to staff it. Therefore, finding mitigating actions and alternative solutions is critical to the delivery of improved health outcomes and reduced health inequalities.

A focus on ensuring care is accessed in the right setting which means moving activity, treatment and resources towards more preventative rather than reactive treatments, as part of the solution. As will ensuring that the wider social determinants of health are addressed through effective alignment of vision, plans and effort with local authority and VCSE partners. For example, the development of the "Community Paradigm" concept and relevant application to local circumstances will be one of the key platforms for making local services both sustainable and effective in supporting improved outcomes for the population.

All partners recognize the importance of developing new and innovative solutions to these challenges. Successful implementation of existing initiatives holds part of the answer, but creating the environment and opportunity for new initiatives is equally important.

Strategic Context - Operational performance - Priorities for year 2, 2024/25

Reducing backlogs and long waits for elective care

- Eliminate waits of over 65 weeks by September 2024, except where patients choose to wait longer.
- Deliver 107% elective activity target for 2024/25
- Increase the proportion of outpatient attendances that are for first appointments or follow up appointment attracting a procedure tariff to 45.4%.

Reducing long waits for cancer care

- Meet the cancer faster diagnosis standard by March 2025 so that 77% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase the performance of the 62-day standard to a minimum 70% by March 2025 and continue to reduce the number of patients waiting longer than 62 days to start treatment.
- Supporting earlier diagnosis by implementing Targeted Lung Health Checks, liver surveillance, Non-Specific Symptoms pathway, post-menopausal bleeding pathway

Improving access to primary care services

- Reduce unnecessary GP appointments and improve patient experience by making it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Recover dental activity, improving units of dental activity towards pre-pandemic levels

Long term Plan and Transformation of services

- Development of a Women's Health Hub, aiming to improve access and experience for women, and reduce health inequalities.
- Improve access to mental health support for children and young people in line with the national ambition and increase delivery of full annual physical health checks
- Increase the number of adults and older adults completing a course of treatment for anxiety or depression via NHS Talking Therapies
- Work towards eliminating inappropriate adult acute out of area placements
- Improve access to perinatal mental health services
- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan
- Reduce reliance on inpatient care for people with a learning disability and/or autism, while improving the quality of inpatient care

Improving access to diagnostics

- Increase the percentage of patients that received a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostics waiting time ambition
- Implement one-stop clinics aligned to Community Diagnostic Centre's / alternative ways of working delivering outpatients efficiently to reduce long waits.

Reducing long waits for urgent care

- Improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025
- Improve category 2 ambulance response times to less than an average of 30 minutes across 2024/25

Strategic Context – Workforce - Creating a sustainable inclusive workforce

During the first year of our JFP, 2023/24 we have delivered

A greatly improved approach to workforce planning. Through our professional faculties, organisational joint working, improved training and greater use of data, teams have become more confident in workforce planning, understanding their baseline today and how to resolve immediate operational issues and what needs to change for the workforce of the future.

A successful year of recruitment, which has reduced the number of vacancies across the NHS. Each organisation has had their own recruitment programme and there has been a system-wide attraction programme to create a bigger pool of people from whom to recruit. This reduces competition between providers. Most of the NHS Trusts have recruited to their establishments and are now managing turnover.

Reduced turnover, through a range of mental health and wellbeing programmes across the system. A combination of retention programmes, more flexibility, stay interviews, greater development and a focus on inclusivity has led to a greater number of people choosing to stay within the NHS. This is turn makes the recruitment activity more effective as recruitment then supplements rather than replaces.

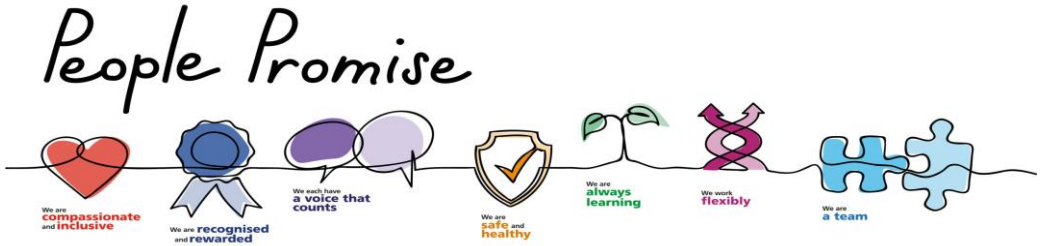
A shared vision around workforce, which is in line with the NHS Long Term Workforce Plan. Our approach to growing the pool of people available locally, growing our own skills in partnership with our local education providers, including Worcester University, retaining our staff through organisational support and crucially, being prepared to review and reform how services are delivered when workforce is not available is signed up to by NHS providers. This has translated into a shared approach to growing future nurses to mitigate against potential high levels of retirement over the next five years. It also means that organisations are working together to maximise the potential of the new Three Counties Medical School.

Our joint learning and collaboration environment through the ICS Academy. The Academy brings together professional groups who understand their own workforce locally and decide how to further develop them and bring on those with the highest potential. It also hosts a learning management system which enables all system partners to access the same training and development, including the highly successful Oliver McGowan autism training and a range of leadership interventions.

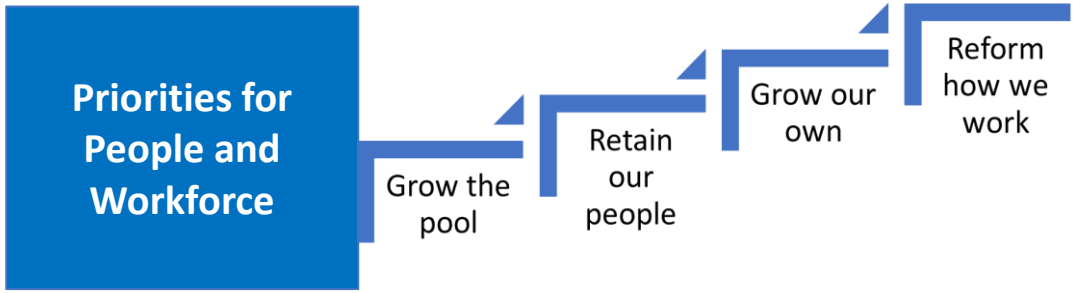
Reformed services. Working with clinical and operational leads, organisational development experts have helped to our experts to understand their workforce challenges and reimagine how services can be delivered. This has created changes in the way in which some of our most fragile services are provided to patients and residents and has made use of new roles in some services, such as Advanced Clinical Practitioners.

Across Herefordshire and Worcestershire, NHS providers come together to determine our collective focus under the banner “Better Done Together”.

The quality of the care provided across the NHS is dependent upon having the right number of people, with the right skills in the right places and ensuring that all of our people feel supported, included and developed. The NHS has therefore committed to a People Promise which describes the type of culture that we want to have:



Each NHS provider has a people plan which aligns to the NHS People Promise and a number of workstreams to ensure that this culture thrives within their organisations. The annual Staff Survey provides a measure as to the success of these workstreams.



This is underpinned by the establishment of an ICS Academy which brings together functional groups to discuss their workforce needs (known as faculties) including for Medical, Nursing and Midwifery, Healthcare Science, Pharmacy, Allied Health Professionals, Voluntary Community Social Enterprise Sector and the Social Care Sector. The Academy also provides some learning and development across all organisations within the system.

Strategic Context – Workforce – Growing the pool

The ICS strategy is to grow-your–own skills wherever possible, particularly in entry level roles and Nursing and Allied Health Professional roles, encouraging local people to stay within the system and develop their career here. There is a differentiated approach to attracting and recruiting into the system, depending upon the types of skills that we require.

Targeted attraction and recruitment of Health Care Assistants, Health Care Support Workers and Care Workers through marketing and promotional material provides a pool of potential future nurses, Allied Health Professionals and other roles in short supply, which can be developed through the use of apprenticeships. It also reduces reliance upon agency staff.

Job fairs, working with Job Centres and greater marketing about the types of roles available to people within the NHS is enabling us to attract people into NHS roles today. Here, we advertise the immediate roles available across a host of different skill sets, as well as the potential opportunities for the future, so that people understand that they are getting a job now and a career for the long-term.

Outreach to schools, discussions with university students, careers fairs and a greater focus on work experience and placements starts to establish a future pipeline of people who will want to join the NHS in the future.

There are different approaches being developed towards the attraction and recruitment of medics as these skills take longer to develop and are less easy to grow through apprenticeships. More targeted recruitment and personal relationships play a huge part in bringing medical skills to our system.

International recruitment remains part of our approach to bringing in fresh skills and ensuring a great pastoral experience is a key area of focus. We aim to bring down our overall reliance on this route, in line with the NHS Long Term Workforce Plan.

Medical Staff	Clinical Support	Nursing and Midwifery
• Vacancies being covered by medical locums in the short term. Limited international recruitment. Longer term, attract more graduates to the area and grow-your-own with the opening of the Three Counties Medical School in Worcester University. • Medical 'faculty' work together with TCMS to increase the number of trainees across the system. • Working with Worcester University to increase the number of medical student places available and support local people enrolling into these. • Greater use of physician associates. (Increase by 5% by Y3) • Greater use of Advanced Clinical Practitioners (20% by Y3)	• Growing numbers of Health Care Assistants and Health Care Support Workers through greater outreach. (Bring NHS vacancy rate to 5%) • Promotional material to attract those New to Care including online presence. • A range of recruitment events including physical and online career fairs. (Clear demonstration that recruitment events bring in new staff) • Work with schools and further education to bring more people into the NHS through placements. (Increased placement numbers) • Clarity of development offers available to everyone. (Development pages on ICS Academy intranet launched)	• Vacancies being covered by agency nurses in the short term, international recruitment of nurses in the medium term and a longer-term strategy of 'grow-your-own' nurses through apprenticeships for nurses and nurse associates. (System agreement to develop 100 nurses per annum. Significantly reduce agency spend within 3 years) • Establishment of a nursing and midwifery 'faculty' (workforce group) designed to look at the highest risks to the function. • A nurse retention programme in development to retain skills. (Net nurse numbers begin to increase) • Work ongoing with the Nursing school in Worcester University to offer more placements and ensure more graduates opt to stay in Herefordshire and Worcestershire. (Increased numbers joining NHS from University) • Greater use of Advanced Nurse Practitioners (target in development)

Strategic Context – Workforce – Retaining People

Healthcare is a rewarding career but it can be stressful. Sickness and turnover has been high since COVID and is only now starting to reduce. For 23/24, NHS Trust providers are anticipating circa 13% turnover which has reduced slightly from last year. Sickness sits at around 6%. Managing these numbers down is a critical part of retention.

Exit interview data and HR theory is clear that people want to feel that their wellbeing is supported, they have career opportunities to progress, they have good relationships with their line managers and that they feel a sense of belonging. Pay and reward are of course important factors but where the above is in place, they become slightly less pivotal.

Retention activities are therefore built around ensuring that these things are in place. Reducing sickness through strong Occupational Health Support and providing quick access to Wellbeing support for staff provides the basic cornerstone of retention. Offering plenty of development opportunities to move around in one's career and working with leaders and line managers to improve their capability means that people feel valued and empowered by their managers.

Work around the staff survey and engagement mean as part of creating an Inclusion and EDI strategy mean that everyone, regardless of their background feels that they form an important part of the organisations in which they work. Through the work of the faculties and understanding key operational risks, these interventions will be targeted where they are likely to make the biggest difference.

The ICS Academy (launched in April 2023) provides a virtual meeting place for system people discussions and training and will act as a key retention tool.

Activities to deliver this include:

- A joint system Occupational Health offer designed to act quickly to keep people in work. (Joint approach agreed by end of calendar year)
- A joint talent and leadership development offer, available to all providers at ICS Academy, linked to career conversations and pathways (available by end calendar year)
- Developing a Belonging and EDI Strategy which brings together staff networks, ensuring everyone feels that they have representation. (May 2024)
- Joined up Freedom to Speak Up Champions networks, which develop joint learning and feedback for the system (End March 2025)
- Pastoral support for international recruits (underway)
- Greater joint planning off the back of the staff surveys (end calendar year)

Strategic Context – Workforce – Growing our Own and Reforming Services

Growing our Own

While we will continue to attract people into our system as much as possible, our rurality will always present some challenges alongside the opportunities of being a beautiful place to live and work.

We therefore will focus on growing our own skills, offering job opportunities and long term careers for those that want to work within our system. The coming together of the organisations across the system offers a far wider range of options for people and an eco-system that they can move around in, while knowing that the experience that they gain will continue to benefit the sector locally.

Through offering a greater range of development opportunities for our various professions, developing educational links with further and higher education providers, creating more placements for the new Three Counties Medical School in Worcester University and making it easier for people to move around our organisations, we are creating an environment where Herefordshire and Worcestershire is a wonderful place to come and learn and grow.

The establishment of our apprenticeship hub, which brings together system apprenticeship leads enables us to practically understand how we are prioritising our organisational levies and target these at the system risk areas. A case in point is the system approach to developing more nurses through the trainee nurse associate and registered nurse apprenticeship route.

Activities to deliver this include:

- The development of a system-wide grow our own nurse programme which enables all organisations to access funding to develop a greater number of trainee and fully registered nurses.
- Greater range of placements across the system including in the VCSE and Social Care Sectors.
- Development of innovative new roles, drawing upon clinical knowledge. This includes new apprenticeships, Physician Associate roles, Nurse Associate roles, greater use of Advanced Clinical Practitioners and Healthcare scientists.
- Development of career pathways by profession.

Reforming Services

While we can act quickly to bring in some of the skills we need, there are others that are so scarce nationally or take so long to grow that we must instead think differently about how we deliver our services. Making greater use of digital tools must also drive reform of services for the patient or user.

Providing organisational design and development expertise to clinicians and operational colleagues to think differently about the delivery of services is our approach to reimagining how services might be provided. This is supported with ongoing workforce planner business partnering to each service pathway so that when workforce is identified as a risk, they are able to help the service to consider how else it might continue to deliver.

Enhanced digital and workforce partnerships will provide real enablers of change, ensuring a user-centred design approach to transforming services and ensuring that people feel able to deliver the changes needed.

Activities to deliver this include:

- Developing workforce planning capability across the NHS through a transformation programme focussed on reviewing public health data for service pathways.
- The development of the faculties in workforce planning and consideration of public health data for their function.
- Deeper understanding of the operational workforce risks by service line using the STAR framework approach and how to mitigate those in the short and long term.
- The development of more integrates, cross-organsiational / systemwide roles where appropriate.
- Focussed work on converting high agency spend into longer term sustainable workforce through the use of apprenticeships, new roles and digital solutions.
- Aligning digital and data with people and workforce to increase the digital capability of staff, enabling them to be more open to future digitalisation of services.

Strategic Context – Finance - The financial history and financial plan for 2024/25

Actual Spending V Formula Allocated to Herefordshire and Worcestershire

Prior to the pandemic the system was under-funded against target using the national funding formula. The closing distance from target in 2019/20 for the 4 CCGs in the ICS area was -3.52%, equivalent to £35m. Any overspends against this allocation were funded using non-recurrent funding sources.

During the pandemic costs were fully funded and system baselines were reset at actual spend levels. In essence, process resulted in historic overspends being incorporated into financial baselines and resulted in a significant change to the base funding level for H&W ICS.

Going into 24/25 this the system is now overfunded against target using the national funding formula by around 3.9%, a slight reduction on the previous year of 4.6%.

Change in spending pattern in recent years

Growth in spend over this period was seen in all areas, with the exception of running costs. Whilst the greatest value was seen in acute services, similar percentages were seen across other areas - most notably the large increase in continuing care. The relatively smaller increases in community services and primary care are not consistent with our forward-looking ambitions around a shift upstream to more prevention, providing care in the right setting to reduce pressure on services further downstream – such as acute care. The ambition over the life of the Joint Forward Plan is to address this imbalance going forward.

Spend Area	19/20	24/25 Plan	Increase	
Acute	£559.2m	TBC	TBC	TBC
Mental health	£110.5m	TBC	TBC	TBC
Community Services	£130.0m	TBC	TBC	TBC
Continuing Care	£68.0m	TBC	TBC	TBC
Primary Care	£147.1m	TBC	TBC	TBC
Primary Care Prescribing	£125.6m	TBC	TBC	TBC
Running costs	£16.3m	TBC	TBC	TBC

The 23/24 financial outturn

The original financial plan for 2023/24 was for a £19.2m deficit. However, during the year, like in many other Integrated Care Systems, a number of financial risks materialised and new issues emerged. Combined, these created a more challenging financial environment than foreseen at the start of the year. In the end of the system financial outturn was a deficit of £44.8m.

The Plan for 2024/25

The 2024/25 NHS financial plan is still draft and therefore this section will be updated in due course.

Whilst a draft plan has been submitted to NHS England as part of the operational planning process, it has not yet been accepted and further amendments are required. The Joint Forward Plan will be updated to reflect the final accepted plan in due course. Any other section of the JFP that is materially affected by the final financial plan will also be reviewed and refreshed in line with the final submission. It is anticipated that this may result in new risks being identified regarding performance standards and delivery trajectories.

Spend Area	Integrated Care Board	Worcs Acute	Health and Care Trust	Wye Valley	ICS Total
23/24 plan	+£0.2m	£0.0m	+£2.9m	-£22.3m	-£19.2m
23/24 out-turn (deficit)	+£0.4m	-£34.7m	+£2.9m	-£13.4m	-£44.8m
24/25 plan (deficit)	TBC	TBC	TBC	TBC	TBC
Delivery Plan Requirements for 24/25					
Efficiency savings	TBC	TBC	TBC	TBC	TBC
% efficiency saving	TBC	TBC	TBC	TBC	TBC
Trust Agency expenditure	TBC	TBC	TBC	TBC	TBC
% of Staffing Cost	TBC	TBC	TBC	TBC	TBC

Strategic Context – Finance – Best use of resources and benefits realisation

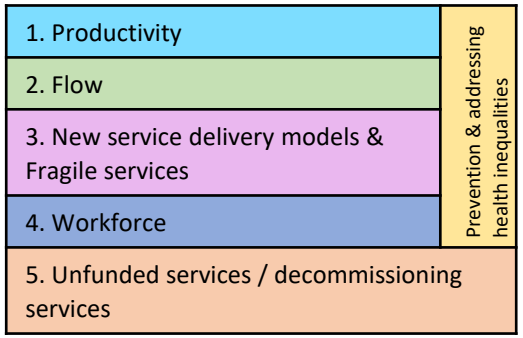
Herefordshire and Worcestershire health and care partner organisations work together each year to develop a local operational plan that meets strategic and financial objectives as well as delivering the right services for our population. In 2023/24, the ICS started the process earlier to allow more time to plan ahead for the coming 2024/25 financial year. This has enabled teams that contribute to this process to better understand how the planning process fits within the work they do, how it feeds into organisational priorities and how these deliver the Joint Forward Plan and Integrated Care System Strategy.

Best use of resources

This three-year work programme has emerged from the operational planning work that has been undertaken during 2023/24 to understand the **existing** and **new** interventions or initiatives that will tackle the priority areas we are trying to address, which can be summarised as:

- Reducing demand for services
- Optimising cost of provision
- Achieving sustainable care models and workforce

The Best Use of Resources work programme has 5 areas of focus, with a cross-cutting theme:



Work has been undertaken to determine the expected delivery status during 2024/25 and future years.

New Investment Standards

A number of new Investment Standards have also been developed for 2024/25 to support the Best Use of Resources programme:

- Children's Investment Standard
- Best Value Care in the Right Setting or "Left shift"
- Prevention and addressing Health Inequalities
- Virtual Wards
- Growing our own nursing workforce

It is anticipated that any investment will deliver cashable savings rather than cost avoidance and will require a quantified return on investment.

Benefits realisation

A benefits realisation framework has been developed to ensure that each intervention or initiative impact can be quantified from an activity & performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

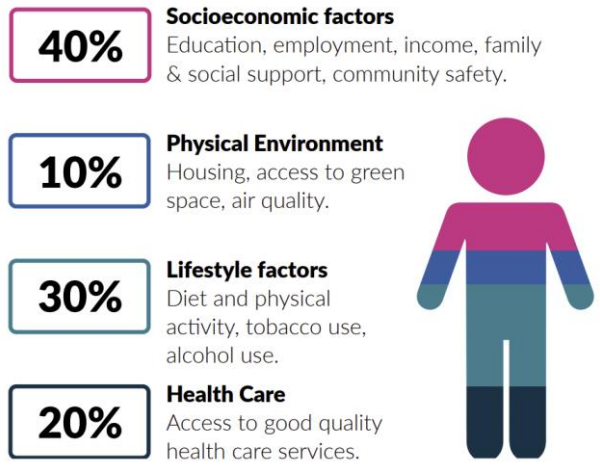
The core focus

Driving the shift upstream to more prevention and best value care in the right setting

What do we mean by driving the shift upstream to more prevention and best value care in the right setting?

A greater focus on prevention

The major focus of the JFP is on driving a shift to a model of healthcare that places greater emphasis on the **importance of preventing ill-health** rather than a focus on treating the symptoms of it. The NHS cannot achieve this by working in isolation only through effective partnership working and good engagement with communities. This is the emphasis of the Health and Wellbeing Strategies and the Integrated Care Strategy. The core focus of NHS partners in this JFP is on the "20%" of factors that contribute to people's health and wellbeing outcomes (as per the diagram right).



Adapted from an illustration of the impact of healthcare and non-healthcare factors on a person's health. Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014).

Whilst it is not the core business of the NHS to focus on the wider determinants of health, such as education, employment, housing and environment, as a major employer of around 2.5% of the local population (circa 20,000 employees), many of whom live in the ICS area, NHS bodies clearly have an important role to play and contribution to make.

The focus of this plan though is on the core business of the NHS, which is the provision of services. Through implementation of this plan, there will be a drive through planning and resource allocation approaches over time that increasingly rebalance the prevention v treatment equation:

During the early phases of implementation, the service areas outlined in appendix one, through their respective programme boards, will be charged with the task of identifying what specific actions can be implemented to contribute towards this overall ambition.

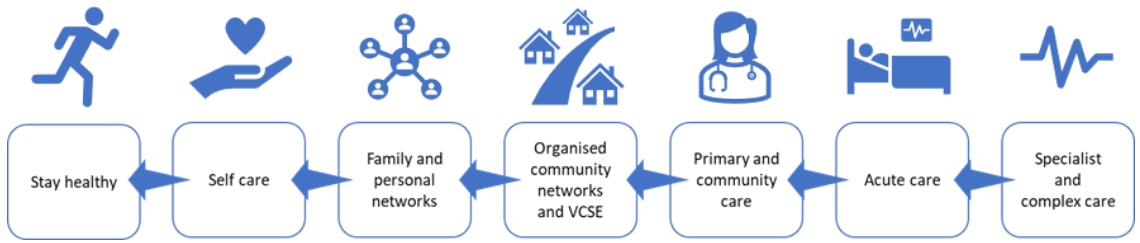
This ambition will also be incorporated in the medium-term financial strategy, which will be developed during Q2 of year 1, to be published by September 2023.

Providing best value care in the right setting

The role of the NHS is to provide care and treatment for people when they need it. The second element of shift in focus is on ensuring that the care is provided in the most optimal setting for the person's needs at any given point in time. Optimal represents the balance between quality, safety, appropriateness of setting and best cost care. Optimal is not just about cost reduction and financial savings, although savings are a clear beneficial by-product of getting optimal care.

Achieving optimal care settings will typically result in faster recovery from illness and a greater chance of return to independence. For example, a co-produced document called *"Supporting patients' choices to avoid long hospital stays"* highlighted that people's physical & mental ability and independence can decline if they are spending time in a hospital bed unnecessarily. As well as being at risk of acquiring hospital acquired infections, for people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Thus, there is a significant quality and service improvement benefit to be achieved by getting this right.

Providing care in the optimal setting requires NHS partners to work together to deliver more care towards the left-hand side of the spectrum below.

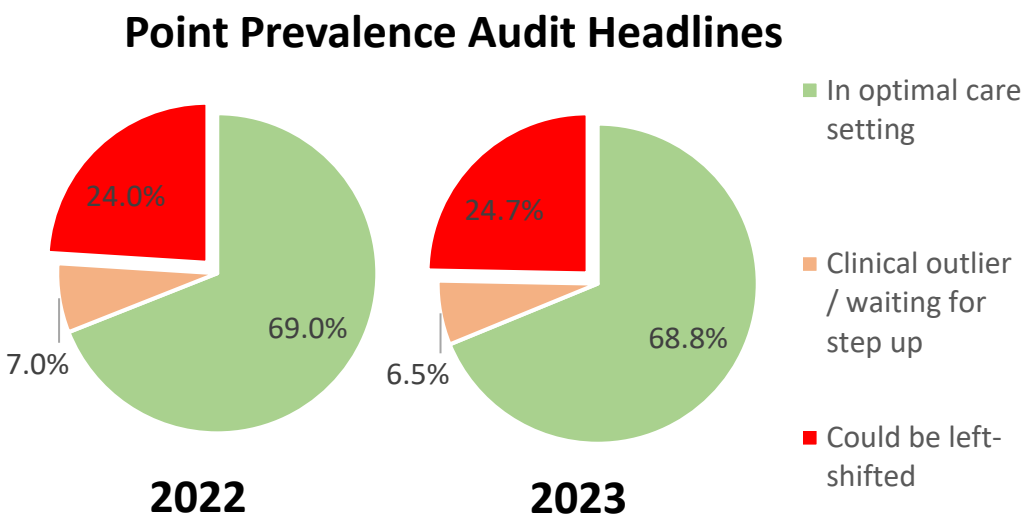


The Point Prevalence Audit we undertook in September 2022 identified that, at the time of the audit, 24% of people could be cared for further along towards the left-hand side of the diagram above. The financial opportunity associated with this cohort, if scaled up annually, was in the region of £12 to £15m, even taking account of the need for the additional capacity required to accommodate them in the other setting. Alongside the quality improvements, the opportunity to achieve this shift in focus is therefore very compelling.

Understanding the issues and opportunities around "optimal care settings" – The Point Prevalence Audit

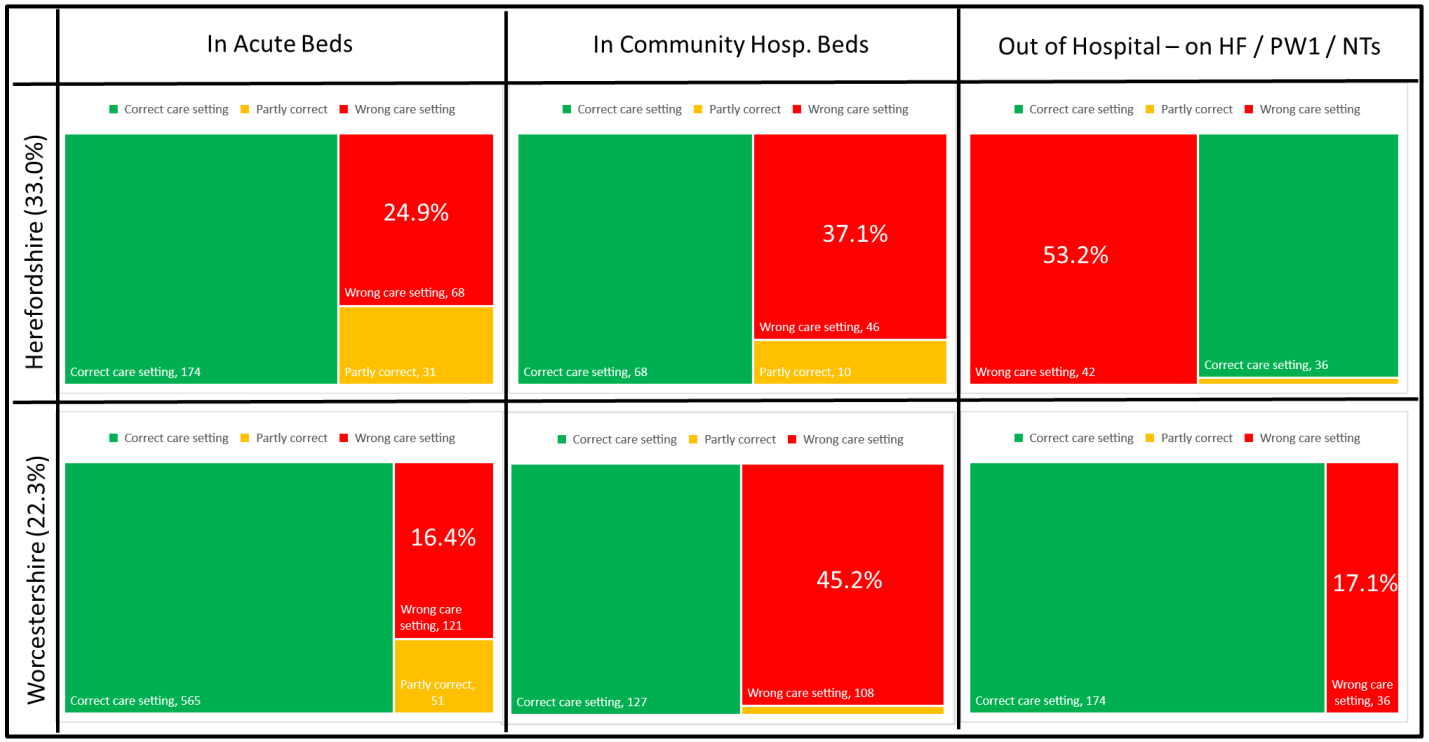
The Point Prevalence Audit

In September 2023 the system wide **Point Prevalence Audit** was conducted to assess the extent to which people in the health and care system are cared for in the most optimal care setting for their needs at the time. The audit, which replicated the method from a year before looked at 1,660 people across 88 care settings – including acute beds, community beds, discharge pathways and other home-based care such as community teams and virtual wards. The study showed that around 69% were in the right care setting, 7% were clinical outliers or waiting for "step-up" care, but 24% could have been cared for in a lower level of care, that would have been more optimal for their needs.



- 1,660 patients audited over 88 care settings to answer the question
- ***Is this the optimal care setting for the patient's needs today?***

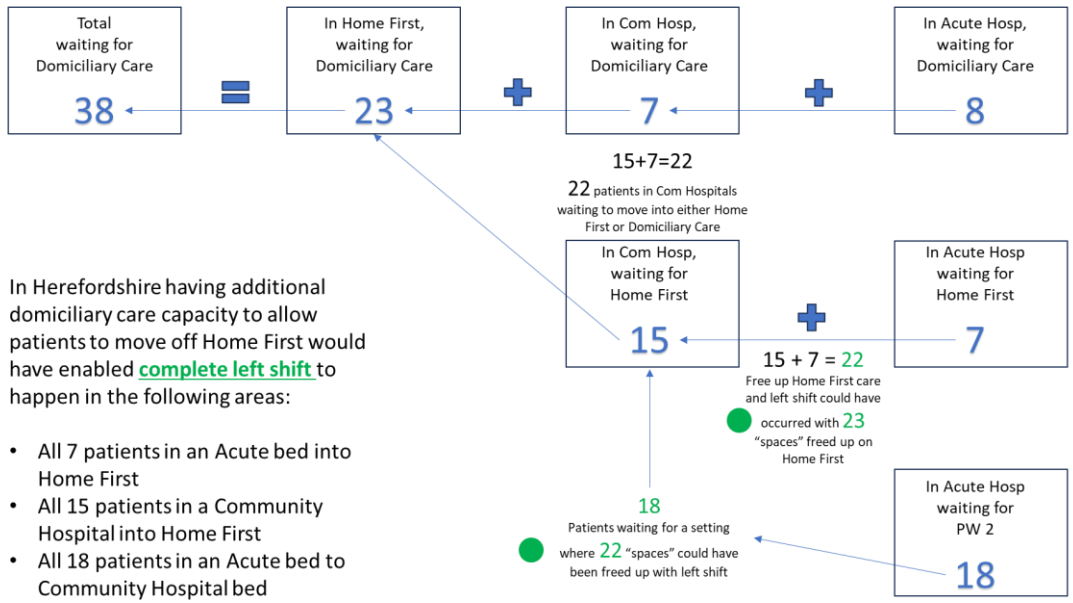
2023 Detailed results – analysis by setting



Whilst the overall percentages have not changed significantly between 2022 and 2023, the patterns across the two counties are very different. For 2023, in Herefordshire there was a significantly greater proportion of patients in acute settings deemed ready for step down and a particularly significant issue in out of hospital care. More than half of patients were deemed to be ready to move out of that care setting. This pattern was not replicated in Worcestershire. There was a significantly smaller proportion of patient in out of hospital settings waiting to move, but nearly half of patients in community hospitals were ready for step down.

What would it take to achieve "left shift" in the two counties

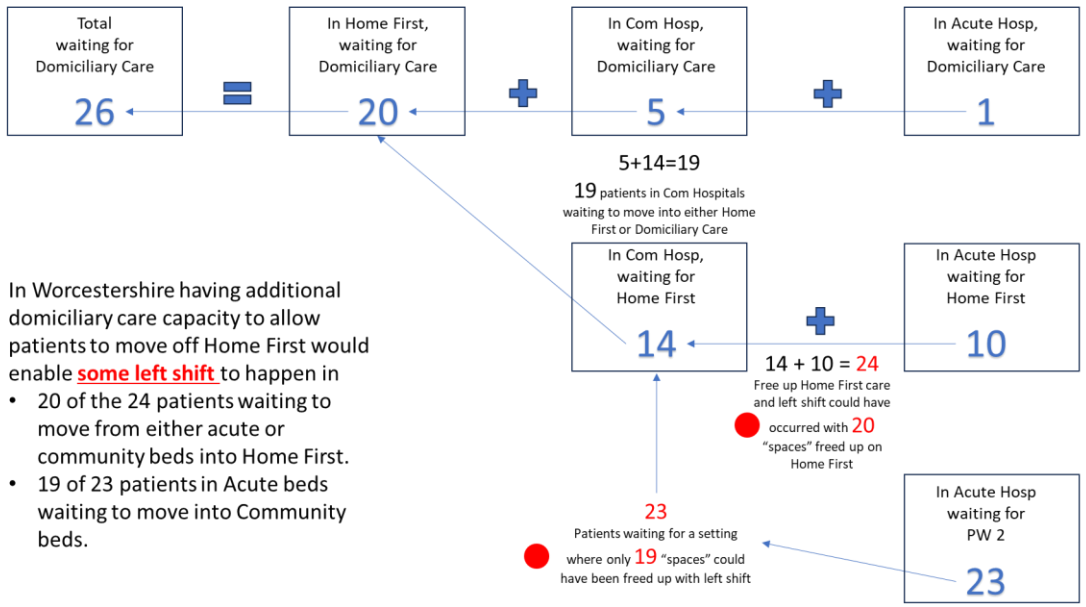
Left Shift in Herefordshire



In Herefordshire having additional domiciliary care capacity to allow patients to move off Home First would have enabled **complete left shift** to happen in the following areas:

- All 7 patients in an Acute bed into Home First
- All 15 patients in a Community Hospital into Home First
- All 18 patients in an Acute bed to Community Hospital bed

Left Shift in Worcestershire



In Worcestershire having additional domiciliary care capacity to allow patients to move off Home First would enable **some left shift** to happen in

- 20 of the 24 patients waiting to move from either acute or community beds into Home First.
- 19 of 23 patients in Acute beds waiting to move into Community beds.

- On the day of the PPA, with 23 people in total waiting to depart out of hospital settings, but only 22 people waiting to enter on that day, **complete left shift** could have occurred if capacity in domiciliary care could have been accessed in a more timely way.
- Similarly, with 22 patients waiting to depart community hospital beds, but only 18 patients waiting to enter them, again **complete left shift** could have realistically been achieved if the right domiciliary care capacity was accessible.

- On the day of the PPA, with 20 people in total waiting to depart out of hospital settings, but 24 people waiting to enter on that day, **some left shift** could have occurred if capacity in domiciliary care could have been accessed in a more timely way.
- Similarly, with 19 patients waiting to depart community hospital beds, but 23 patients waiting to enter them, again **some left shift** could have realistically been achieved if the right domiciliary care capacity was accessible.

The financial modelling to calculate the annual cost of "getting it wrong" demonstrated an opportunity cost of **£21.1m**. Whilst this is theoretically realisable saving to the NHS, it is not a saving to the Integrated Care System as a whole because it would necessitate a significant increase in social care spending. Furthermore, the calculation represents a "perfect" scenario, where people can immediately be moved to the correct care settings. Rarely is it the case that optimization of this nature can be achieved so the total figure should be viewed as a theoretical opportunity cost, of which a proportion should be realizable as a financial saving.

Building system consensus towards driving the shift upstream to more prevention and best care in the right setting

Achieving this shift in focus cannot be achieved without system consensus. Practical implementation requires capacity to be shifted between different care settings and different providers. Typically, it involves building capacity in social, primary and community settings to free up resources in bedded facilities in community hospitals, acute hospitals and mental health inpatient facilities.

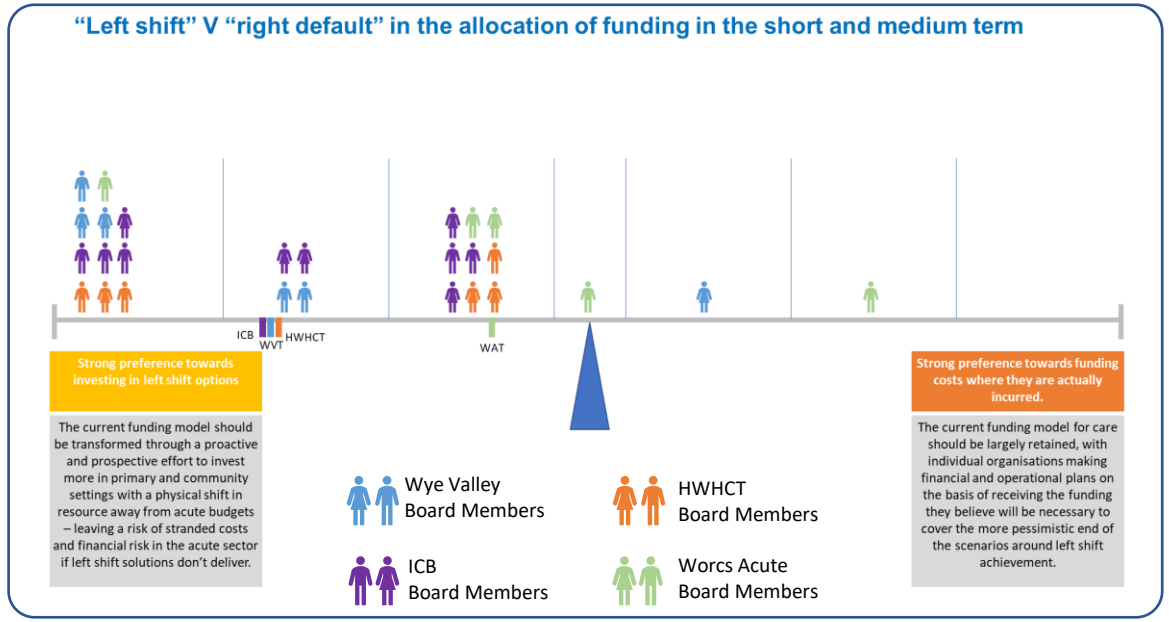
In order to test this consensus a **strategic choices** exercise was undertaken with the main board of the ICB and the non-executive directors of the three NHS Trusts. Individual Board Members were invited to review a briefing pack and complete a Mentimeter exercise to explore their individual perspectives on the shift in focus. For two questions, they were offered mutually exclusive options and asked to move a "slider" towards each option they thought was most desirable – the stronger the viewpoint, the further the slider should be moved. The results are shown the in charts to the right.

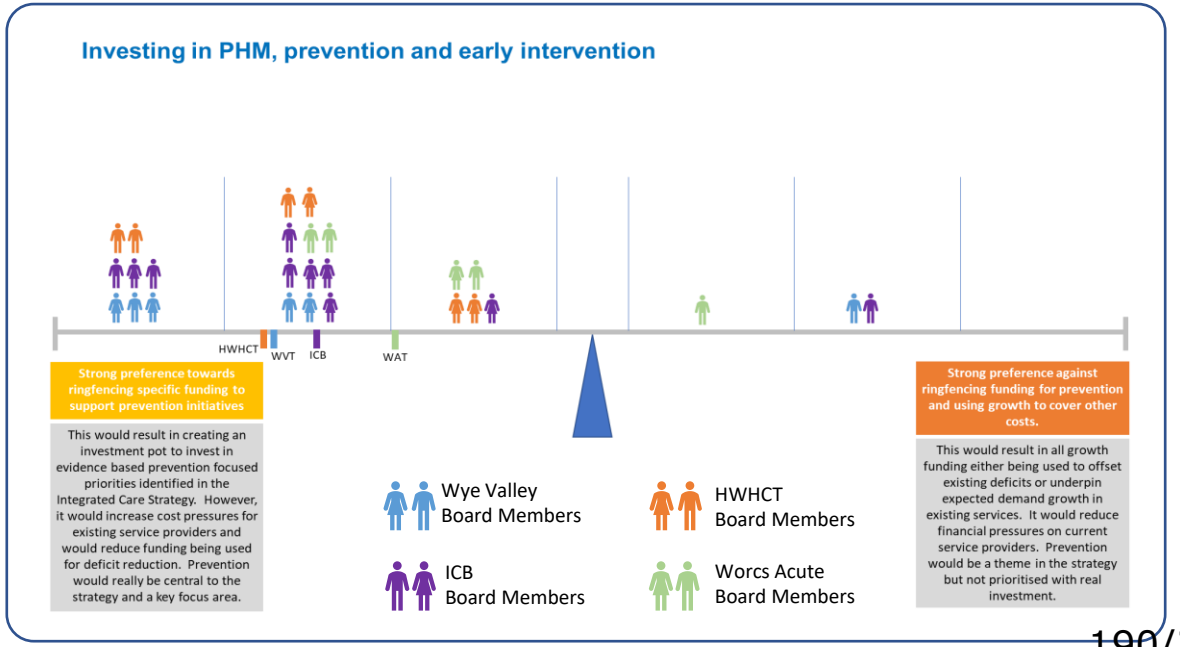
The scores were aggregated up to form the organisational score and the results were used in facilitated discussions at a series of face-to-face workshops. Participation in the exercise across each organisation is shown in the table below:

H&W Integrated Care Board	Wye Valley Trust	H&W Health and Care Trust	Worcestershire Acute NHS Trust
• Chair • Chief Executive • 5 Non-Executive Members • 2 Primary Care Partner Members • 1 Local Authority Partner Member	• Chair • Managing Director • 3 Non-Executive Directors	• Chair • Chief Executive • 4 Non-Executive Directors	• Chair • Chief Executive • 3 Non-Executive Directors

The charts show the results, both from an individual perspective (anonymized) and from the collective aggregate organizational view. There is clearly a preference across all organisations for setting a strategy that aspires towards the shift in focus (top chart) and supporting this with a funding regime that ringfences investment for prevention initiatives (bottom chart).

This strong degree of consensus provides a strong platform from which to drive the shift in focus as as the core foundation of the Joint Forward Plan.

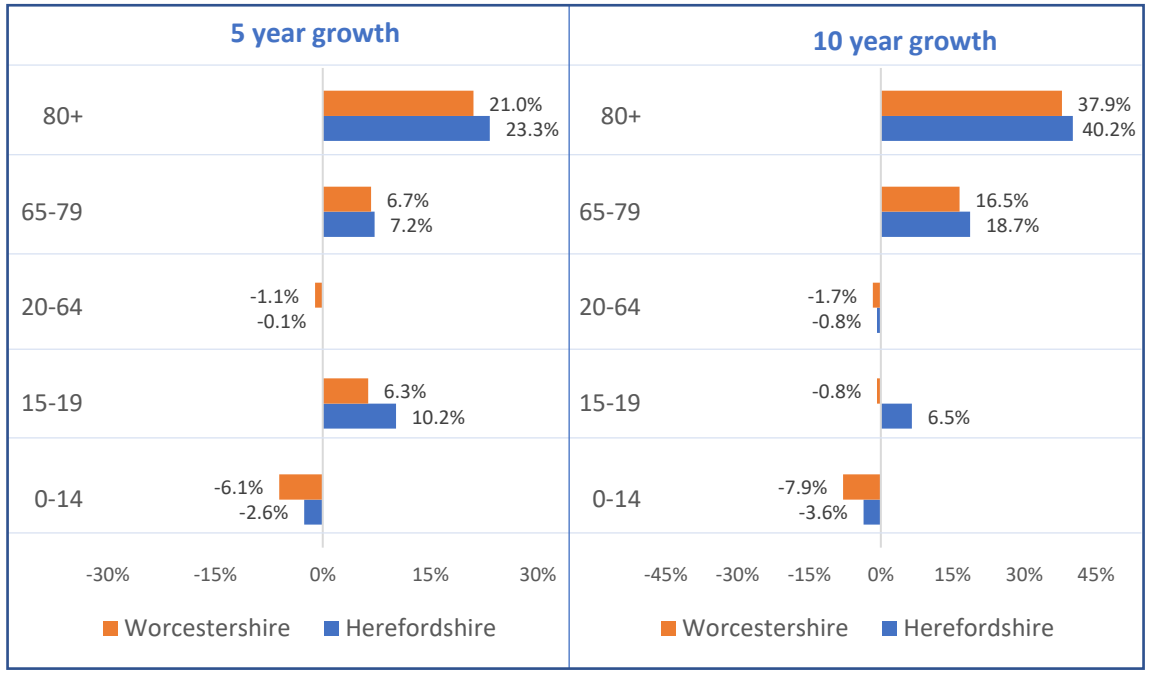




Developing a better understanding of future demand and capacity requirements

The final element in the strategic planning work to support the development of the JFP has been the development of a system wide **strategic demand and capacity model**. The point prevalence audit results indicated that there is a mismatch between demand and capacity; which ultimately leads to people being treated in care settings that are not optimal for their needs, frequently at higher cost to the system. The first phase of the demand and capacity model work has been to quantify the future impact over 5 years of not optimizing the provision of care. The second phase of the work, to be conducted during the first 3-6 months of JFP implementation will be to model the potential solutions to mitigate that growth in demand.

Population growth: Population numbers are forecast to grow most in the older age groups in the population – more than 20% over 5 years and nearly 40% over 10 years for people aged 80 years or more.



Likely Impact on Frailty Demand: Whilst age alone is not an indicator of future health demand, it does provide a basis for calculating likely levels of frailty that services are likely to be responding to. Initial model projections suggest the following impact:

Frailty Risk Category	10 Yr impact – Herefordshire	10 Yr impact – Worcestershire
No frailty score	+21%	+21%
Low score	+19%	+17%
Moderately low score	+28%	+27%
Moderately high score	+33%	+32%
Highest score	+36%	+38%

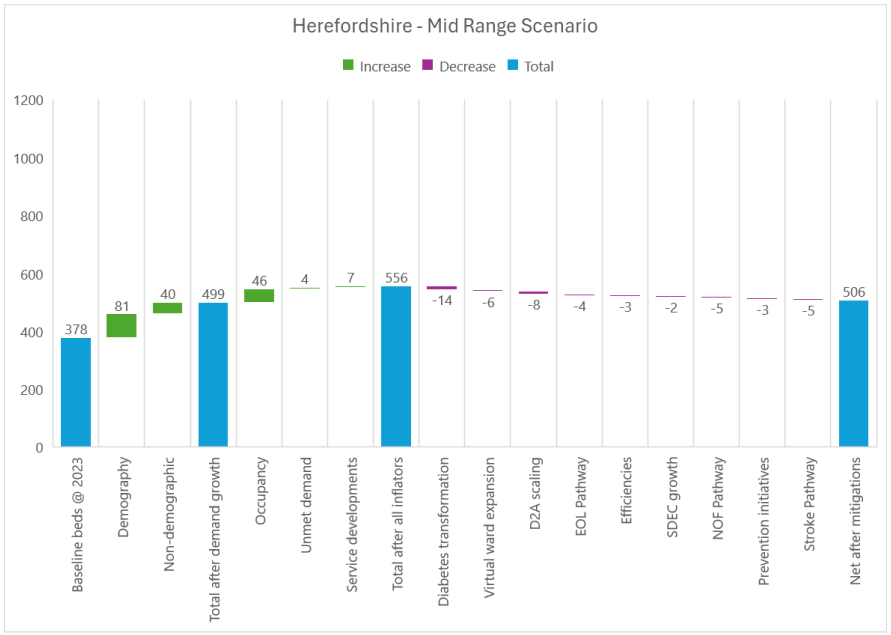
Unmet demand: The model calculates the impact of unmet demand (such as people waiting in ambulances or on trollies in A&E that would be admitted if beds were available). However, they are often cared for in unconventional settings for their whole hospital stay.

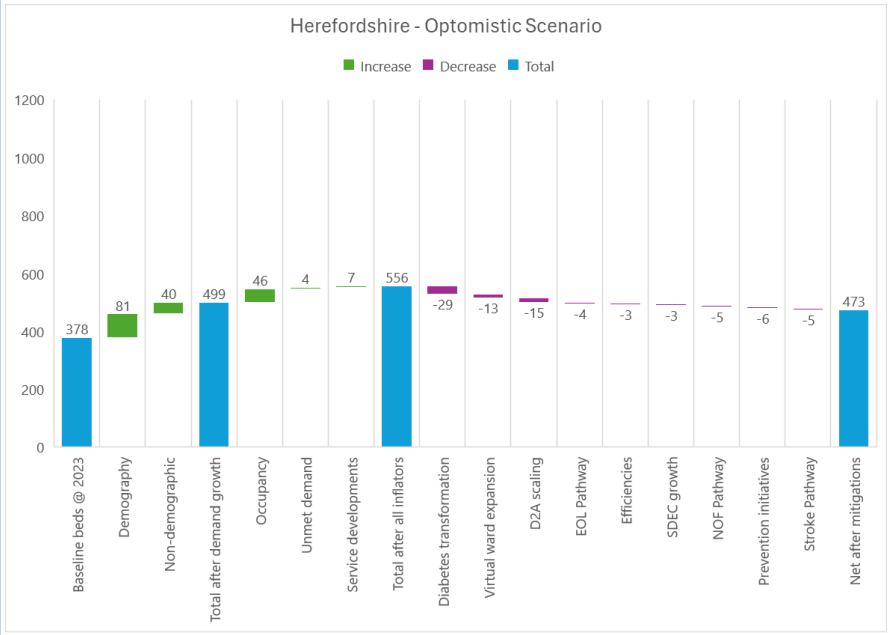
Sub-optimal flow: The model also calculates the impact sub-optimal flow on projected future bed numbers. There are two main mitigations to this, one of which is increasing the size of the bed pool to enable better flow, the other is to optimize practice to ensure that patients are only admitted when necessary and don't have any delays to their discharge.

Initial aggregate demand impact: Bringing together all aspects of growth, the draft model indicates future demand growth that will need to be mitigated by actions to be delivered under the JFP is an additional 274 beds.

Aggregate acute bed requirement in 10 years under the do nothing scenario	Acute Bed Impact	
Baseline beds	1,229	
Demographic growth	+236	
Non-demographic growth	+129	
Measure of un-met demand	+8	+311
Impact of sub optimal flow	+83	
New service developments	+28	
Mitigations, efficiencies and transformation programmes	-123	
Net ten year bed requirement for acute care	1,540	

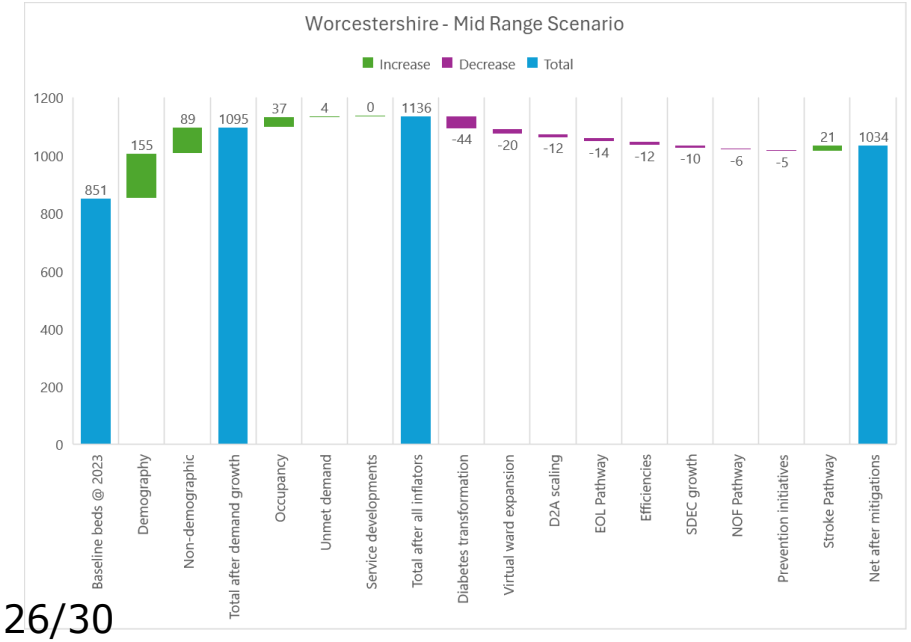
Developing a better understanding of future demand and capacity requirements – modelling the mitigations

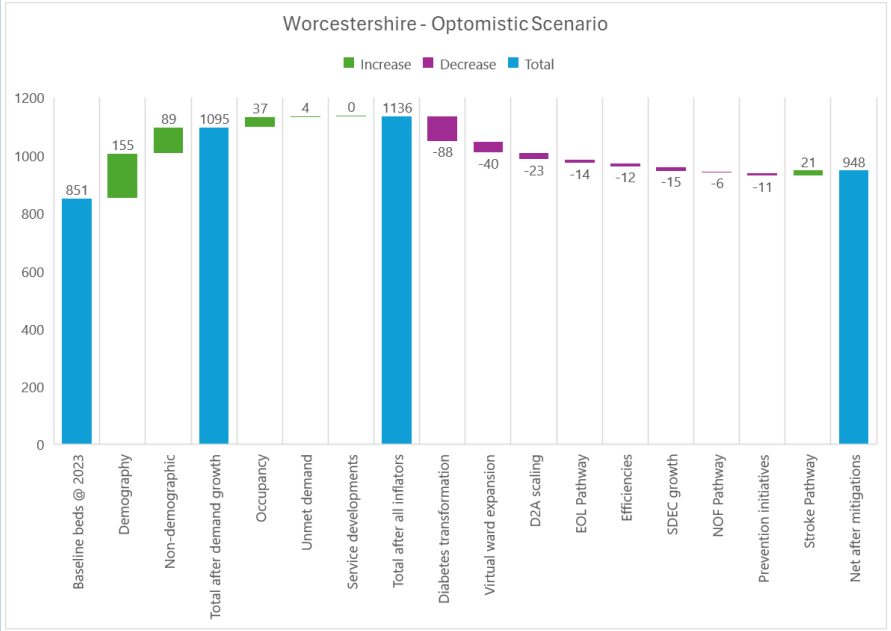




Herefordshire

- **Mid-range scenario** bed requirement by 2033 grows from 378 beds to 506 beds (+128).
- **Optimistic scenario** bed requirement by 2033 grows from 378 beds to 473 beds (+95).
- **Occupancy improvement** calculation is equivalent to 46 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations**: The biggest mitigation opportunities are diabetes transformation and D2A pathways.





Worcestershire

- **Mid-range scenario** bed requirement by 2033 grows from 851 beds to 1034 beds (+183).
- **Optimistic scenario** bed requirement by 2033 grows from 851 beds to 948 beds (+97).
- **Occupancy improvement** calculation is equivalent to 37 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and virtual ward scaling.

Population Health Management - Supporting the shift upstream to more prevention and best care in the right setting

Introduction

Population Health Management or PHM is for everyone working in integrated care. All ICS Partners working together to improve population health by data driven planning and delivery of proactive care to achieve maximum impact with the resources available, alongside the demand and capacity modelling described above.

PHM is a key strategic enabler delivery of the core areas of focus (Appedix 1) and the cross cutting themes (Appendix 2). PHM is not a new concept and is something that system partners already do. However. it is only at its most effective when both aspects come together and are tackled as part of a single coherent strategy. In essence, PHM has two major components to it:

Combining data to improve our understanding of health risks and opportunities for the population

Putting that data into the hands of people who can organise interventions to make a difference

PHM is already happening across Herefordshire and Worcestershire. For example:

- The PCN level health inequality plans that have been developed to identify and tackle specific local health issues with communities have been developed using PHM principles, including pre-diabetes and evidence-based interventions to prevent people at risk developing diabetes.

- Population health data shows that black men over the age of 45 are two to three times more likely to develop prostate cancer. As well as flagging a risk in terms of population health outcome, this analysis also exposes a health inequality that targeted action can help to address. In response to this knowledge a proactive screening pilot for Herefordshire residents, has been undertaken.

- Your health van is targeting unregistered and seldom heard members of the population, based on learning from the COVID vaccination programme, and linking into social prescribing impacting the wider determinants of health.

These are just a few of many examples that we could draw upon.

What next?

The ICB will facilitate the development and deployment of a of a system wide Population Health Management Framework during 2024/25, this will include:

- Building on the work done to date to create the local Core20Plus5 approach.
- Identifying a clear leadership and programme delivery structure, brining together information, clinical and strategy capabilities.
- Endorsing a clear vision of PHM as an iterative evolution towards a new operating model to guide the change over a 5 years period.
- Calculating the return-on-investment time to support the shift upstream to prevention and enable Developing a community driving adoption, spread and sustainability via use cases choices, and building a movement.
- Developing a PHM analytics capability – including a clear road map linked to the wider analytics development plan and building on the work of the local place-based intelligence cells.
- Developing an approach to linked data sets – including clear road map linked to the refreshed digital strategy.
- Building on the governance platform established through the Analytics Board and Health Inequalities, Prevention and Personalisation (HIPP) Programme Board

How will we deliver?

Developing a robust framework for Population Health Management is a central tenant of the shift upstream to prevention and will therefore become a key corporate project in 2024/25. Learning will be drawn from the national PHM Academy with opportunities to learn from other systems as well as from within Herefordshire and Worcestershire.

The HIPP Board will be responsible for overseeing the development of the framework – With specific aspects being delivered through the ICS Analytics Board.

Engagement Approach

Developing the Joint Forward Plan – Engagement approach

As a health and care system we are committed to close working with individuals, communities, partners and wider stakeholders. In developing the **structure and content** of our second Joint Forward plan, we have built on existing insights from recent engagement, these include:

- **The HW Integrated care strategy : 3 phases of engagement** - A thematic review of relevant existing patient and public engagement undertaken over the last two years. Extensive stakeholder engagement and broader feedback following the publication of the draft integrated care strategy.
- **Joint forward plan insights** – Complimenting the Integrated Care Strategy engagement, narrowing the scope to focus in on health services in line with the NHS Long term plan.
- **Specific engagement** – With NHS partners, including the 3 NHS Trusts, General Practice representatives and the Integrated Care Board.

The engagement strategy for the JFP recognises the benefit of aggregating together information from various sources and using this as a basis for filling in gaps in knowledge. The table below describes some of the engagement that has been undertaken by the ICB in partnership with providers:

Engagement activity – 2023/24
• Engagement insight summary reports for programme areas
• Mental health inpatients services – Pre consultation engagement
• Long term conditions public engagement and existing review of engagement
• Engagement review urgent care
• Engagement review elective, diagnostic and cancer
• Health care information public survey (health literacy)
• Primary Care Access Recovery Programme – With Healthwatch
• Autism and ADHD engagement
• Children and Young People baseline engagement (Action for Children)
• Menopause – Patient representatives on workshop
• d/Deaf engagement – with partners
• Engagement on communications for ICB communications & engagement framework

In addition, these specific engagement activities there are various ongoing programmes of engagement with patient representatives engaging in meetings and specific activities.

Engaging individuals and communities

You can find more detail in **Appendix 2: Key enablers**, about our commitment to early engagement and ongoing dialogue with people and communities. You can also find out more about our wider system approach to engagement in our **ICS Engagement Strategy**.

Involvement opportunities are made available here:

https://www.hwics.org.uk/get-involved/involvement-opportunities

The Joint Forward Plan is owned equally by the ICB, the three NHS Trusts and the two General Practice Organisations that operate across the system. This joint ownership means that we can work together to support effective engagement and evaluation of delivery throughout the life of the plan.

Engagement insights will be used to develop programmes and also to evaluate their effectiveness. With the publication of the Joint Forward plan being an opportunity to share the core areas of focus for the system over the next few years. This should make it easier for local people to understand where change and improvements are being made and to get involved.

Next steps

- Opportunity to feedback and get involved in more in-depth engagement for specific clinical services pathways
- Embedding engagement insights into the delivery of the core strategic intent: ***"Driving the shift upstream to more prevention and best care in the right setting"***

Implementing the Joint Forward Plan

The implementation approach for the Joint Forward plan reflects the point in time when it was developed - the beginning of 2023/24. At this point in time a number of other key strategies and plans had been developed, or recently approved including:

- **NHS System operational plan for 2024/25** - This outlines the key operational delivery priorities for healthcare during the first year of the Joint Forward Plan. (Not yet available)
- **The Integrated Care Strategy for 2023-2033 –** This brings together a broad range of partners across the Integrated Care System, around a shared vision for improving health and well-being for everyone and three key priority areas.
- **Worcestershire Joint Local Health and Wellbeing Strategy** – This identifies a key priority focus on Good Mental Health and Well Being, supported by healthy living at all ages; safe thriving and healthy homes, communities and places; quality local jobs and opportunities.
- **Herefordshire Joint Local Health and Wellbeing Strategy** – This identifies two key priorities of Providing the Best Start in Life for Childrens" and "Mental Health and Wellbeing", supported by six enablers: access, living and ageing well, good work for everyone, supporting those with complex vulnerabilities, housing/homelessness, reducing carbon footprint.

The Joint Local Health and Wellbeing Strategies and the Integrated Care Strategy provide the long-term frame, with the Joint Forward Plan translating this into NHS focused medium-term delivery priorities; and the Operational Plan focusing in turn establishing the annual priorities.

Year 2 implementation focus

During the second year of implementation there are two main streams for the Joint Forward Plan:

- **Stream 1:** Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the approach to Population health management, evidence based decision making increasing the provision of pro-active care.
- **Stream 2:** Continued delivery of the year 2 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1.

There is a significant role for existing programme boards with the system governance structure to develop, align content and instil ownership of delivery of the plan from the outset.

Stream 1: Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the approach to Population health management, evidence-based decision making increasing the provision of pro-active care.

Stream 1: Driving the shift upstream to more prevention and best care in the right setting.	Phasing
Senior leader – Review of strategic choices and next steps	Q1 2024/25
Implementation of investment standards for 2024/25	Q2 2024/25
Strategic analysis around opportunities – Through engagement with the ICB, Trust Boards and General practice representative boards	September to December
Developing and embedding a Population Health Management approach to drive service redesign to better meet people needs	2024/25

Stream 2: Continued delivery of the year 2 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1.

Stream 2: Delivery of year 1 priorities for core areas of focus and cross cutting themes	Phasing
Delivery of the year 2 priorities for the core areas of focus: See appendix 1.	2024/25
Delivery of the year 2 priorities for the cross-cutting themes: See appendix 2.	2024/25
Ongoing focus on system development, ensuring that mechanisms for collaboration are strong and effective in enabling delivery of the priorities within the JFP.	2024/25

Joint forward plan – 24/25

Appendix 1:
Core areas of focus

This section sets out how the Joint Forward Plan addresses national requirements set out in **the NHS Long Term Plan** and **local priorities** to ensure the NHS makes a positive contribution to improved health outcomes for the population through delivery of high-quality patient centered pathways that are overseen by programme boards across the ICS. This includes a summary of what we have delivered in 2023/24 and what our focus is from 2024/25 and beyond.

Version: Final draft 22ND May 2024

Delivering High quality, patient centred integrated pathways: INTRODUCTION

There are a broad range of work programmes across Herefordshire and Worcestershire, within place and neighbourhoods. These are established to develop and deliver programmes of work focused on local and national priorities including those set out in the https://www.longtermplan.nhs.uk/.

In this section you will find a high-level summary of year 1 delivery, and the priorities that are developed and overseen at a system level through Herefordshire and Worcestershire ICS Programme Boards.

Core areas of focus can be found in this document, which include:

1. Maternity and neonatal care
2. Early years, children and becoming an adult
3. Elective, Diagnostics and Cancer Care
4. Frailty
5. Palliative and End-of-life
6. Learning disability and autism care
7. Mental health and wellbeing
8. Long-term Conditions
9. Stroke care
10. Urgent and emergency care
11. Primary Care
12. General Practice
13. Pharmacy, Ophthalmic and Dentistry

Cross cutting themes can be found in Appendix 2 and include:

1. Quality, Patient safety and experience
2. Clinical and care professional Leadership
3. Medicines and pharmacy
4. Health inequalities
5. Prevention
6. Population health management
7. Personalised care
8. Working with communities
9. Commitment to carers
10. Support veteran health
11. Addressing the needs of victims of abuse
12. Digital data and technology
13. Research and innovation
14. Greener NHS

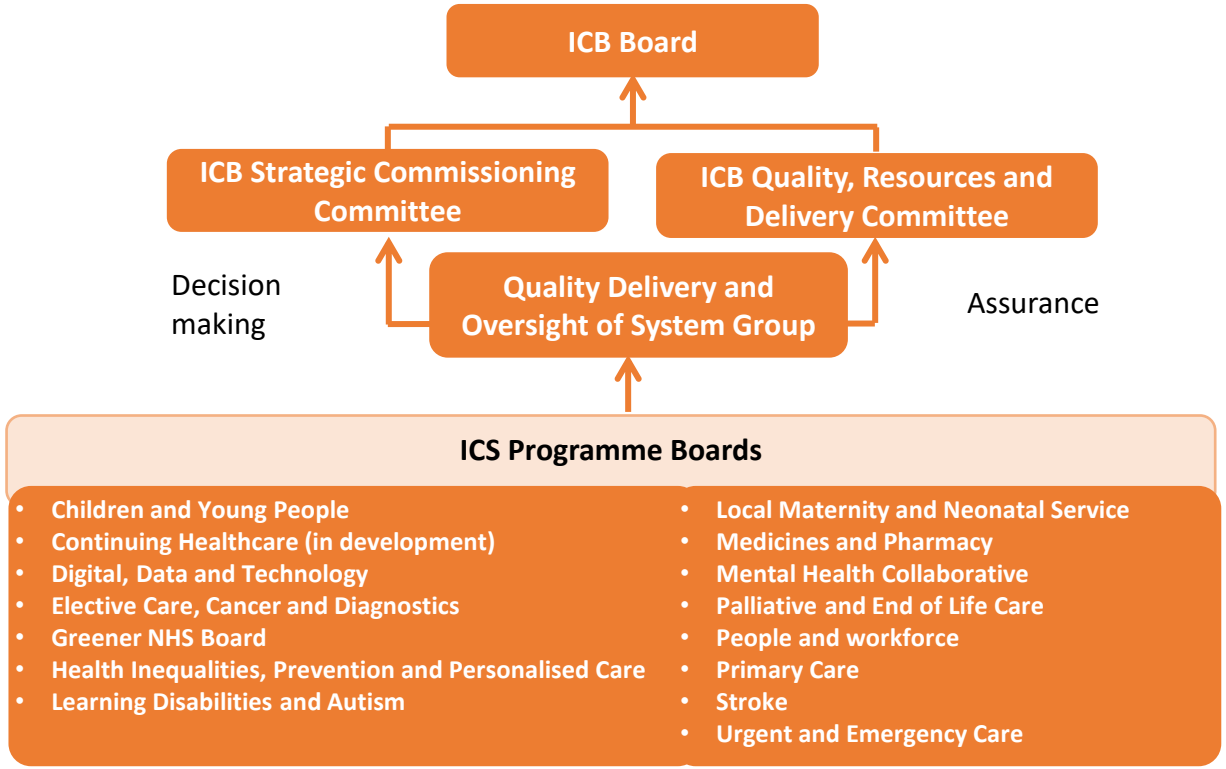
The role of an ICS Programme Board

The ICS Programme Boards are responsible for overseeing delivery of programmes across Herefordshire and Worcestershire, including the Joint Forward Plan, which will include regular reporting on progress against plan delivery and mitigating / escalating risks to delivery through to the ICB Quality, Resources and Delivery Committee.

The ICS Programme Boards bring together organisations to coordinate and oversee delivery of improvement and transformation activities across Herefordshire and Worcestershire. They are responsible for setting the strategic direction and ensuring that comprehensive delivery plans and monitoring frameworks are in place. Whilst the Programme Boards are not decision-making forums, the governance framework allows timely decision making through the ICB Strategic Commissioning Committee.

Joint ownership

The membership of each ICS Programme Board represents the key stakeholders engaged in a particular programme area, including NHS and Local authority partners, HealthWatch, networks and alliances and representatives of the patient voice, in addition to operational and clinical staff. The chart below summarises the governance structure.



Core areas of focus

In this section we answer the following questions for each core area of focus. The programmes of work included will be reviewed and refreshed in the Joint Forward Plan annually.

1. Why this is important?
2. What we are doing
3. What will we deliver and when?
4. Where you can find more detail

High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

1. Why is this important?

The Local Maternity and Neonatal System (LMNS) vision is to have a collaborative system that provides consistent, high quality, sage personalised care that is delivered equitably according to local need.

High quality maternity and neonatal care is essential in ensuring every child across Herefordshire and Worcestershire has the best start in life. During 2023 there were 6254 deliveries across our LMNS. Our smoking in pregnancy rates are higher than the national ambition of 6% at 8.9% for 2023. Initiation of breastfeeding rates across the LMNS as a whole during 2022/23 were higher thanthe national average. However, we know that there are groups within our population where breastfeeding is lower. In 2023 over one quarter of women who booked for maternity care had BMI>30. All of these population health factors contribute to health inequalities and poor outcomes for babies and Family's. Therefore, our LMNS strives to work in partnership to improve our local picture by reducing health inequalities and providing safe, personalised, equitable care.

The LMNS consists of Herefordshire & Worcestershire Maternity and Neonatal Voices Partnerships, Wye Valley NHS Trust, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Integrated Care Board, Herefordshire and Worcestershire Health and Care NHS Trust and the 2 Local Authority Public Health Teams. These organisations work together to improve outcomes for Family's across our local area.

2. What have we delivered in our first year, 2023/24?

- The LMNS has completed a 3-year pilot of Perinatal Pelvic Health Services and agreed to commission a sustainable service for women from 2024/25 that will be available across Herefordshire and Worcestershire.
- The Maternity and Neonatal Voices Partnership (MNVP) has been continued to be resourced and supported. A Neonatal Champion has been recruited to ensure the voices of local Family's who experience neonatal care are heard.
- The LMNS has supported a system led approach to ensuring both trusts are compliant with the expected delivery level of the Saving Babies' Lives Care Bundle Version 3. This will have an impact on reducing neonatal and maternal mortality, still births and intrapartum brain injury.
- The LMNS has continues to implement the Perinatal Quality Surveillance model, ensuring that there is trust board and ICB oversight of key factors that impact on perinatal quality and safety, such as staffing, culture and learning from incidents.
- The LMNS has worked with stakeholders to co-produce a strategy that outlines clearly our deliverables and local plans for implementation to align with the NHS England three Year Delivery Plan for Maternity and Neonatal Services.
- The LMNS now jointly conducts Perinatal Mortality reviews to ensure shared learning to improve care.
- The Digital and Equity and Equality strategies are being refreshed to ensure a continuous focus on digital innovation and reducing health inequalities.
- The LMNS programme team has conducted a series of insight visits, supported by NHS England Regional Perinatal team to review quality, safety and culture within our system.
- The LMNS has coproduced a video with the MNVP providing information about induction of labour for local service users. Helping to ensure women and birthing people can make informed decisions about their care.

3. What are the priorities going forward?

The shared priorities of the LMNS are:

- High quality, safe maternity and neonatal care
- Listening to local women and birthing people and our staff
- Information, to identify and act on issues as early as possible
- Reducing Health inequalities

High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Listening to women and Family's with compassion	• Enabling women to have personalised care through personalised care and support planning. • Providing Perinatal Pelvic Health services that meet the needs of patients. • Delivering care equitably through the implementation of the Local Maternity and Neonatal System Equity and Equality plan. • Enable and empower our Maternity and Neonatal Voices partnerships to represent our local Family's and co-produce Maternity and Neonatal services	2025/26
Supporting our workforce	• Developing and implementing local evidence-based retention action plans • All staff having the supervision, training and support they need.	2025/26
Developing and sustaining a culture of safety	• Sharing learning from incidents across the Local Maternity and Neonatal System and learning from incidents at a national and regional level. • Promoting positive culture through supportive leadership. • Identifying any concerns raising them early and addressing them.	2025/26
Meeting and improving standards and structures	• Implementing national evidence-based guidance such as the Saving Babies Lives' Care Bundle V3 and monitoring local progress against outcomes. • Using evidence-based tools such as MEWS and NEWTT-2 to better detect concerns and act sooner on safety issues. • Making better use of digital technology in maternity and neonatal services through implementing the Local Maternity and Neonatal System digital strategies. • Have regular oversight and open scrutiny of data to identify issues and inform learning.	2025/26
High quality, safe, equitable care	• Developing on the learning from the implementation of the Three-Year Plan for Maternity and Neonatal Services. • Continuing to facilitate a workforce and culture that supports learning and delivers safe, equitable care.	2027/28

5. Where you can find more detail?

There are two active Maternity and Neonatal Voices Partnerships (MNVP) in Herefordshire and Worcestershire, this is an opportunity for members of the public to have a say in how maternity services are run in both counties.

If you would like to get involved please contact:-

hwicb.herefordshiremvp@nhs.net – Herefordshire MNVP
hwicb.worcsmvp@nhs.net- Worcestershire MNVP

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

1. Why is this important?

- Across Herefordshire & Worcestershire Children and Young People (CYP) represent approx. 19% of our population, with approximately 140,000 0-19 years old (Public Health Profiles 2021).
- Overall, this is a good place to live. There are relatively low levels of poverty and deprivation, and many children and young people are happy.
- For children and young people living in areas of high deprivation or experiencing poverty, there are barriers to accessing services.
- Some children and young people are at the biggest risk of poor outcomes. Including those with additional needs; exposed to family and behavioural risks; or with experience of the care system.
- 14.1% of children in Worcestershire and 12.2% in Herefordshire are living in low-income Family's.
- 65% of children achieve a good level of development at the end of reception in Worcestershire and 71.8% in Herefordshire.
- Emotional wellbeing is a cause for concern in 39% of looked after children in Worcestershire and 42% in Herefordshire.
- The prevalence of overweight (including obesity) of children in Reception is 20% in Worcestershire and 25% in Herefordshire.
- Hospital admissions for children aged 0-14 is a rate of 71.9 per 10,000 for Worcestershire and 100.1 per 10,000 for Herefordshire.
- In Worcestershire 3.9 % of pupils have an Education Health and Care Plan and 2.6% in Herefordshire.

2. What have we delivered in our first year, 2023/24?

- Rolled out the national Asthma Care Bundle across clinical sectors, delivered a pilot programme of community-based nurse led intervention and support to children at risk of poor asthma control. Identified overlap with areas of health inequality, worked with housing colleagues on environmental factors and schools to support awareness raising and improve pupil attendance.
- Established a 2-year pilot programme of youth workers employed to support young people with long term conditions to transition from children to adults' health services, supporting personalised care and self-management.
- Recruited to a pilot psychological therapy programme to assist those children & young people with epilepsy who are experiencing emotional health challenges
- Employed a Designated Clinical Officer for Special Education Needs & Disabilities (SEND) in Herefordshire to ensure health contributions to Education Health & Care Plans are quality focused, timely and specific to the needs of the child.
- Agreed additional recurrent funding to support Paediatric therapist recruitment to Herefordshire Physical Therapies to reduce waiting times and improve timeliness of Education Health & Care Plans.
- Agreed additional recurrent funding and associated processes in Worcestershire to meet the medical responsibilities of children being placed for Adoption.
- Initiated an evidence-based review of current models of children's therapy delivery across the ICS, phase 1 demographic data collection is complete; and redesign of delivery models based on data has commenced.
- Provided additional non-recurrent funding to Worcestershire community health services to improve timeliness of health advice to Education Health & Care plans for SEND and to support a demand & capacity analysis.
- Commenced work with parents, carers and other stakeholders to redesign local neurodiversity pathways to ensure consistency across ICS and more timely diagnosis.

3. What are the priorities going forward?

- Continue to deliver the NHSE National Children and Young People's Transformation Programme to meet the commitments in the NHS Long Term Plan, as identified in the delivery plan.
- Enhance preparation for adulthood, recognising the needs of young people with long-term conditions and/ or with complex needs.
- Work with partners across the system to develop an outcomes-based data dashboard to understand the varying needs of our community.
- Use data and insights in evidencing effectiveness of pilot projects in Epilepsy, Diabetes and Asthma specially on addressing health inequalities.
- Engage in Public Health-led Best Start in Life, particularly in (1) early language and communication skills (2) early identification and appropriate support of child development (at universal level).
- Continue to improve Special Educational Needs and Disabilities provision, including future model of community health services to address the needs of children and young people.

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Asthma - to support CYP with asthma, including diagnosis, care planning, and reducing emergency admissions.	• Evaluate Children's Community Asthma Team • Establish an approach for Asthma Friendly Schools • Establish a structured approach for roll-out of training & Asthma Competencies Framework (including schools & Primary Care) • Establish robust referral process with housing providers in both counties	By 2024/25
	• Embed the Asthma Care Bundle, risk stratification in Primary Care, understand & support clinical and CYP training needs • Toolkit for schools with training & support	By 2027/28
Epilepsy - Standardised approach to management of childhood Epilepsy.	• Improvement to the capacity of epilepsy nurse specialist support across ICS. • Audit for need for psychology and mental health support for patients on the Epilepsy caseload. • Work with partners to develop a pathway for psychological support .	By 2024/25
	• Engagement in Regional pathway mapping • Embed pilot projects as business-as-usual	By 2027/28
Obesity – to support a reduction in overweight and obese children across ICS.	• Integrate a CYP Healthy Weight Strategy within an ICS Wide All Age Healthy Weight Strategy. • Pilot Social Prescribing/Coaching roles to take a Whole Family Approach	By 2024/25
	• Develop and embed a CYP Obesity Care Pathway. • Hard-to-reach CYP & Family's at risk of obesity & in areas of deprivation, are supported to access & shape support to address barriers to lifestyle changes.	By 2027/28
Diabetes - Reducing inequality and variation in outcomes.	• Pilot use of technology with individuals affected by health inequalities. • Agree transitions pathway for 16-25 years old, and implementation.	By 2024/25
	• Evaluation of pilot and agree roll-out. • Prevention and education aligning with Obesity workstream and improving care and outcomes for CYP living with type 2 diabetes.	By 2027/28

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Infant Mortality - Improved systems for identifying and supporting Family's/women whose children are at risk of infant mortality due to modifiable risk factors.	• Agree the Infant Mortality Strategy, in collaboration with Local Maternity and Neonatal Services Board.	By 2024/25
	• Work with Early Help Partnerships to implement the strategy.	By 2027/28
Urgent & emergency care	• Develop a robust seasonal illness plan • Re-launch Handi App in Worcestershire / Launch Handi App in Herefordshire. • Develop common conditions pathway document	By 2024/25
	• CYP are engaged in transition services and effective management of long-term conditions to avoid crisis presentations. • Consistent pathways across the ICS to provide CYP appropriate care in the most appropriate setting.	By 2027/28
CYP & Family's (CYPF) have access to timely Neurodiverse (ND) diagnostic assessments & support.	• Re-design ND Care Pathways to reduce waiting times for diagnostic assessments. • Work with CYPF and partners to improve support offer pre & post ND diagnosis. • Improved access to EWMH support, advice, information and training for ND CYP and their Family's and for professionals across the system. • Ensure information and sign-posting of support for ND CYP, Family's and Non-specialists professionals is available & accessible in a centralised-hub.	By 2024/25
	• Raise awareness and understanding of Neurodivergence in CYP workforce. • Embed CYP components of All-Age Autism Strategy. • Improve timely and appropriate access to services providing support, advice, information, training and interventions across the system. • Provide ND accessible services delivered by skilled and trained providers. • Increase uptake of services by ND CYP and Family's.	By 2027/28
Special Educational Needs and Disability (SEND)	• Increase number of children who are school-ready with appropriate plans in place. • Review Paediatric Therapies model of delivery to enhance timely support	By 2024/25
	• Further develop joint commissioning of support & intervention services • Working with education settings to enable greater inclusion • Improve transition into adulthood • Development of a blended workforce	By 2027/28
Address healthcare inequalities to improve outcomes for Children and young people	• Identification of specific interventions to address inequalities experienced by the 'Plus' groups. • Implementation of Best Start in Life	By 2024/25

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery

Mental Health and Emotional Wellbeing Transformation Plan.	• Improve timely information, advice, and support
	• Improve mental health services within schools.
	• Enhance pathways to avoid crisis & enhanced community-based solutions
	• Promotion of prevention and early intervention activities –
	  • Emotional wellbeing tool for primary schools
	  • SHOUT text messaging service to prevent a decline in mental health, nipping in the bud, and a pattern of attendance to A&E
		By 2024/25

	• Increase support within schools • Redesign Neurodiverse pathways • Improve mental health support for 0-25yrs • Increase take-up of annual health checks for 14-25 yrs	By 2027/28
Health and Wellbeing of Children Looked After (CLA)	• Ensure statutory health assessments for CLA are completed within timeframes and health needs are identified and addressed. • Ensure the health needs of CLA placed outside of the ICS are met. • Improve the process & timeliness of Adoption Medicals in Worcestershire.	By 2024/25
CYP Community Health Services	• Review service specifications for CYP community health services • Review Community Paediatric provision • Complete review of Children Community Nursing services with particular focus on EoL care in Herefordshire • Agree future model of service provision in Therapy Services incorporating 'The Balanced Approach' - universal, targeted and specialist provision. • Review of Worcestershire Child Development Service • Develop a universal strand of provision in Occupational Therapy and Physiotherapy with a prevention / early intervention focus • Review Child Development Centre offer which links to early identification and supporting emerging needs.	By 2024/25
	• Embed system adoption of universal, targeted and specialist approach within children community health services linked with development of the Best Start in Life programme with a focus on prevention and Family Hubs • Explore shared workforce opportunities across the system.	By 2027/28
Children's Cancer and planned Care	• Work with NHS across Region to ensure specialist care continues to meet children's needs. • Support & enhance Paediatric oncology shared care unit (POSU) at Worcester Acute Hospital to deliver injection-based outpatient chemotherapy • Develop level 2 Paediatric Critical Care capability at Worcestershire Acute Hospital.	By 2025/26

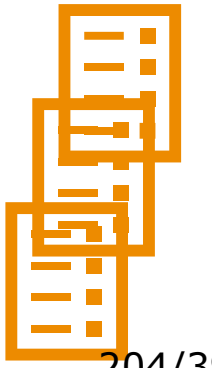
4. Where you can find more detail?

Engagement opportunities are circulated through parent carer forums and the ICS communications system.

We listen to the voice and experience of children, young people and Family's facilitated by Action for Children and specific feedback via existing youth forums, compliments and complaints.

The identified priorities reflect the Place based Children & Young Peoples Plan where regular updates are provided

Requests for information can be made to the CYP team at hwicb.cypteam@nhs.net



High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

1. Why is this important?

To improve patient safety, outcomes and experience we must eradicate all long elective, cancer and diagnostic waits for assessment and treatment.

Waiting times remain in a challenged position post-COVID with waiting times being higher than we would like.

Despite having the 2nd lowest referral rate per 1,000 population, demand has increased circa 14% year on year.

During the pandemic there was a significant reduction in the number of patients being referred with suspected cancer. This has now recovered, but a combination of reduced capacity and sustained levels of increased demand has meant patients are waiting longer for their diagnosis and treatment.

In addition to recovering services, cancer incidence is expected to increase, with Cancer Alliances nationally predicting a 10% increase in cancer referrals.

2. What have we delivered in our first year, 2023/24?

- Elimination of elective waits over 104 weeks, and over 78 weeks for most specialties.
- Continued good performance against diagnostics targets, although a small number of challenged modalities remain.
- Patient Initiated Follow Up (PIFU) and Personalised Care Follow Ups (PCFU) delivered across a range of specialties (ongoing focus on 24/25).
- Fragile services framework agreed with agreed ways of working to increase service resilience and sustainability.
- Provider accreditation framework developed to support patient choice.
- AI pilot commenced in dermatology in Worcestershire, streamlining referrals into secondary care.
- Piloting of Community Breast Clinics for low-risk patients.
- FIT in primary care 77% (as of Nov 23), highest achievement in the Midlands.
- Improvement in key of getting it right first time (GIRFT) metrics across a range of specialties.
- Consistently performed above stretch target for Specialist Advice.
- Development of common conditions documents to support management in primary care.
- Implementation of GIRFT Further Faster programme across both providers, working to reduce 52-week waiting times.
- Launch of Patient Initiated Mutual Aid System (PIDMAS).
- Launch of elective hub in Worcestershire, with a Herefordshire hub planned for 2024.
- Approval and commencement of CDC2 development in Hereford City.

3. What are the priorities going forward?

- Recovery of elective, cancer and diagnostic services. This includes achievement of cancer standards, restoring waiting times in diagnostics, and elimination of elective waiting times above 65 weeks by September 2024 and above 52 weeks by March 2025.
- Transformation of services to maximise productivity and quality across the elective, cancer and diagnostics pathways.
- Collaborative working across the ICS to embed national best practice.
- Improvement in patient choice
- Delivery of a personalised outpatient model that better meets individual patient need and improves quality of care and patient outcomes.
- Improvement in the resilience of identified vulnerable services.
- Digitalisation of services to enhance patient pathways and patient experience e.g. patient portal, remote consultations, remote monitoring
- Delivery of services in primary care and through our screening programmes to increase the number of patients diagnosed with cancer earlier (stages (I/II)
- Delivery of Best Practice Timed Cancer pathways across the ICS to ensure patients are assessed, diagnosed and treated quickly, thereby improving their outcomes.

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Restore waiting times for elective, diagnostics and cancer	• Work collaboratively with all providers locally and nationally to increase capacity to support elimination of long waiting times • Delivery of system elective hubs - Alexandra Redditch (WAHT) and Hereford (WVT) • Launch of Community diagnostic centre in Hereford – increase volume of diagnostic capacity • Elimination of 65 week waits by September 2024 and recovery of waiting times for diagnostics within 6 weeks	By 2024/25
Outpatient transformation • Referral Optimisation • Maximise Productivity • Reduction of follow ups • Reduce elective waits	• Continue to embed patient initiated follow up (PIFU), helping put patients in control of their follow up appointments and achieving national requirement (5% discharged/moved to PIFU pathway) • Deliver an appropriate reduction in outpatient follow up activity (contribute to required 25% reduction in line with operational planning guidance) • Explore opportunity to embed one stop clinics, aligned to diagnostic development of Community Diagnostic Centres. • Offer Specialist Advice and develop support to help patients prepare for their appointments. • Embed GIRFT and Further Faster to maximise productivity and support reduction in waiting times. • Identify opportunities for digital support/solutions to support patient pathways.	By 2024/25
Improving screening uptake	• Reducing variation in screening uptake in the registered and non-registered population; • Optimisation of the PCN DES Supporting Earlier Diagnosis – targeting non-responders and hard to reach groups;	By 2024/25
Supporting earlier diagnosis	• Implementation of Targeted Lung Health Checks and FIT testing in primary care; • Targeting populations at higher risk of developing cancer; • Implementation of Non-Specific Symptoms pathway; • Implementation of routine testing for Lynch Syndrome and Liver surveillance	By 2024/25
Implementing Best Practice Timed Cancer Pathways (BPTP)	• Ensuring 5 BPTP are in place across the ICS with a focus on achieving above the 75% 28-FDS standard; • Undertake Demand and Capacity modelling across diagnostics to identify opportunities for innovation/transformation to ensure sustainable timely access; • Transformation and innovation in pathology services	By 2024/25
Empowering patients through personalisation of care	• Optimisation and expansion of Personalised Care Follow-up pathways; • Development of a Patient Portal to support self-management; • Improving support services for patients living with cancer; • Use of digital technology to support self-management	By 2025/26

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Understand and address health inequalities in elective and cancer care	• Refresh clinical prioritisation framework • Ongoing understanding of inequalities in access, experience and outcomes of care for Core 20, BME populations and Inclusion Health Groups.	By 2024/25
Longer term vision for planned care	• Development of a 5-year strategy for H&W Elective, Cancer and Diagnostics	By 2024/25

4. Where you can find more detail?

- Delivery plan for tackling the COVID-19 backlog of elective care
- Clinically Led Specialty Outpatient Guidance
- Getting It Right First Time
- *Regional and national strategies for cancer can be found at:* Home - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)
- NHS England » NHS Five Year Forward View
- *Link to the National Cancer Patient Experience Survey:* Homepage - National Cancer Patient Experience Survey (ncpes.co.uk)

High quality, patients centred services: FRAILTY

Theme 4

1. Why is this important?

Herefordshire & Worcestershire has an older population structure than the rest of England, with over 65 years increasing and younger populations decreasing.

By 2030 (compared to 2021), it is predicted that the number of people aged 80-84 will increase by 48% in Herefordshire and by 51% in Worcestershire. The increase in the over 85 age group is 36% in Herefordshire and 35% in Worcestershire.

Frailty is a long-term condition in which multiple body systems gradually lose their in-built reserves, resulting in an increased risk of unpredictable deterioration from minor events.

Frailty prevalence is significant, there are 7,139 people aged 65+ registered with a GP in Herefordshire & Worcestershire, coded as living with severe frailty or of having a Rockwood score of 7,8,9 which is 8% of our registered population. Half of our 85+ population will live with frailty.

2. What have we delivered in our first year, 2023/24?

- Development of a Frailty Strategy
- Expansion of the Falls Response Service in a winter pilot, to respond to non-injured fallers from 999/111 referrals as well as pendant alarm calls. An average of 70 non-injured fallers per month are now seen by the Falls response service.
- Re-procurement of the Falls Response Service to secure provision for the system.
- Review of the current falls prevention pathway
- Launch of home for lunch campaign
- Single point of access launched, improving access to the right service to meet peoples' needs, avoiding unnecessary hospital admission (in both Herefordshire & Worcestershire)

3. What are the priorities going forward?

The Herefordshire & Worcestershire ICS Frailty Strategy aims to support health and care organisations across Herefordshire and Worcestershire to collaborate and enhance integrated care services for people at risk of or living with frailty.

Our integrated care vision is that **"People living in Herefordshire and Worcestershire who are at risk of, or living with frailty will, live well in a supportive community with accessible, personalised and coordinated high-quality care delivered in the most appropriate setting whenever they need it."**

The Strategy has nine key strategic outcomes:

1. Increase community interventions measures to prevent the onset and progression of frailty
2. Increase early identification of people living with or at risk of frailty
3. High quality proactive comprehensive assessment of people living with or at risk of frailty.
4. High quality accessible and coordinated personalised care for people living with frailty, their Family's and carers in every care setting
5. Frailty attuned acute care which facilitates timely discharge and smooth transitions between care settings
6. High quality reablement and rehabilitation after a period of illness and at times of transition from hospital
7. High quality end-of-life care for people with frailty, their Family's and carers.
8. Compassionate, timely and effective advanced care planning in all health and care settings.
9. A workforce with the appropriate skills to provide specialist care to patients in all health and care settings.

The strategy will be underpinned by place based operational delivery plans.

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Prevention of frailty	• Improved access to strength and balance classes across the system. • Ensure provision of a community Falls prevention service across the system.	By 2025/26
Standardised approach to the identification of patients living with frailty	Develop and maintain frailty registers across primary care and community services, with agreed approach to risk stratification	By 2024/25
Develop proactive care delivery	Review national proactive care framework Development of proactive care pathway and resources	By 2025/26
Support a consistent approach to comprehensive Geriatric assessment	Develop digital comprehensive geriatric assessment Promote take up of comprehensive geriatric assessment	By 2024/25
Workforce	Review Primary Care Networks and Community services workforce roles and responsibilities, with common competencies for core frailty team. Establish model of integrated core frailty team working across primary care, community and secondary care services.	By 2025/26
Support care homes	Support care homes to recognise signs of deterioration in their residents' health Offer education and training on clinical aspects of frailty to care homes	By 2024/25

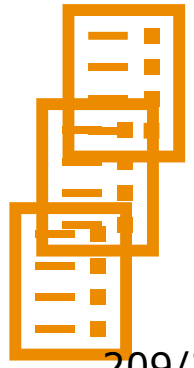
4. Where you can find more detail?

NHSE (2019) *The NHS Long Term Plan*. Available from: NHS Long Term Plan v1.2 August 2019

NHSE (online) Ageing well and supporting people living with frailty. Available from: NHS England » Ageing well and supporting people living with frailty

British Geriatric Society. (2023) *Joining the dots: A blueprint for preventing and managing frailty in older people.* Available from: Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk)

British Geriatric Society (2020) End of life care in frailty: Identification and Prognostication. Available from: End of Life Care in Frailty: Identification and prognostication | British Geriatrics Society (bgs.org.uk)



High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

1. Why is this important?

Ageing population

Herefordshire and Worcestershire's population is due to increase by approximately 5.4%. H&W have older population structures than the rest of England, with over 65+ increasing and younger populations decreasing.

Increased multimorbidity

The ageing population increase will reflect a significant increase of people living with dementia, frailty and other long-term conditions.

Increased number of deaths

Nationally, deaths are predicted to increase by 22% 2030-2040

Increased number of people dying at home

- The majority of bereaved Family's included in the national VOICES survey believed the deceased had wanted to die at home (81%), with a selected sample showing 22% had home as place of death documented on death certificates.
- Community services will need to be available to support people to die well at home, if it is their wish and where it is possible.

2. What have we delivered in our first year, 2023/24?

- We are improving the sharing of information with the use of the Shared Care Record. This has an End-of-Life tab which shares data coded in EMIS in line with the End- of-Life Professional Record Standards Body data set for appropriate health provides across the system to view.
- We have enhanced the palliative care register with a new palliative care register EMIS template to support primary care to collect and code this information.
- ReSPECT ECHO (Extension of Community Healthcare Outcomes) sessions have been delivered to nurses within nursing homes.
- A palliative and end-of-life ECHO session is available every month for healthcare professionals across the ICS.
- Our digital ReSPECT plan has been signed off by the Resuscitation Council UK.
- A standard advance statement document has been created for use across the system.

3. What are the priorities going forward?

The Palliative and End-of-Life Programme Board is implementing the Herefordshire and Worcestershire Personalised End-of-Life Care Strategy 2020-2025, working in partnership with representatives across the ICS.

The vision is that "adults and children living in Herefordshire and Worcestershire, regardless of their diagnosis, will be supported to live well until the end of their life". It is imperative that care at the end-of-life is compassionate, tailored to the dying person and people important to them, and includes effective communication and assessments.

The six strategic outcomes are:

1. Increased and early identification of people who would benefit from end-of-life support and personalised care planning
2. High quality care for people at the end of life, their Family's and carers in every setting
3. Accessible, coordinated and digitally enabled palliative and end-of-life services for all patient groups
4. A workforce with the appropriate skills to provide people at the end of their life with high quality care and support
5. High quality bereavement care, support and information available to all
6. An embedded ReSPECT process which supports compassionate, effective and timely Advance Care Planning in all care settings

The key areas of delivery are:

- 24/7 Single point of access for palliative and end-of-life care advice and support for patients
- Making the best use of digital opportunities to improve communication and sharing of information, e.g. digitalisation of ReSPECT and Advance Statement; digitalisation of the palliative care register; and developing the Shared Care Record (ShCR)
- Review of Bereavement services
- Review of Anticipatory medications
- Development of Palliative and end-of-life care Virtual Ward

High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when?

Priorities	Deliverables	Year of Delivery
24/7 Single point of access to timely support and advice	Review 23/24 pilot	By 2024/25
Coordinated education and training across the ICS focusing on communication and clinical skills to improve timely recognition of dying, promoting personalised care and advance care planning discussions	Early identification, ambitions mapping, ICS academy, End of Life Care Hub (ECHO) opportunities for sharing learning	By 2024/25
	Continued ambitions self-assessment, developments required based on those assessments. Continued development and work with ECHO hubs and the ICS academy	By 2027/28
Shared access to electronic patient information	Complete capability to share information: - Shared Care Record interoperability with EMIS. - Worcestershire out of hours access to the Shared Care Record	By 2024/25
	Develop access for Care Homes to Shared Care Record	By 2027/28
Embed digital ReSPECT process	Launch and promote digital ReSPECT Launch and promote digital Advance Statement	By 2024/25
	Review data collection, patient and carer feedback to inform promotion and take-up of ReSPECT	By 2027/28
Increased early identification of people who will benefit from end of life support and personalised care planning	Develop education for Primary Care and other practitioners.	By 2024/25
	Review of the new primary care template Develop ICS wide palliative care register-possibly with using clinithink	By 2027/28

High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when continued ?

Priorities	Deliverables	Year of Delivery
High quality care for people at the end of life, their Family's and carers in every setting	Data dashboard to include core 20+5 data. Identify inequalities, geographical inequalities, engaging with hard-to-reach communities. Continue anticipatory medication work. CHC FT review and re procurement. Palliative and End of Life Care (PEoLC) Virtual Ward pilot	By 2024/25
	Review services and address inequalities ICS PEoLC virtual ward Review impact of changes from the anticipatory medications work CHC FT impact of new service	By 2027/28
Data dashboard and strategic needs analysis (SNA)	Work with data analytics team to create new data dashboard and collect new data to inform population needs. Meet with stakeholders to explore results of the SNA	By 2024/25
	Continue to monitor and update data dashboard Develop any proposals to reflect findings of the SNA	By 2027/28
High quality bereavement care, support and information available to all	Bereavement group, mapping of services and update leaflets	By 2024/25
	Continue to monitor and review bereavement services	By 2027/28

5. Where you can find more detail?

Palliative and End of Life Care Programme:

- Herefordshire and Worcestershire Personalised End of Life Care Strategy 2020-2025
file (herefordshireandworcestershireccg.nhs.uk)

- Ambitions for Palliative and End of Life Care: A national framework for local actions 2021-2026
ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

- NHSE NHS England » Resources and support

- Please email jadebrooks@nhs.net for more information, or to become a patient representative or person with lived experience on any of the palliative and end of life care groups.

High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

1. Why is this important?

National LeDeR report findings from 2021:

- 49% of deaths avoidable/ amenable to good health and social care (and at least 2 times higher than general population)
- Life expectancy 20 years less than general population

In addition, for autism, life expectancy is 16 years less than average for population, and over 80% of autistic adults experience mental health difficulties in their life.

The issues are complex. One of the main factors is that people with a Learning Disability and autistic people (LDA) are underserved groups and do not have consistent access to health services in a timely way due to lack of reasonable adjustments and diagnostic overshadowing. This means health care is sometimes accessed or provided at a late stage of presentation, when the health condition is at an advanced stage or the person is in a crisis (leading to Mental Health Act assessment and hospital/ restricted environment admissions, Emergency Department attendance) and fundamental universal services such as routine vaccinations and or cancer screening are delayed or missed.

2. What have we delivered in our first year, 2023/24?

- Maintained AHC take-up above national target
- Over 50% of GP Practices assessed as sensory friendly
- Contributed to development of national RADF rollout, including GP UAT site
- Fully recruited to key worker service and halved number of CYP in T4 beds
- Agreed investment and service development plan in LD services for 2024/25 to improve personalised care and support
- Tackled delay in completing LeDeR reviews so that national targets will be met or exceeded by March 2024
- COVID vaccination rates highest in region
- Invested £72k to tackle autism waiting list for adults
- Empowered engagement with ReSPECT for people and their Family's through series of workshops
- Supported awareness of bowel health, contributing to increased uptake in bowel screening for people with a learning disability
- Following Step Together Review, invested in specialist epilepsy nursing for children and young people

3. What are the priorities going forward?

The Learning Disability Partnerships and the All-Age Autism Board have oversight of the plans to improve outcomes for people with disabilities and people with Autism.

Our vision for people with a learning disability is that all people with a learning disability can live healthy and positive lives, and we will do this by promoting reasonable adjustments and tackling health inequalities across the system.

In section 3 you will see the areas we are going to address in line with the NHS Long term plan commitments:

- Taking action to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- The whole NHS family will improve its understanding of the needs of people with learning disabilities and autism, working together to improve their health and wellbeing. Including training for the workforce, reasonable adjustments and a digital flag in patient records by 23/24.
- Reducing the waiting times for children and young people with suspected autism, and designated key workers for children and young people with the most complex needs.
- Increased investment in personalised care and community support.
- We will continue to focus on improving the quality of inpatient care and timely discharge where appropriate.

High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
GP practices are sensory-friendly and accessible to autistic people	Over 66% of practices assessed and environmental reasonable adjustments in place, led by autistic people	By 2024/25
Good quality Learning Disability Annual Health checks routinely given to all people with a Learning Disability	Sustain up take of AHCs at 85%, Health Action Plans over 90%, including 14-24 year olds, supported by quality improvement programme focusing on Health Action Plans	By 2024/25
Vaccination and screening rate for people with a learning disability and autism comparable to general population	Awareness raising and targeted work, built around AHCs	By 2024/25
Reduction in avoidable deaths - Learning from the Deaths of People with a Learning Disability Review programme (LeDeR)	Programmes of work following on from LeDeR Learning into Action workstream. Current focus is healthy lifestyles; suicide reduction for autistic people	By 2024/25
Reduction in waiting times for autism diagnosis	Comprehensive review of neurodivergence pathway for CYP to ensure consistency across ICS and more timely diagnosis	By 2024/25
Support to autistic people post-diagnosis	Continued investment in adult support service	By 2024/25
Raise awareness and inclusion of autistic people in mainstream services	Continued roll-out of Oliver McGowan Mandatory Training programme	By 2024/25
Reduce number of young people in Tier 4 beds with LDA and sustain current low adult numbers	Develop Key worker model for adults; invest in community forensic services; sustain low number of young people in T4 beds and reduce numbers of adults in locked rehab beds.	By 2024/25
Increase community Occupational Therapist, Physical Therapist, Speech and Language Therapist and epilepsy support capacity	Deliver service enhancements following agreed investment in community health service	By 2024/25
Tackle heath inequalities Ensure that people with complex needs are supported to live in the community and admission to in-patient units is avoided	• Over 85% of eligible people with a learning disability have an annual health check and over 90% of those have a health action plan • Vaccination and screening uptake is at least on a par with the rest of the population • In-patient rates are in line with or better than the national targets • Waiting lists for community support is less than 18 weeks • Oliver McGowan Mandatory Training has been rolled out across the system	By 2027/28

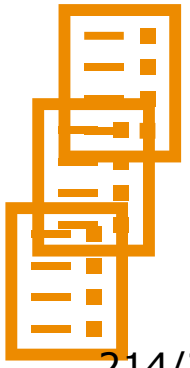
5. Where you can find more detail?

https://www.hwics.org.uk/our-services/learning-disabilities-and-autism

Co-production underpins our approach and we work closely with the Learning Disability Partnership Boards and the Autism Partnership Boards in Herefordshire and in Worcestershire. Experts with lived experience are actively involved, with support, in all strategic developments, and co-chair the Partnership Boards. Family carer voices are also strongly represented.

People with a learning disability can contact SpeakEasy NOW if they wish to become involved https://speakeasynow.org.uk/contact-us/

Our partnership arrangements also include the Acute and Community Provider Trusts, both Councils and the voluntary and independent sector.



High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

1. Why is this important?

We know that people are waiting longer than they should to access diagnosis and treatment.

After a decade of improving population wellbeing the COVID-19 pandemic is widely considered to have negatively impacted population mental health and wellbeing. Measures of population wellbeing worsened, particularly during the two main waves of the pandemic and have not fully recovered to pre-pandemic levels.

The proportion of adults aged 18 and over reporting a clinically significant level of psychological distress increased from 20.8% in 2019 to 29.5% in April 2020, then falling back to 21.3% by September 2020. There was a subsequent increase to 27.1% in January 2021, followed by a further decrease to 24.5% in late March 2021.

While there has been considerable economic recovery from the initial shocks of the COVID-19 pandemic, new challenges have emerged, with high levels of inflation and a rise in the cost of living.
Concerns have been raised about the impact this may have on population mental health, and nationally providers continue to report greater acuity of need across mental health services.

Furthermore, these challenges have highlighted and widened some of the existing inequalities in mental health and wellbeing in the population.

2. What have we delivered in our first year, 2023/24?

- Performance and quality within NHS Talking Therapies has increased, including reduced inequality of outcomes for patients across age bands, and from BAME communities.
- Perinatal mental health services have been expanded to provide greater access, longer treatment periods and partner assessment
- Inappropriate Out of Area Placements have been reduced, though there is scope for further improvement
- Quality standards have been achieved and embedded within Early Intervention in Psychosis services

3. What are the priorities going forward?

A key strategic development as part of the creation of the Integrated Care System has been the establishment of a **Mental Health Collaborative,** which brings together commissioning and provider functions, primary and secondary provision and broader connections to local stakeholders.

The overarching reason for creating the mental health collaborative has been to put the responsibility for organising services and pathways as close as possible to the front-line services that provide patient care. This marks a significant change from the traditional commissioning model of developing detailed services specifications that providers respond to; much more towards a model of agreeing outcomes that providers design service delivery models to address.

Priority areas for 2024-25 include:

1. Increasing access to NHS Talking Therapies
2. Increasing access to Individual Placement Support (IPS) services
3. Redesigning Inpatient and Rehabilitation Pathways across the ICS
4. Reduction of Out of Area Placements, including reinvestment of these funds back into local services
5. Delivery of community rehabilitation function within community mental health transformation

In addition, there are five other workstreams for the ICS that include and reflect the long-term plan priorities for mental health in addition to local priorities. These are:

The role of the Herefordshire and Worcestershire Mental Health Collaborative is described in more detail in Appendix 2, theme 15.

High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

4. What will we deliver and when?

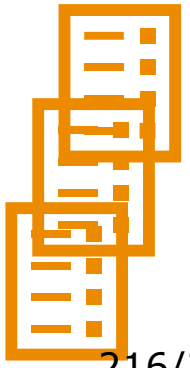
Priorities	Deliverables	Year of delivery
Children and young people	Annual system-wide transformation plan – Prevention and access	By 2024/25
NHS Talking therapies	Delivery of all access and waiting standards	By 2025/26
Early intervention in Psychosis	Continue to deliver required standards and embed learning	By 2024/25
Dementia Diagnosis	Diagnosing Advanced Dementia Mandate pilot evaluation and increase of post-diagnostic services	By 2024/25
Perinatal Mental Health	Continue to deliver expanded and extended access, and provision for partner assessment	By 2024/25
Out of areas placements (OAP)	Reduction of inappropriate OAPs to nil	By 2024/25
Physical Health for people with a serious mental illness (SMI)	Increased uptake of SMI health checks across primary and secondary care, supported by improved joint-working approaches across agencies	By 2024/25
Adult community mental health	Full delivery of transformation in line with new national Community Mental Health Framework, notably community rehabilitation functions	By 2024/25
Suicide prevention	Review of Suicide Prevention Strategies and expansion of programme	By 2024/25
Urgent mental health care	Access to all-age 24/7 Urgent Mental Health support via 111	By 2024/25
Our 5 Mental Health Strategy priorities are: • Community Empowerment • Prevention and Self-Care • Accessible Services • Person-Centred Services • Integrated Services	• Review of Mental Health Strategy for 2024-26 • Delivery of new national priorities • Reduction in health inequalities for people experiencing mental health illness	By 2027/28

5. Where you can find more detail?

The Herefordshire and Worcestershire Mental Health Strategy 2022-2026 is available here:
https://herefordshireandworcestershireccg.nhs.uk/policies/corporate/corporate-2/1201-mh-strategy-full-version/file

The Worcestershire Health and Wellbeing Strategy 2022-2032 also contains a strong mental health focus and is available here:
https://www.worcestershire.gov.uk/sites/default/files/2023-02/health_and_wellbeing_strategy_2022_to_2032.pdf

Public engagement opportunities are advertised through the ICB and local authority websites, as well as on the Herefordshire and Worcestershire Health and Care NHS Trust website.



High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

1. Why is this important?

The prevalence of LTCs in H&W is projected to increase substantially over the next 10 years. Approximately 20, 000 more people will be living with Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Stroke or Diabetes in 2033 compared to 2023. This increased prevalence is estimated to cost the system £11 million more per year in urgent care utilisation alone.

These projections are in part driven by the increase in are over 65-years old population, which we anticipate to increase by 36, 000 by 2030. However, we are also seeing an increasing prevalence of type 2 diabetes in the 15-19 and 40-49 age ranges in our two counties, demonstrating a need for increased education and prevention to improve quality of life for younger people with LTCs and to prevent LTCs developing so early in life.

We are increasingly aware of growing excess mortality resulting from cardiovascular disease and this trend is greatest in our most deprived communities. People in our most deprived communities are developing multiple LTCs at a younger age than those in our least deprived communities. It is essential that we tackle this inequality difference to ensure all people can live as well as possible.

2. What have we delivered in our first year, 2023/24?

- Cardiovascular disease forum established, focussing on improvements to high cholesterol identification and management.
- Pulmonary rehabilitation forum established and supported self-management resource developed.
- Roll out of video library for patients, enabling education and supported self-management across long-term conditions.
- Continuous Glucose Monitoring is being delivered as business as usual.
- All Primary Care Networks delivering Spirometry testing, recording a 180% rate increase since the start of 2023/24.
- Fractional exhaled nitric oxide (FeNO) testing LES in place in Worcestershire.
- Reviewed Home oxygen service, with improvements carried out and provision in line with national guidance.
- Continuation of the National Diabetes Prevention Programme demonstrating high retention rate and good weight loss outcomes.
- Roll out of NHS Type 2 Diabetes Path to Remission Programme.
- Reduction in both major and minor amputation rates resulting from Diabetes Foot Care service improvements.
- Standardisation of formularies, to reduce reliever medication reliance and move to greener options.

3. What are the priorities going forward?

The work on long-term conditions is overseen by several Programme Boards: Children and Young People Programme Board; Elective Diagnostics and Cancer Programme Board and the Health Inequalities, Prevention and Personalised Care Programme Board. A long-term conditions strategy is in development, with the following priorities:

Prevention

- People will be actively signposted to appropriate education and organisations that can increase their knowledge, skills and confidence to live as well as possible, reducing their risk of developing long-term conditions.
- People will have improved access to evidence-based high impact interventions that prevent deterioration of long-term conditions.

Early and Accurate Diagnosis

- People who are at increased risk of developing a long-term condition will be proactively identified and supported.
- More people will have their LTC(s) identified sooner and closer to home.

Personalised Management

- People will be provided with education, support and resources to enable them to take a more active role in decisions about their care.
- People with multiple LTCs will receive proactive, holistic assessments, including medication and mental health reviews

Right care in the right setting

- Increase collaboration by services to enable care to be delivered as close to home as the complexity allows.
- Increase adoption of digital technologies that enable more effective self-management outside of a hospital setting.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Long Term Conditions Strategy	Development of a long-term condition strategy, focussing on prevention, early and accurate diagnosis, personalised management and the right care in the right setting. Development of place-based partnership strategy delivery plans.	By 2024/25 By 2024/25

High quality, patients centred services: LONG TERM CONDITIONS

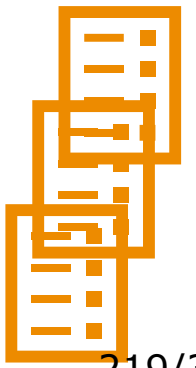
Theme 8

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Cardiovascular Disease (CVD)	Continued and enhanced delivery of high impact interventions for secondary prevention: • Community pharmacy hypertension case finding • Cholesterol search and risk stratification • NHS health check • Case finding and direct-acting oral anticoagulation to prevent atrial fibrillation related strokes • Cardiac rehabilitation for patients post-ACS and diagnosis of heart failure • Optimisation of hypertension treatment • Optimisation of heart failure treatment through annual reviews • Optimising management post ACS, including lipid management.	By 2024/25, but ongoing throughout delivery of JFP
Diabetes	To begin / continue delivery of the following nationally identified priorities: • Continued delivery of 9 diabetes care processes, including enhancements, e.g. the roll out of the Type 2 Diabetes in the Young programme. • Continuation of Type 2 Diabetes Path to Remission programme. • Delivery of NICE Technology Appraisal for Hybrid Closed Loop. To begin / continue delivery of the following locally identified priorities: • To develop a workforce model , that enables integration and better meets anticipated future demand, including for specialist diabetes care. To begin / continue delivery of the following high impact interventions for secondary prevention: • Improved identification of individuals at high risk of Type II Diabetes and signpost to NHS Diabetes Prevention Programme. • Improve equity of quality and access to Diabetes structured education across the two counties.	By 2024/25 but ongoing throughout delivery of JFP
	• Improve the Digital offer for enabling supported self-management in Type 1, including in Children and Young People. • Improve pre-diabetes screening and symptom awareness. • Development of a Diabetes Support Team in Primary Care Networks to deliver care closer to home.	By 2027/28
Respiratory	• To continue to work to reduce inequalities in access, experience and outcome in pulmonary rehabilitation. • To consider adoption of the Getting it Right First Time Programme. • To create equity of access for FeNO in Herefordshire.	By 2024/25
	• For Herefordshire to achieve accreditation for Pulmonary Rehabilitation service. • Achievement of Pulmonary Rehabilitation 5-year plan • To have a coordinated asthma transition pathway.	By 2027/28

5. Where you can find more detail?

- Multiple_LTCs_Survey_-_Engagement_Report_-_Final.pdf (hwics.org.uk)
- https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/
- National Asthma and COPD Audit Programme (nacap.org.uk)
- pulmonary-rehabilitation-service-guidance.pdf (england.nhs.uk)
- spirometry-commissioning-guidance.pdf (england.nhs.uk)



High quality, patients centred services: STROKE CARE

Theme 9

1. Why is this important?

1. Lack of 7-day service provision in Hyper Acute/Acute stroke services, and unlikely to deliver in current format;
2. Current medical workforce challenges mean moving the service from 5 – 7 days (in and out of hours) is unlikely to be achievable;
3. Services at both Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trust (WAT) are classed as fragile due to longstanding medical establishment staffing gaps;
4. Increasing demand for stroke services over the next ten years increase this challenge further with expected demand to increase by 16% at WAT and 15% at WVT.
5. Achievement of **key clinical and performance standards** will continue to be a challenge and unlikely to be achievable unless changes are made to the existing service models;
6. National Clinical Guideline 2023 recommendations presents challenges in compliance;
7. Stroke services have a current risk score of 16 on H&W ICB Risk Register

2. What have we delivered in our first year, 2023/24?

- Sustainable delivery of 7-day acute stroke care model
  - Pre-consultation engagement recommendations incorporated into work programme;
  - Evaluation framework developed and panel facilitated to agree preferred clinical model of one HASU/ASU on centralised site
  - Preferred clinical model agreed by Stakeholders and timeline for Clinical Senate process agreed.
- Service Improvement programme
  - Roll out of 'Rapid AI' technology at both HCH and WRH to support advanced imaging and workflow to enable physicians to make faster, more accurate triage or transfer decisions;
  - This technology enabled a joint H&W Out of hours medical rota for Thrombolysis decision making implemented;
  - Programme commenced reviewing quality improvement opportunities across HW Stroke Rehabilitation pathway.

3. What are the priorities going forward?

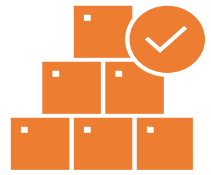
ICS Stroke Programme Board (SPB) involves stakeholders across the stroke pathway (Herefordshire, Worcestershire and Powys Teaching Health Board) Healthwatch, West Midlands Ambulance Service, Stroke Association and Patient engagement. The Programme Board focusses on the entire Stroke Pathway, from Hyper-acute to Rehabilitation.

Priority 1: The Stroke Programme Board is committed to delivering a new, **sustainable 7-day acute stroke services model**. This will modernise how services assess and treat patients; ensuring optimal clinical model of care and the best use of resources across the entire pathway, including staffing and use of technology. To achieve this vision, the Stroke Programme Board has commenced a pre-consultation process and a preferred clinical model has been identified. This model will be subject to demand and capacity modelling, workforce requirement review, equality and financial assessments and a full public consultation process in line with NHSE guidance. It is recognised that this model will require capital investment and is the longer-term strategy required to deliver sustainable stroke services for the future.

Priority 2: The **Stroke Services Improvement programme** focusses on:

- Workforce development
- Digital enablers
- Performance Standards
- Development of patient pathways, in line with national standards

The Stroke Programme is aligned to and supported by the Integrated Service Delivery Network (ISDN) and The National Stroke Quality Improvement in Rehabilitation (SQuIRe) programme.



4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Service Improvement Programme	• Workforce developments resulting in robust medical and nursing workforce with joint working/posts across Hereford County Hospital and Worcester Royal Hospital to ensure resilience. • Advances in digital technology embedded, with virtual consultations part of everyday practice where appropriate. • Development of a service specification for an integrated community stroke service. • Development of Clinical Guidelines for Stroke. • Improvement in performance standards.	By 2024/25
Sustainable delivery of 7-day acute stroke care model	• Completion of NHS Gateway assurance (one and two), Clinical Senate process undertaken and public consultation commenced (subject to approval of Business Case).	By 2024/25
	• Stroke services transformed with agreed clinical pathways embedded and services delivered in line with national guidelines and performance standards.	By 2027/28

5. Where you can find more detail?

In January 2022 we considered all the previous patient and public feedback we had received about stroke services. This was summarised in a paper, which is available here.

A further Stroke Services issues paper was written in September 2022 and further engagement undertaken :-

Stroke Services :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

Integrated Community Service Specification - Feb 2022

National Clinical Guideline for Stroke 2023

High quality, patients centred services: URGENT AND EMERGENCY CARE SERVICES

Theme 10

1. Why is this important?

The Urgent and Emergency Care (UEC) system in Herefordshire & Worcestershire is in a challenged position. However, ICB and system partners remain committed to making sustainable improvements across the entire health system to support timely care and efficient patient flow.

The National delivery plan for recovering UEC services sets out core indicators to Increase urgent and emergency care capacity by March 2024 including:

1. No less than 76% of patients (in Emergency Departments) are seen within 4 hours
2. Ambulance category 2 mean response time is less than 30 minutes
3. Achieve an average adult G&A bed occupancy of 92% or below

The system forecast outturn for 2022-23 against these targets which demonstrate the challenged situation are:

1. 62.8%
2. 49.2 Minutes
3. 92.8%

2. What have we delivered in our first year, 2023/24?

- Enhancements to emergency care provision with a new Emergency Department (Worcester Royal), and improved areas for delivery of ' same Day emergency care' (medical and surgical).
- Launch of Single point of access covering Community and Acute Trusts, improving the coordination of people to the most appropriate service (in both counties).
- Growth in the number and type of virtual wards across the system.
- Creation and implementation of NHSE Tier 2 urgent and emergency plan, with associated Emergency Access Standard improvement trajectory (to 76% by March 2024).
- Integrated Care System Frailty strategy developed with local delivery plans.
- Overarching urgent and emergency care strategy developed, setting out the work of the ICS urgent and emergency care Programme Board.
- System Coordination Centre fully compliant with national standards and oversight of the day-to-day urgent and emergency care pressures.
- Implementation of national call-before-convey requirement, building upon the success of the urgent community response service.
- Home for Lunch campaign to promote earlier in the day discharges.
- Improvements to Discharge Pathways.

3. What are the priorities going forward?

- The Urgent and Emergency Care Programme Board is driving forward improvements for a responsive and affordable urgent and emergency system that meets the population's needs. This includes preventative or activities to manage ill-health before it becomes an emergency, and timely and efficient patient flow, resulting in less ambulance handover delays and minimalising waits within Emergency Departments.
- Within the Integrated Care Strategy is a commitment to "Making the right service the easiest service to access and providing it as close to home as possible". Ensuring the UEC strategy delivers against this commitment will lead to better services and ultimately improved outcomes for patients across primary, community and acute services. Our plan over 5 years includes a focus on admission avoidance and integrating urgent care.

The six priorities are:

1. Population management - To apply population health management approach to identifying those most at risk
2. Care at Home - To maximise the coordination of services to proactively intervene early and prevent the deterioration of frailty and ill-health
3. Future model of urgent care - To establish a model of integrated urgent care that supports people to access advice and interventions.
4. Emergency care - To consistently demonstrate an effective and efficient emergency care provision.
5. Discharge and recovery - To have a 'zero delay' approach to discharge planning with coordinated support for people to optimise their recovery.
6. Operational resilience - To demonstrate effective resource allocation to de-escalate or prevent pressure.

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Population Health Management	• Implement data gathering on health inequalities • Undertake population health assessments • Tailor approaches to people most-at-risk of requiring urgent & emergency care • Recovery of elective care waiting times	By 2024/25 By 2025/26 By 2025/26 By 2025/26
Care at Home	• Care at Home delivered by Integrated Neighbourhood Teams • Development of virtual hospital • Frailty competent workforce • Full coverage of falls response service	By 2025/26 By 2024/25 By 2026/27 By 2024/25
Future model of urgent care	• Improve same day urgent care pathways 24/7. • Delivery of a single point of access and enhance care navigation • Encourage people to use NHS111, mental health crisis support and HandiApp. • Enhance community-based services for people who do not need hospital care.	By 2024/25 By 2024/25 By 2026/27 By 2026/27
Emergency care	• Consistently achieve under 30 minutes category two ambulance response times. • Achieve high performing Emergency Departments • Implement 'front door' streaming to right care setting • Maximise same day emergency care, including access to diagnostics 7-days	By 2024/25 By 2026/27 By 2024/25 By 2026/27
Discharge and Recovery	• Commit to returning home sooner #Homeforlunch • Enhance Frailty Rehabilitation & Discharge pathways • Improve Discharge-to-Assess pathways across the system • Promote Home First and community support for patients	By 2024/25 By 2025/26 By 2025/26 By 2024/25
Operational resilience	• Operate a fully compliant System Coordination Centre • Conduct annual winter and surge planning • Run public awareness campaigns to support people to use the right service • Develop shared training, common approaches and local knowledge across the workforce • Operate 7-day working across urgent & emergency care	By 2024/25 Ongoing By 2024/25 By 2026/27 By 2026/27

5. Where you can find more detail?

The ICB and ICS system partners are refreshing the UEC Strategy, a link will be shared when this is available.

More information and context for the ICBs priorities can be found within the national recovery plan:

- B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf (england.nhs.uk)

Findings from Healthwatch talking to our patients will inform the focus of other workstreams to ensure care in the right place, at the right time, as close to home as possible, further engagement will be planned with Herefordshire:

What patients told us about why they "walk in" to A&E Departments in Worcestershire | Healthwatch Worcestershire

1. Why is this important?

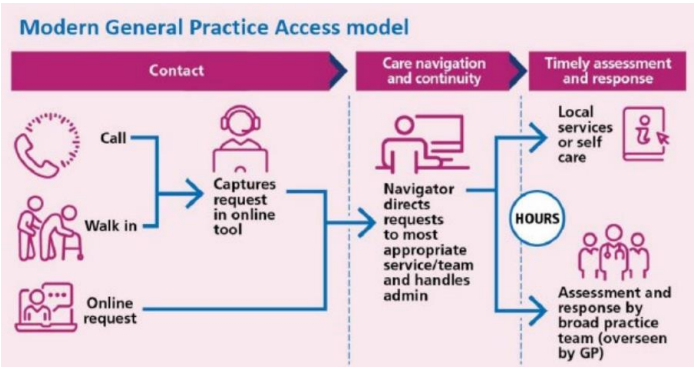
- Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS & providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.
- Despite this, there are real signs of genuine & growing discontent with primary care – both from the public who use it & the professionals who work within it. Across Herefordshire & Worcestershire 76% of patients rated their experience with their practice as good. National average is 71%. As an ICB we are ranked 6th best in the Country.
- There are a number of workforce challenges in primary care. Across Herefordshire & Worcestershire, just under 50% of the GP workforce are 10 – 15 years from retirement. Overall, there has been a reduction in the number of GP partners & salaried GP's from 2021 to 2024.

2. What have we delivered in our first year, 2023/24?

Primary Care Access Recovery Plan - Implementation of the local Herefordshire and Worcestershire Primary Care Access Recovery Plan, in year one of this two-year programme we have:

- Delivered 5.5 million appointments in General Practice. This is 18% more appointments than before the COVID-19 pandemic. GP Practices are now providing patients with access to around 500,000 appointments a month. This is almost 100,000 appointments per month more than pre-pandemic.
- 37 practices have commenced implementing the Modern General Practice Access (MGPA) model to tackle the 8am rush, provide rapid assessment and response and avoid asking patients to ring back to book an appointment. 72 practices (91%) to date have signed up to move to this in the next 2 years.
- 100% of practices have cloud-based telephony in place. 100% practices have released online access to patient records. 100% practices have a digital communication tool Accurx and 100% practices have Online Consultation solutions in place.
- Self-referral pathways for patients– adult audiology is now live with 4/5 providers enabled.
- Primary-Secondary Care Interface 'working better together principles' drafted with stakeholders. Developed implementation plans for key documentation for the areas of focus – eg discharges. A discharge template letter has been developed, ready for adoption across both Herefordshire and Worcestershire Trusts.

- The Herefordshire & Worcestershire ICB's published Primary Care Access Plan was approved by the H&W ICB Board on 15 November 2023, which can be accessed via the website at agenda item 10: PC Access Recovery Plan



- The ICB will support all practices to move to the Modern General Practice Access (MGPA) model over the next 12 months to improve ease of contact, patient experience and enable practices to better manage workload and demand.

Workforce

- Development of continued recruitment to ARRS roles, maximising available funding through oversight and assurance processes. 388 additional direct patient care staff recruited up to Mar 24, to contribute to our share of 26,000 national additional roles target.
- Workforce retention and wellbeing focus. Successful delivery of retention and recruitment schemes to General Practice with high uptake and positive feedback.
- Co-production of workforce priorities and actions across all partners.
- Primary Care participation in national staff survey. Local staff wellbeing survey undertaken.

Estates

- Finalisation of the PCN Clinical and Estates Strategies (Phase 2) and commencement of Phase 3 Integrated Estates programme in preparation for the development of the ICS Infrastructure Plan 24/25.

High quality, patients centred services: PRIMARY CARE SERVICES

Theme 11

3. What are the priorities going forward?

Enabling General Practice Strategy priorities

Planning and oversight is currently governed via the GP Sustainability and Transformation Forum, with overall accountability with the Strategic Commissioning Committee. Delivery via Herefordshire General Practice and General Practice Worcestershire Boards.

Integrated Neighbourhoods Teams – developing and supporting services delivered at a neighbourhood level – are central to transformation priorities of the Herefordshire & Worcestershire Integrated Care System

Enhancing services in primary care by prioritising workforce, estates and technology investment at a neighbourhood level will enable our citizens to have better local access to a wider range of services they need when they need it

Creating the conditions to better manage patient demand for primary care will enable GP practices to provide continuity of care to those who want and need it and give increased focus to prevention – support the ICS aspiration to reduce inequality and enhance outcomes.

All designed to ensure that the people who need and want to access primary care can get it, and that GPs have more time to provide continuity of care and deliver more preventative care going forward

5. Where you can find more detail?

- **Long Term Plan**
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

- **Hewitt Review**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachmentdata/file/1148568/the-hewitt-review.pdf

- **Fuller Stocktake**
https://www.england.nhs.uk/wp- content/uploads/2022/05/next-steps-for- integrating-primary-care-fuller-stocktake- report.pdf

4. What will we deliver and when?

Priorities	By Year 2	Year of delivery
Implementation of Fuller Report	• Lead & co-ordinate ICS response to Fuller & the moving towards a new model of care at Neighbourhood level. Starting in 2024\25 we want the System to orientate itself around 15 Neighbourhoods to reflect the needs of our Communities.	By 2024/25
General Practice	• Lead the co-production of a "Enabling General Practice" 3 year strategy with short, medium and long-term priorities beyond the ending of the PCN DES Network. Set in the context current pressures, whilst raising ambition. • Drive a standardised and consistent offer to all residents of the highest standard • Focus and target unwarranted variation across all practices and see an improvement across accessing and ease of contact with practices as well as a broad range of long term conditions • Co-produce with General Practice a transformation programme which supports all practices in reaching their potential and builds capacity within practices to manage change and drive improvement	By 2024/25
Primary Care Estates	• Develop the local Primary Care Estates Infrastructure Plan (Q2 24/25)	By 2024/25
Primary Care Access Recovery Plan	• Engage on at scale solutions which sit within our PCARP and use this as a springboard to resilience, sustainability and transformation • Lead and coordinate the response to Year 2 of the National Access Recovery Plan – supporting practices and PCNs deliver their Access Improvement Plans, navigating the national Improvement Programme and Support Level Framework to maximise implementation of transformation support tools locally to enact the necessary change.	By 2024/25
Delegated responsibilities	• Development of a dedicated 'Primary Care & Community Programme Board' to replace the current governance structure and provide an expanded platform to include Pharmacy, Ophthalmic and Dental delegated responsibilities which the ICB became responsible for from April 2023.	By 2024/25
GP Retention Review and refresh around	• Implement a GP Retention Plan and expect a drop in numbers leaving in early stage of their careers and a rise in well being • Review years 1 and 2 of – Enabling general practice and Dental Access strategy • Redefine priorities based on progress made and updated PCN/General Practice Contract from April 2024	By 2027/28 By 2024/25

General Practice Worcestershire's vision is to offer patient-centered healthcare which is high quality, cost-effective and fully integrated with our local partners to ensure a sustainable health service for our communities across Worcestershire. Our vision will be delivered by ensuring we have a happy, valued, supported multi-disciplinary workforce across General Practice.

What we delivered in 2023/24…

Access-

- ✓ Working towards delivery of the national access priorities including modern general practice access – with a number of practices going through the MGPA programme in year 1.
- ✓ Offered over **50, 000** additional same day appointments in addition to GP practice appointments and Enhanced Access.
- ✓ Supported the rollout of Your Health roving vans in Partnership with the ICB, Public Health and District Collaboratives

Workforce-

- ✓ Working towards supporting the ambition to recruit to the ARRS workforce to meet national targets
- ✓ Recruited an additional 86 WTE primary care network staff during 23/24
- ✓ Supported a further cohort of the partnership programme, in order to support the GP Partner model.

Sustainability

- ✓ **T**hrough General Practice Worcestershire Board, working to become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient.
- ✓ Developed a new local enhanced services for Fractional Exhaled Nitric Oxide testing in general practice and expanding our safeguarding network model. Bringing new investment into general practice.

Delivery of Integrated Neighbourhood Teams

- ✓ **W**orking with the ICB, developed an overarching programme and timeline for implementation of the Fuller stocktake in Year 1, with phased delivery, via a Place-plan over the next five years.
- ✓ Continued District Collaborative working, with a focus on Prevention and Tackling Health Inequalities. Increase in community involvement in local services such as menopause, smoking cessation, ageing well, diabetes prevention events, as well as an increase in patients accessing screening services.
- ✓ Working with our Community and Acute partners on Frailty, Virtual Ward, Primary/Secondary interface.

Work with the ICB on the "Enabling General Practice" 3 year strategy

- ✓ General Practice Worcestershire Board established and includes elected practice manager, ICB, LMC. The Board held an all-practice event in November 2023 with partners from across Worcestershire.

What will we deliver over the next five years?

- **Access-** delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care.

- **Workforce-** support the ambition to recruit to the ARRS workforce, stabilise general practice workforce including the partnership model and retaining the workforce including clinical roles in training. Development of a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.

- **Sustainability**-Become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. Continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.

- **Delivery of Integrated Neighbourhood Teams -** continue with the programme and timeline for implementation of the Fuller stocktake with phased delivery, via the Place-plan over the next five years.

- **Deliver the general practice actions outlined in the "Enabling General Practice" 3 year strategy – progressing** beyond the ending of the PCN DES in 24/25, focusing on sustainable and resilience general practice.

High quality, patients centred services: GENERAL PRACTICE WORCESTERSHIRE

GENERAL PRACTICE WORCESTERSHIRE

Theme 12

General Practice Worcestershire's vision is to offer patient-centered healthcare which is high quality, cost-effective and fully integrated with our local partners to ensure a sustainable health service for our communities across Worcestershire. Our vision will be delivered by ensuring we have a happy, valued, supported multi-disciplinary workforce across General Practice.

What we delivered in 2023/24…

- ✓ **Access-** working towards delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care.
- ✓ **Workforce-** working towards supporting the ambition to recruit to the ARRS workforce to meet national targets by 23/24, stabilise the general practice workforce including the partnership model and retaining the workforce including clinical roles in training. We are working with General Practice colleagues across the ICS to develop a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.
- ✓ **Sustainability**-through General Practice Worcestershire Board, we are working to become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. We will continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.
- ✓ **Delivery of Integrated Neighbourhood Teams -** working with the ICB, we have developed an overarching programme and timeline for implementation of the Fuller stocktake in Year 1, with phased delivery, via a Place-plan over the next five years.
- ✓ **Work with the ICB on the "Enabling General Practice" 3 year strategy -** with short, medium and long term priorities beyond the ending of the PCN DES Network, focusing on sustainable and resilience general practice.

What will we deliver over the next five years?

- **Access-** delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care.
- **Workforce-** support the ambition to recruit to the ARRS workforce, stabilise the general practice workforce including the partnership model and retaining the workforce including clinical roles in training. We will develop a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.
- **Sustainability**-Become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. We will continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.
- **Delivery of Integrated Neighbourhood Teams -** continue with the programme and timeline for implementation of the Fuller stocktake with phased delivery, via the Place-plan over the next five years.
- **Deliver the general practice actions outlined in the "Enabling General Practice" 3 year strategy – progressing** beyond the ending of the PCN DES in 24/25, focusing on sustainable and resilience general practice.

High quality, patients centred services: PHARMACY, OPTOMETRY AND DENTAL (POD)

Theme 13

1. Why is this important?

On the 1st April 2023, NHS England delegated the commissioning of the Pharmacy, Optometry and Dental (POD) services to H&W ICB.

The Office of the West Midlands (OWM) was established to support the six ICBs to deliver their commissioning responsibilities.

The Office of the West Midlands (OWM) is hosted by BSoL ICB who provide, oversight, leadership, and support for the workforce who were transferred from NHSE. This arrangement is supported by a formal hosting agreement between the West Midlands ICBs. All decisions are made through the 3 tier Joint Commissioning arrangement and their sub-groups which each ICB is a member of.

Herefordshire & Worcestershire has the Strategic Lead Role for POD services. What this means is – Simon Trickett, via the West Mids CEO Group is the Chief Exec lead for specific programmes such as developing a needs-based allocation formula to support Dental Services for example and escalating any issues to NHSE that may require dispute/resolution.

Specialised Services will be devolved in April 2024, and potentially services such as Childhood Vaccinations & Immunisations and screening programmes in the future.

Over the last 10 years there has been a decline in the number of Dental Practitioners providing NHS dental services to patients, this is particularly prevalent in Herefordshire and improving access to Dental services is a key priority in 2024/5.

2. What have we delivered in our first year, 2023/24?

- Formal establishment of Joint Commissioning arrangements with West Midlands ICBs through the implementation of the Office of the West Midlands (OWM) and the implementation of a 3 Tier Governance Structure.
- Collaborated with the Office of the West Midlands (OWM) to develop a West Midlands wide Dental Strategy due to be published March 24.
- Draft Dental Equity Audit has been developed, which will inform future commissioning intentions, due to be published March 24.
- Successfully commissioned two new dental contracts in Hereford City, which will provide much needed additional dental access for around 7,000 residents.
- Developed relationships with Local representative Committees such as the Local Dental Committee (LDC), Local Optometric Committee (LOC) and Local Pharmaceutical Committee (LPC) to understand the challenges and opportunities for providers to inform future strategic commissioning intentions.
- Worked closely with Community Pharmacies to implement the community pharmacy element of the national Primary Care Access Recovery Plan. In the first year of this two-year programme we have:
  - Pharmacy first commenced for seven common health conditions at the end of January - Sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women without the need to visit a GP practice.
  - Oral contraception service has been expanded – in April 2023
  - Blood pressure check service has been expanded - encouraging utilising technology, to improve efficiency of referrals to community pharmacies. 89 pharmacies signed up to deliver service.
  - Discharge medicine service - Working closely with secondary care pharmacy teams to increase referrals into this service. All 3 NHS Trusts have commenced the service – next steps are full digital integration into discharge pathways.
  - Approved for 3 H&W sites to host Independent prescribing pharmacist clinics – acute conditions; contraception; hypertension and CORE20PLUS5 initiatives.

3. What are the priorities going forward?

Where next?

- Continue to focus on dental access and implement the National Dental Recovery Plan priorities.
- Implementation of local Dental Strategic Action Plan supporting the West Midlands Dental Strategy and West Midlands Dental Health Equity Audit.
- Continue to build relationships with Community Opticians, and the development of integrated pathways
- Work with Community Pharmacies to understand the impact of the Pharmacy First National Scheme and development of integrated pathways

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Primary Dental services	Development of a short, medium and long-term local strategic action plan for primary dental services to align with the National Dental Recovery Plan, West Midlands Dental Strategy and West Midlands Dental Health Equity Audit.	By 2024/25
Delegated respon sibilities	Development of a dedicated 'Primary Care & Community Programme Board' to replace the current local governance structure and provide an expanded platform to include Pharmacy, Ophthalmic and Dental delegated responsibilities.	By 2024/25
Implement the Dental Recovery Plan priorities	Implement the national New Patient Premium across all applicable Dental Contracts Increase/Rebase the average UDA value in line with the national average of £28	April 24
Increase Dental Access	Mobilisation of 2 new dental services in Hereford City to increase access for patients Plans to commence procurement for dental activity in Evesham in Q1 2024/25	June 24 April – June 24
Ophthalmic	Continue to build relationships with Community Opticians and develop integrated pathways where clinically appropriate	During 24/25
Pharmacy	Work with Community Pharmacies to understand the impact of the Pharmacy First National Scheme and further develop integrated pathways	During 24/25

5. Where you can find more detail?

Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)

Pharmacy First: what you need to know - Department of Health and Social Care Media Centre (blog.gov.uk)

High quality, patients centred services: SPECIALISED SERVICES

Theme 14

1. Why is this important?

Specialized Services are a diverse portfolio of NHS pathways accessed by a small group of people living with rare or complex conditions, including cancer, neurological, genetic and complex mental health needs – accounting for £4.1bn of NHS funding.

ICBs were established to work with all partners to create a system where decisions are taken as locally as possible.

The April 2024 delegation of 59 of the 79 specialized services means that ICBs will have decision making authority for these specialized acute services, thereby facilitating the provision of joined-up care for patients that supports integrated commissioning with a focus on local population health management, the tackling of health inequalities and ensuring best value.

What does this mean for the population of Herefordshire & Worcestershire – it means that the ICB will be able to influence the development of an integrated care pathway (for example, a cancer pathway) thereby ensuring that it reflects the local needs of our population.

2. What have we delivered in our first year, 2023/24?

2023/24 has been identified as the stepping stone to full delegation with a significant amount of joint work between NHSE and ICBs to facilitate the safe transition of the 59 services in 2024/25. During 2023/24 the 11 Midlands ICBs have work together jointly to gain assurance on 4 key domains:

- Quality, Finance and Contracting
- Resources
- Service Opportunity
- Delegation Risks

3. What are the priorities going forward?

The over-arching national priorities for Specialized Services in 2024/25 are:

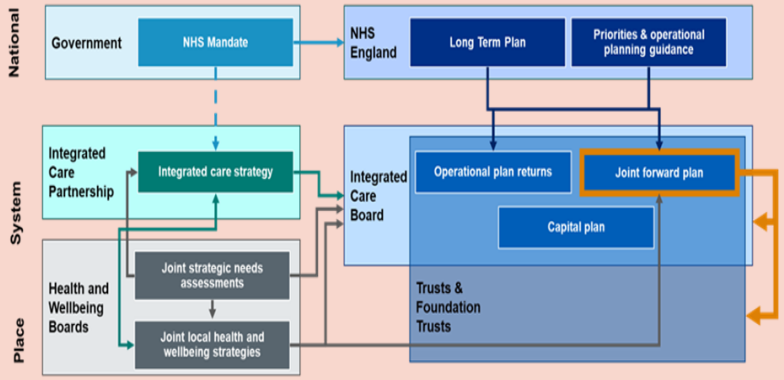
- Transformational recovery
- Tackling and reducing health inequalities
- Achieving financial stability

For 9 focus areas:

- Pediatric Critical Care
- Neonatal Intensive Care
- Haemoglobinopathy
- Acute Aortic Dissection
- Adult Critical Care
- Oncology Pathways
- Spinal Cord Injury
- Multiple Sclerosis
- Severe Asthma

High quality, patients centred services: SPECIALISED SERVICES

Theme 14

Priorities	Deliverables	Year of delivery
To demonstrate NHSE priorities align with wider system partnership (ICB) ambitions, support subsidiarity and be delivery focused.	Production of an Integrated Commissioning Plan for 24/25 building on existing local strategies and plans, emphasising collaboration with local entities, and reflecting universal commitments. Whilst maintaining a delivery focused approach, incorporating specific objectives, trajectories, and milestones to ensure actionable plans and measurable outcomes 	**2024/25**
	Delivery of the integrated commissioning plan	**2025/26 and beyond**

5. Where you can find more detail?

NHSE Midlands

Plan not published yet – Link to be included pre-publication

Joint forward plan – 24/25

Appendix 2: Strategic Enablers – Cross cutting themes

The section also identifies **how key enabling strategies** will be delivered to support the improved outcomes described in the core areas of focus section.

The section also describes the **strategic system developments** that will ensure that the system has the right structures, capacity and capabilities to deliver the plan.

Version: Final Draft 22ND May 2024

Strategic Enablers - cross cutting themes and strategic development areas

Cross Cutting Themes

Underpinning and supporting delivery of the core areas of focus outlined in Appendix 1 are a set of strategic enabling functions. These "cross-cut" all service areas and are fundamental components of delivering high quality, patient centred integrate services:

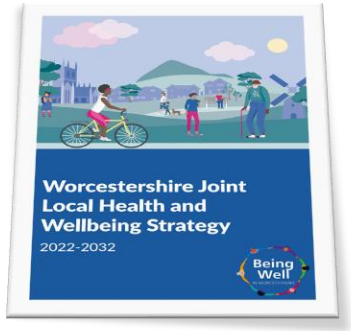
1. **Quality safety and patient experience**
2. **Clinical and care professional leadership**
3. **Medicines and pharmacy**
4. **Health inequalities**
5. **Prevention**
6. **Personalised care**
7. **Working with communities**
8. **Commitment to carers**
9. **Support veteran health**
10. **Addressing needs of victims of abuse**
11. **Digital, data and technology**
12. **Research and innovation**
13. **Greener NHS**

Strategic System Developments

In addition, there are a suite of strategic system developments that will support improved ways of working to maximise the opportunity for integration, enable greater focus on upstream prevention and delivery of best value health care in the right settings:

14. **Mental health collaborative**
15. **NHS Trust collaboratives**
16. **One Herefordshire Partnership**
17. **Worcestershire Place Partnership**
18. **Office for the West Midlands ICBs**

Together these supporting enablers provide the platform from which local NHS and Primary Care Partners can work together to deliver the priorities set out in the Integrated Care Strategy, the two Joint Local Health and Wellbeing Strategies and the NHS Long Term Plan



1. Quality, Safety and Patient Experience

Theme 1

Why is this important?

- What matters to people matters to us
- We have collective and individual responsibility to act in a manner that seeks to eliminate avoidable harm and safeguard those in need of health and social care
- ICB has a Duty to ensure continuous quality improvement and as an ICS we are committed to this
- Learning and improvement cultures enable collaboration that leads to assurance of sustainable improvements in safety, clinical effectiveness and personalised experience

What have we delivered in our first year 2023/24?

- Cross system working on driving improvement across Maternity services culminating in CQC rating of 'good' for maternity care across the system
- Improved partnership working across safeguarding
- Embedding cohesive system working across IPC practices

What are the priorities going forward?

- Improving indicators and experience of emergency care
- Meeting or exceeding agreed thresholds for Health Care Acquired Infections.
- Safeguarding - deliver on implementation of the new statutory guidance Working Together to Safeguard Children 2023
- Progress with improving aspects of patient safety described in each Trusts Patient Safety Improvement Plan within our ICS, building a culture that supports improvement (through PSIRF implementation)
- Delivering the national ambition to reduce still births, maternal and neonatal deaths and intrapartum brain injury
- Improve services and outcomes for local people through implementing the Quality Transformation programme for Mental Health (including Culture of Care workstream).
- Increase awareness and system commitment to Trauma informed approaches to care delivery.

Where can we see more detail?

System wide PSIP on ICS webpage

ICS System Quality Group

The ICS System Quality Group met bi-monthly during 2023/24. The key aim of the group is to generate a shared commitment to improving quality and enable progress to be made on key system wide priorities.

The Group consists of key senior leaders from across the ICS and partner organisations who have a commitment to continuous quality improvement. Through discussion on key agenda items members have started to establish agreement about key cross cutting system priorities for improvement that are not otherwise managed through ICS Programme Boards.

During 2023/24 members have shared learning themes generated from organisation, 'place', system or Regional level processes, for the purpose of enabling system wide improvement.

What are we measuring?

During 2024/25 population health level dashboards will provide refreshed opportunities to understand what matters to people and track progress against priorities

- Rates of infection and antimicrobial prescribing
- Trends in mortality from specific causes and excess mortality
- Key metrics aligned to Saving Babies Lives Care Bundle
- Metrics agreed within each Trust and the ICS Patient Safety Improvement Plan

Who is accountable?

ICS Forum for HCAI, Local Maternity and Neonatal System Board, ICS Mental Health Collaborative, ICS System Quality Group

Next steps

Continue working with partners across the system and regulators to agree, through the ICS System Quality Group, key system quality priorities that add value over and above the quality focus of each of the ICS Programme Boards.

2. Clinical and Care Professional Leadership

Theme2

Why is this important?

As a system we are committed to embedding clinical and professional leadership throughout Primary Care Networks, neighborhood's, place and system structures and in our multidisciplinary forums across Herefordshire and Worcestershire. We have very string Clinical and professional Leadership forums in our two places, which are key but also are devleoping a culture of grass roots clincial engagement in service redesign, the system is held acocuntable to this through the Clinical Advisory Subcomiitee which oversees Clinical transformation and policy.

Clinical and professional leaders

- Are trusted voices – connected with patients, communities and people working in health and care services
- Have the knowledge and expertise to make difficult decisions about how to use our limited resources most effectively, taking account of these int eh decisions they make
- Can use their diverse professional voices to create innovative solutions to problems
- Work effectively together across system and place, avoiding duplication, adding value, making a difference
- Are committed to collaboration and will seek to understand each others' professions and the unique contribution they make to improving health and care outcomes for local people – Including those who haven't been as involved in the past.
- Will make time for networking and building relationships across sectors
- Build on good practice and what works well, understanding that the transition to statutory ICS is an opportunity
- Embody leadership values and behaviours reflecting and connecting place and system

What will we deliver and when?

Clinical and Care leadership through delivering priorities: There is a strong clinical presence in the existing governance structures in H&W that support clinically led decision making

- Clinical leadership in the delivery of the **Getting it Right First Time** (**GiRFT) priority clinical areas**, focused on clinical productivity as a key enabler for reset and recovery and supporting the best use of resources programme.
- ICB Medical director, chair the **Quality, Delivery and Oversight** group and **Clinical advisory sub-committee,** providing support and challenge around solution focused decisions.

Who is accountable?

Clinical leader are in post to increase the capacity and capability in the ICB, driving improvement and transformation, Reporting to the CMO:

- Deputy Chief Medical Officers
- Interim Chief Clinical information officer
- Primary care, Veteran, military health and Vaccinations
- Clinical lead for social change
- End of life
- Ageing well and frailty

Where can you see more detail and get involved?

- The Clinical and Care Professional Leadership Framework describes the approach.

3. Medicines and Pharmacy

Theme 3

Why is this important?

- Medicines are the most common medical intervention in the NHS[1] and are an important part of preventing disease or slowing disease progression.
- An NHS survey[2] in 2016 found 48% of adults had taken at least one prescribed medicine in the last week.
- In December 2023[3], 6.7% of over 75s in H&W were prescribed 10 or more regular medicines in primary care compared to a national average of 9.82%.
- However, medicines are not always taken correctly, and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1]
- The World Health Organisation[4] estimated that in some countries approximately 6-7% of hospital admissions appear to be medication related; two-thirds of which are considered avoidable. The problem is likely more pronounced in the elderly, because of multiple risk factors, one of which is taking multiple medicines.
- The NHS in 22-23 spent £18.5 billion on prescribed medicines in primary care in England.[5] H&W annual spend on medicines is in excess of £230 million, with approximately £152 million in primary care.
- Antimicrobial resistance (AMR) which is the loss of antimicrobial effectiveness is increasing. The UK Government recognizes this and supports effective and careful use of antimicrobials (antimicrobial stewardship AMS) in the NHS. [6]
- Community pharmacy is an essential part of primary care, offering easy access to health services with 80% of people in England living within a 20-minute walk of a pharmacy.[7] Community pharmacy is delivering an increasing number of clinical services, supporting the primary care access recovery plan.
- The expertise of pharmacists and the role of pharmacy technicians has evolved and expanded significantly to deliver clinically focussed person-centred care integrated into multidisciplinary care teams and local systems across primary care, in general practice, in community care and in hospital pharmacy. This has led to pressures within the existing workforce which combined with the reforms to Foundation Year (FY) training for pharmacists makes workforce a key priority.[8]

Who is accountable?

- Medicines and Pharmacy Board, involving representatives from all sectors of the pharmacy profession across the ICS, with oversight of the Medicines and Pharmacy Strategy.

What will we deliver and when?

- Our vision is to ensure the population of Herefordshire and Worcestershire receive safe and effective access to medicines and technologies at the right time and in the right place. Working collaboratively, we will strive to improve and transform services, reduce health inequalities and deliver new ways of working, always keeping the population and patients at the heart of activity.

References

1. NICE Medicines Optimisation Quality standard Introduction | Medicines optimisation | Quality standards | NICE
2. HSE 2016 Summary of findings (hscic.gov.uk)
3. Data from Epact polypharmacy dashboard
4. World Health Organisation Medication Errors
5. NHSBSA: Prescribing Costs in Hospitals and the Community
6. NICE. Antimicrobial Stewardship
7. Delivery plan for recovering access to primary care. May 2023
8. NHSE. Initial education and training of pharmacists (IETP) reform. February 2024

3. Medicines and Pharmacy

Theme 3

	Our key priorities are:	What we have delivered in 2023/24	What we plan to deliver in 2024/25
Improve Health Outcomes	• Defined clinical use of medicines and technologies across the ICS through up to date and approved clinical policy, guidance and position statements.	• The introduction of key new technologies for chronic kidney disease, diabetes, heart failure, migraine, and weight management. • Roll out of online dressings ordering to community trust staff. • Horizon scanning and planning for new interventions anticipated during 2024/25. • Managing National Patient Safety Alert on valproate • Policy development to support medicines access for patients after they have been in hospital under the Mental Health Act.	• Introduction of anticipated new medicines for endometriosis, kidney disease, migraine, and weight management. • A 5 year plan for hybrid closed loop systems for managing blood glucose in type 1 diabetes. • Extension of the eligibility for COVID-19 treatments • Ongoing work in relation to the National Patient Safety Alert on valproate
Reduce Avoidable Harm	• Working across all sectors to co-ordinate work designed to improve medication safety focusing on high-risk medicines. • Focus on safety as patients move between organisations eg. discharge from hospital with changes to medicines supported by the Discharge Medicines Service (DMS) across the ICS. • Increase system awareness and undertaking in medicines audits. • Support and implement local antimicrobial stewardship (AMS) plans.	• Infrastructure to implement a local Community Pharmacy Intervention Scheme. • Introduction of Discharge Medicines Service • Use of structured medication reviews to focus on patients at high-risk of hospital admission due to medication. • Development of an AMS strategy. • Primary care audit of antimicrobial prescribing.	• Implementation of a Community Pharmacy Intervention Scheme. • Increasing the use of the Discharge Medicines Service • Introduction of an ICS Medicines Safety Group • Production of a primary care AMS dashboard to focus on total antimicrobial prescribing, course length and choice of antimicrobial agent.
Productivity & Achieving Best Value	• Working with clinicians to ensure cost effective medicines choice and reducing use of medicines or technologies considered ineffective or low priority.	• Initiatives to promote use of cost-effective products including treatments for eye disease and blood thinning through: ➢ Primary care contracts ➢ Agreed guidance and position statements • Introduction of a digital prescribing support system. • Improved use of technology e.g Electronic Prescribing and Medicines Administration system (ePMA)	• Introduction of biosimilar medicines, as they become available, across dermatology, gastroenterology, rheumatology and diabetes. • Review available medical retinal treatments. • Improve use of blood glucose testing strips with the lowest acquisition costs.
Service Delivery & Sustainability	• Develop a pharmacy workforce plan to help build a sustainable workforce across all sectors of pharmacy • Using community pharmacy professional expertise for common conditions management; safe medicines use following hospital discharge; blood pressure checks; contraception services; vaccination services and new clinical services as they are introduced. Ensure referral pathways are robust for complete episodes of care.	• Production of Pharmacy Faculty workforce newsletters, attendance at careers/recruitment events and supporting providers with the Foundation Year training reforms. • Increased awareness and use of Community Pharmacy Consultation Service (CPCS). • Introduction of Pharmacy First and preparation for Community Pharmacy Independent Prescriber Pathfinder Programme. • Working together locally and across the Region to understand and plan for future service needs to support the aseptic (sterile) preparation of medicines. • Introduction of the digital 'Pharmacy Connect' to promote good communication between professionals and pharmacists working in different sectors	• Launch of Community Pharmacy Independent Prescriber Pathfinder Programme. • Development of strategies for workforce and community pharmacy to complement the overall Medicines and Pharmacy Strategy. • Explore options for improving the number of pharmacist FY placements in Herefordshire and Worcestershire e.g. by creating a database of Designated Prescribing Practitioners (DPP) and supporting existing pharmacist Independent prescribers to become DPPs • Increase pharmacist use of 'Pharmacy Connect' • Further increase vaccination programme delivery via community pharmacies
Greener NHS	• Promote the use of environmentally friendly medicines and packaging	• Ensuring sustainability considerations for all new medicine applications. • Promoting switches away from unit dose eye drops to alternative preservative free eye drop bottles. • Eliminating the use of desflurane by using lower carbon anaesthetic gases	• Improve use of inhalers with a lower carbon footprint • Consideration of available medicine/device recycling schemes. • Identifying solutions to reduce use and waste of nitrous oxide

4. Health Inequalities

Theme 4

Why is this important?

- ICB's and Local Authorities have legal duties to have regard to reduce health inequalities
- The NHS Long Term Plan requires every local area to develop plans and take action to reduce health inequalities
- The range in life expectancy across the social gradient of the region is 7.9 years for men and 5.9 years for women in Worcestershire; (Worcestershire JSNA 2022)and 5.4 years for men and 4 years for women in Herefordshire (Herefordshire JLHWS 2023)
- Marmot Review estimated that health inequalities cost society £31bn in lost production per annum to local and national economies
- Higher burden of disease in most deprived neighbourhoods costs NHS 22% more per woman and 16% per man, than in least deprived areas

What have we delivered in our first year 2023/24?

- ICB allocated over £5.3m to work programmes that have tackling health inequalities as their core purpose. With most funding allocated out to Primary Care Networks (PCNs) at almost £3.7m to support the development and delivery of local health inequality plans as part of the Clinical Excellence and Investment Framework (CEIF).
- Analysis of patient waiting lists in elective care through a health inequalities lens and applied this to ED activity to help inform targeting of programmes of work to support the most underserved. Initiatives include the high intensity user programme and a locally commissioned outreach service.
- Commissioned an outreach prevention service in Herefordshire and Worcestershire, targeting our most underserved communities offering a range of services to meet individual needs.
- Outreach service has provided opportunistic earlier detection of atrial fibrillation, high blood pressure/ hypertension, diabetes/ lipid management and delivered GP registration as well as NHS Health Checks.
- The personalised care approach has enabled the service to meet individual needs along with an accessible service.
- Early research and evaluation by Worcester University has provided Plan, Study, Act, Do cycle ensuring the services continually improve and flex the local needs and insight.

What are the priorities going forward?

- The aim of the ICS Herefordshire & Worcestershire strategic intent is to make addressing health inequalities everyone's business. To do this by creating the environment where services support early intervention and prevention. Thus, reducing demand and long-term reliance on the health and care service; avoidable expenditure making services more sustainable.
- A plan has been developed translating the strategic intent into action and this will be delivered over the next year, establishing and developing the first Health Inequalities Ambassadors network for Herefordshire and Worcestershire aligned to the national Core20PLUS Ambassadors initiative, working with the support of NHSE nationally and regionally.
- Maximising on our accessible outreach prevention services by removing barriers to employment opportunities with health and care, promoting opportunities and supporting our most underserved communities to get into work.
- Focusing on the impact of trauma informed care as a golden thread, building on the commitment of the Integrated Care Partnership Assembly.

What are we measuring?

- Development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2024)

Who is accountable?

- Health Inequalities SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of reducing health inequalities sits at system, Place, PCN and neighbourhood level – as such it should cut across all work
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

Core20PLUS5

Strategic approach and agreement on PLUS groups.

- Delivery at place through PCNs, Districts Collaboratives, partnerships at Place and neighbourhood level.

CORE20PLUS5 (england.nhs.uk)

CORE20PLU5 Children and Young People(england.nhs.uk)

5. Prevention

Theme 5

Why is this important?

- Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022:

"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness".

What have we delivered in our first year 2023/24?

- Tobacco Dependency service fully implemented across all acute inpatient and maternity services in H&W as of January 2024. This achieves the Long Term Plan (LTP) deliverable of all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services by 2023/24 (exc. Mental Health inpatients).
- There have been 1,813 eligible referrals into the Digital Weight Management Programme (DWMP), achieving the target of 85%. H&W ICB are currently the third highest referrer into the programme for the Midlands region as well as having the highest number of practices referring into the programme (90%). Mapping of high deprivation areas has been undertaken to establish GP Practices with a high proportion of patients in IMD1 and IMD2.
- T2 weight management programmes - National Diabetes Prevention Programme (NDPP) introduced targeted work to increase self-referrals into the programme. Type 2 Diabetes Pathway to Remission (T2DR) launched in September 2023 - the ratio of acceptance into the programme is higher than anticipated and above levels seen in other ICBs.
- CVD strategy has been drafted. An ICB Workshop was held in November 2024 to discuss opportunities to raise profile of national CVD high impact interventions.
- The development of a local dashboard and intelligence to map the patient journey. This work will complement the CVD Prevent Dashboard and information on this has been shared to promote engagement.
- Prevention outreach response services launched in both Herefordshire and Worcestershire, providing opportunistic testing of AF, blood pressure and lipid optimisation to our most underserved communities.

What are the priorities going forward?

- Developing and delivering a local strategy for Immunisations – Improving access, targeted outreach, integrated into the broader prevention and screening offer
- Introduction of Tobacco Dependency treatment services across Mental Health inpatient wards in H&W, leading to full implementation.
- Facilitation of an ICS Tobacco Control Strategy Event in Autumn of 2024. Purpose is for Places to explore and develop independent tobacco control strategies supported by ICB as system leaders.
- Targeted work for DWMP around eligibility criteria, direct work with the GP practices who are not currently referring into the programme to increase referrals and exploration of ways to engage high deprivation areas for DWMP and NDPP. A broader review of Weight Management pathway.
- Continuation of prevention outreach service across both counties – targeting of unregistered and most underserved populations. Ensuring enhancement of cardiovascular disease and lipid prevention pathways, across the ICS footprint.
- Supporting Public Health colleagues and partners with the Loneliness and Isolation work within Worcestershire – e.g. community grants, development of action plan.
- CVD strategy to be incorporated into a newly developed Long Term Conditions strategy.
- Education session focussing on lipids to be delivered by CVD Clinical Lead.

What are we measuring?

- A key element to the NHS LTP is tackling tobacco dependence, as tobacco smoking is the largest modifiable risk factor for health. The NHS will contribute to reducing the number of people smoking tobacco by delivering on the commitments outlined in Chapter 2 of the document: Prevention and Health Inequalities.
- To help tackle obesity, the LTP states that the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ *(also outlined in the above link to Chapter 2 of the LTP).*
- These metrics will be encompassed as part of the development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2024)

Who is accountable?

SROs in place across the system organisations for Prevention.

- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function is to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

- Information relating to the Long Term Plan priorities can be found here.
- Data is collated on the Regional Dashboards which can be accessed through the FutureNHS Collaboration Platform.
- Details around Your Health and Talk Wellbeing can be found on the ICS website. Information around what the service entails and upcoming events are included:
- Your Health – Worcestershire
- Talk Wellbeing – Herefordshire

6. Personalised Care

Theme 6

Why is this important?

Personalisation means health and care services delivering what matters most to each individual in a way that meets them where they are at. Engagement with our local population has told us that this relies on people having clear expectations of what is expected of them and what they can expect of their health and care professionals and services. Services are then able to offer support that is appropriate to the individual's level of need, making the best use of resources and getting the individual to the right support at the right time.

The Comprehensive model of Personalised Care outlines a three-tier approach to implementation: Universal (whole population) interventions; interventions targeted at those with Long-Term Conditions (LTCs) (30% of the population) and specialist interventions (5% of people with complex needs) (NHS, 2019). The NHS Long Term Plan outlines six interlinked components which underpin delivery: Shared Decision Making (SDM); Enabling Choice; Social Prescribing; Supported Self-Management (SSM); Personalised Care and Support Plans (PCSPs) and Personal Health Budgets (PHBs).

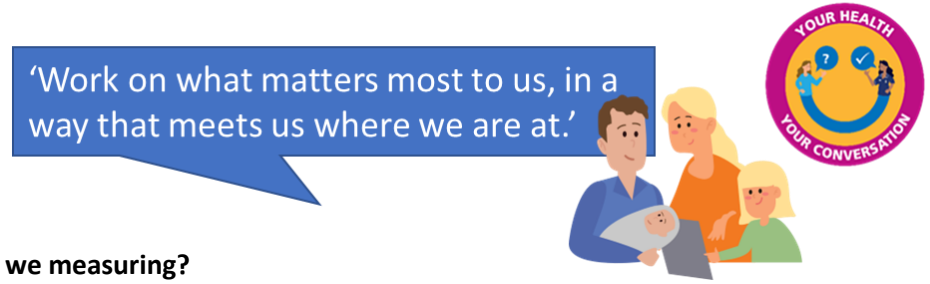
Supporting people with LTCs to self-manage is critical to addressing the rapidly growing demand this population represents . Our approach to supporting people to live well with their LTCs is to to raise awareness of how an individual's knowledge, skills and confidence, also termed activation, impacts on their ability to self-manage.

What have we delivered in our first year 2023/24?

- Developed and enhanced our training offer through the ICS Exchange platform. This now includes a Health Literacy training package and more modular and practical training.
- Health literacy network established, which is developing system wide health literacy commitments and a self-assessment tool to assess organisational maturity.
- Personalised Care Toolkit developed to support system wide colleagues to implement personalisation approaches.
- Multiple examples of patient information improvements across the system, e.g. Pulmonary Rehabilitation Guide, Endometriosis and Frailty videos. This also includes the continued delivery of the Health and Wellbeing and LTC video library.
- Family Coaching service pilot evaluating positively and extended until Q2 24/25.
- Supporting You service pilot (for high intensity users of urgent and emergency care services) evaluating positively.

What are the priorities going forward?

- Continuation of the Supporting You Service.
- Continuation of the Family Coaching Service.
- Continuation of the Health Literacy programme.
- Continued development and delivery of the Health and Wellbeing and LTC video library.
- Development and integration of personalised care ARRS roles.
- Development of Personal Health Budget (PHB) offer outside of continuing health care.
- Development of Peer Support Worker offer.
- Embedding use of Patient Reported Experience and Outcome measures across priority LTC services.
- To have a functional dashboard to measure the impact of personalisation.



What are we measuring?

The dashboard that is in development is anticipated to measure: numbers of PHBs, number of personalised care and support plans (PCSPs), numbers of ARRS role team members and referrals to their services, the number of people accessing personalised care training and the number of registered carers. There are also specific outcome measures in place for the services that are being piloted and for the video library.

Who is accountable?

The Health Inequalities, Prevention and Personalisation Board is responsible for delivery of Personalised Care. This is a system wide meeting, with membership across health, the local authority and the Voluntary, Community Social Enterprise. The SRO is the ICB Chief Nursing officer.

Where can you see more detail and get involved?

Health Literacy - https://teamnet.clarity.co.uk/Topics/ViewItem/5813997c-1f90-477c-9de9-b10e00e42f56

Personalisation Toolkit - https://teamnet.clarity.co.uk/Topics/ViewItem/1680689e-80fe-4368-898e-b086007d97da

Any queries, please email: hw.personalisedcare@nhs.net

7. Working with Communities

Theme 7

Why is this important?

Our ambition is to place greater emphasis on early engagement and ongoing dialogue and partnerships with people and communities. From these early, open and genuine conversations we can work together with local communities, who are often better placed to create solutions to the health challenges we face.

By understanding our communities, working collaboratively to deliver our 10 Principles:

1. Put the voices of our people and communities at the centre of decision-making and governance
2. Strategic engagement early when developing plans
3. Understand our communities' needs, experience, ideas and aspirations for health and care
4. Build relationships with excluded groups, especially those affected by inequalities
5. Work with Healthwatch and the voluntary, community and social enterprise sector
6. Provide clear and accessible information about plans and services
7. Use community development approaches that empower people and communities
8. Use co-production, insight and engagement to achieve accountable health and care services
9. Co-produce and redesign services and tackle system priorities in partnership with communities
10. Learn from what works and build on the assets of all health and care partners

What have we delivered in our first year 2023/24?

During 2023/24 we have worked with all of our partners across the system to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This has included supporting people to sustain and improve their health and wellbeing, as well as working with people and communities to develop our plans and priorities, address health inequalities, and co-design services that equitably address the health challenges that our population faces. Our key deliverables are detailed within the People and Communities Annual Reports and the Insights Reports:

1. People and Communities Annual Report – These reports are published annually and detail how the ICB has worked with ICS partners to engage with people and communities at a system, place and local level.
2. Insights Report – Published quarterly, these reports collate soft intelligence and highlight key themes from the feedback garnered from people, communities and ICS partners, from across Herefordshire and Worcestershire. These insights are fed back to the key ICS and ICB decision makers for their consideration and to highlight any cross-cutting themes between services and areas of focus.

Specific examples of our work include:

1. ICB Engagement Framework – An engagement exercise conducted to seek the views on how the ICB should engage with local people and communities. This exercise collated public feedback on how the ICB could be working with and listening to people across Herefordshire and Worcestershire. This exercise was part of the ICB's commitment to the ICS Engagement Strategy. The feedback received will be used to inform a Herefordshire and Worcestershire ICB communications and engagement framework.
2. Multiple Long Term Conditions –This engagement exercise sought the views and stories of people living with multiple long-term conditions. It focused on how people with multiple long-term conditions felt they were managed and supported by NHS services in Herefordshire and Worcestershire. The feedback received will be used to inform the Herefordshire and Worcestershire ICB LTC Strategy.

Priorities going forward

Our priorities for engagement remain the same. We intend to:

- Listen more and broadcast less, and where engagement is an ongoing and iterative process focused on what matters to people, not something 'done once'
- Hold ongoing conversations with communities about healthcare, built around community groups, forums, networks, social media, and any other place where people come together as a community
- Provide clear and timely feedback to local people about the impact of their involvement
- Develop plans and strategies that are fully informed by engagement with the public and patients
- Use insights and data to improve access to services and support reduction of health inequalities
- Focus on early prevention and supports communities to develop their own solutions to improving their health and wellbeing

Specific programme areas of focus:

- Prevention
- Stroke Services
- Primary Care
- Dental access

What we're measuring

- The ICB's compliance with undertaking our legal duties to involve the public in decision-making about NHS services.
- The feedback, sentiment and key themes that we have gathered from undertaking engagement with people and communities in Herefordshire and Worcestershire.
- The demographic details of the people and the communities we engage with. This is to ensure that we are listening to a wide and diverse range of people, and to highlight where more engagement needs to be undertaken with specific people, groups and communities.

Who is accountable?

- NHS Herefordshire and Worcestershire Integrated Care Board is responsible for ensuring that the statutory duty to involve are met across the system.
- The ICB is responsible for arranging effective health and care services for the Herefordshire and Worcestershire population; demonstrating that decision-making is clearly informed by insight
- Herefordshire and Worcestershire Integrated Care Partnership Assembly is responsible for ensuring that strategies for health and wellbeing are based on the needs and aspirations of local communities, and open to scrutiny and challenge
- The One Herefordshire Partnership and Worcestershire Executive Committee are responsible for delivering health and care services shaped by local need

Where can you see more detail and get involved?

Please see our strategy 'Working with people and communities in Herefordshire and Worcestershire' or for more information or contact the ICB Engagement Team.

8. Commitment to Carers

Theme 8

Why is this important?

Carers are a diverse group, and every caring situation is unique. Carers are people who care for a family member, a friend, or another person in need of assistance or support with daily living. They include those caring for children who have a disability or additional needs, older people, people living with long-term medical conditions, people with a mental illness, people with a disability, people with addiction, people experiencing substance misuse and those receiving palliative care.

The degree to which a carers own life is impacted by their caring role will vary. Parent carers are most likely to be caring the longest and experience the greatest financial impact. Some carers may find themselves caring for more than one person. The physical demands of caring may be greatest for those whose cared for is disabled or is frail. The emotional demands on carers may be greatest for those caring for someone at end of life or caring for someone with poor mental health.

According to the last Census (2021), there were 16,501 and 52,547 carers in Herefordshire and Worcestershire respectively, of which 7,701 (47%) and 25,171 (48%) care for more than 20 hours a week. This represents a rise in proportion of carers providing higher levels of care than in the previous census (around a third). Carer support organisations are in touch with 5,500 carers in Herefordshire, and 14,547 in Worcestershire. Worcestershire Association for Carers receives around 600 referrals per month, 85% of which result in 1 to 1 support. Local intelligence tells us that the complexity of caring roles is increasing. This includes carers maintaining responsibility for increasingly complex clinical needs against increasingly stretched finances. The number of carers is expected to rise by at least 60% by 2030 (Carers Trust).

By supporting carers, we enable people to remain living well within their communities, reducing the demand on health and social care and improving the health and wellbeing of both the carer and the cared for.

What have we delivered in our first year 2023/24?

1. Continued to support system partners to progress against Commitment to Carers statements.
2. Facilitated regular ICS Carer Reference Group (CRG). Key areas progressed include:
    - Empowering Carers at Discharge – checklist and care planning tool.
    - Continued delivery of carer awareness and shared decision-making training.
    - Improved recording of carer status across system partners.
    - Herefordshire carers strategy refresh.
3. Enabled opportunities, through the CRG and place-based forums, for carers to share their views and lived experience, and contribute to co-production of improvements in carer support.
4. Incentivised the following areas in primary care through the 2023/24 CEIF contract:

- Identification of GP practice carers lead.
- Delivery of carer awareness training.
- Drive to increase the number of carers identified and recorded in EMIS.
- Signposting to local carers support.
- Proactive offer of other support to carers, e.g., social prescribing.

What are the priorities going forward?

1. Continue the drive to recognise and support more carers across the system.
2. Work with Primary Care partners to define carers lead role, continue to roll out training, continue to identify more carers and to further develop their support offer.
3. Utilise the Accelerating Reform Fund allocation to enable improvement in carers support across Herefordshire and Worcestershire.
4. Continue to support carers forums across the two counties, strengthening the carer voice in planning and provision of services.

What are we measuring?

1. The number of carers identified across the system.
2. Number of Carer leads and their access to Carer Awareness training.
3. Qualitative progress towards the system Commitment to Carers by each provider organisation.
4. Feedback on patient and carer experience of services via periodic Healthwatch surveys

Who is accountable?

The Carers programme is a component of the Personalised Care programme and accountability sits with the Health Inequalities, Prevention and Personalisation Board. The Carers Reference Group was established to develop and enable delivery against our system commitment to carers. These commitments are integral to place based Carer Strategies held by our County Councils.

Where can you see more detail and get involved?

Visit the ICB carers resource hub: [Resource Hub for Family, Carers and Loved Ones :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)]

9. Supporting the Armed Forces Community

Theme 9

Why is this important?

The Armed Forces community is made up of serving personnel, veterans and their Family's and carers. There are an estimated 2.4 million veterans living in the UK. Within Herefordshire and Worcestershire there are currently approximately 30,000 military veterans. Herefordshire and Worcestershire ICB has a high density of veterans making up about 4.7% of the patient base. The Armed Forces Act 2021 makes it a legal duty on specified public organisations to have due regard to the principles of the Armed Forces Covenant when exercising their functions. These duties apply to ICBs. As an ICB we are working with system partners to give due regard to the health and social care needs of the Armed Forces Community in the planning and commission of services. We are working on building our engagement with this community to build our understanding for how we can support their health and wellbeing.

What have we delivered in our first year 2023/24?

Within the first year alongside signing the armed forces covenant, the ICB has been an integral part in supporting this cohorts through both primary and secondary care. Leads from the system were invited to an Armed Forces Health Symposium where there were valuable conversations to take away to help deliver the promises to the Armed Forces Community.
With the introduction of the Talk Wellbeing Service in Herefordshire, they have reported a large number of veterans engaging with their services and through the training which has been undertaken by the team has supported clinicians in engaging with this group.
More practices in Worcestershire are signing up to the veteran friendly practice scheme too with compared to the first year we are nearly 10% higher in sign up rates.

What are the priorities going forward?

Within the next year it is key to ensure that we can continue to keep signposting the Armed Forces community to healthcare available within the system and to continue the identification of them within the healthcare system.
We will continue to encourage practices to sign up to the veteran friendly practice scheme.

What are we measuring?

There are two key measurables which we are working towards.

1. Increasing the number of veteran friendly practices across Worcestershire (as Herefordshire are already 100%). This is being collated by the Royal College of General Practioners
2. Increase the number of coded veterans on clinical system, initially in Primary Care. This is being supported by local BI teams to assist in sourcing the data.

Who is accountable?

The Clinical Lead on the project is Dr Jonathan Leach OBE, with project management in place to support. This will be delivered through following the key commitments from the Armed Forces Forward View that ICBs use indicators to measure progress. We will work with partner and provider organisations to develop and deliver objectives and actions to reduce any health inequalities and improve healthcare for this population. We will work closely with the service users to understand their needs and requests within the services.

Where can you see more detail and get involved?

If you have any questions or for more information on how to get involved or how this community could benefit your work, please email: hwicb.partnerships@nhs.net

10. Addressing the specific needs of victims of abuse

Theme 10

Why is this important?

The ICB has a duty to address the particular needs of victims of abuse, including an assessment of need. Working with health, social care and statutory partners to support victims, tackle perpetrators and prevent abuse. This includes reducing the health inequalities faced by victims of abuse.

There are a range of initiatives and services in place that will be built upon over the lifetime of the joint forward plan, these include:

- The Serious Violence Duty (SVD) is based on a public health approach which requires co-operation and collaboration including data across a range of partners. This approach to tackling violence means looking at violence not as isolated incidents or a sole police enforcement problem. It is about taking a multi-agency approach to understanding the causes and consequences of serious violence and focusing on prevention and intervention.
- Training plan to support upskilling of roving vaccination team to spot those vulnerable to domestic abuse / serious violence etc
- Collaboration between Policing partners and roving vaccination teams in areas of deprivation and inequality.
- Pan West Mercia data group in development
- District collaboratives – working between district councils, primary care networks, community support officers, voluntary sector to identify needs in the local community
- Funding secured by Herefordshire PCN's to collaborate with 3rd sector organisations supporting victims of domestic abuse, exploitation and youth crime.

What have we delivered in our first year 2023/24?

Services have been developed and commissioned responding to identified cohorts or individuals to support prevention and reduction in serious violence, these are listed below:

- Serious violence duty actions including strategic needs assessment to support action.
- Develop and deliver a system wide group focusing on Domestic Abuse and Sexual Violence prevention.
- Develop system wide data group in partnership with Police, Local Authority, West Midlands Ambulance Service, CSPs and other relevant organisations.
- Develop joint partnership prevention animation in multiple languages to be shown across system.

What are the priorities going forward?

There are a number of services and programmes in place to ensure that we are addressing the needs of victims of abuse, these include:

- **Domestic Abuse and Sexual Violence:** National Task and Finish group – H&W ICS are members of this group leading recommendations for change, setting national priorities and feeding back through to the Government
- **IRIS:** A specialist domestic violence and abuse training support and referral Programme for General Practices that has been positively evaluated in a randomized controlled trial. Iris is a collaboration between primary care and third sector organisations specializing in domestic abuse. (Funding bid has been made and has been successful for Herefordshire Primary Care Networks for a 12-month period).
- **Climb:** A service which delivers early intervention and prevention for those at risk of criminal exploitation.
- **Purple Leaf and West Mercia Rape and Sexual Abuse Support:** A charity providing specialist front line support independent advocacy counselling and those affected by any form of sexual violence
- **Drive perpetrator programme:** A project which aims to reduce the number of child and adult victims of Domestic Abuse by deterring the perpetrator (in Place)
- **Steer Clear:** Prevention Programme working with young people who have been or could be involved in knife crime

What are we measuring?

The overall approach is to ensure that all partners are sharing data and intelligence to build up a comprehensive picture of individuals and communities at risk of serious violence, domestic abuse or sexual violence. Those key hotspots across the system are being looked at and appropriate interventions will be put in place. This will be developed during 2024/25.

Who is accountable?

The integrated care board (NHS Herefordshire and Worcestershire) has a specific duty to address the particular needs of victims of abuse. This will be delivered at place through the Herefordshire community safety partnership, Worcestershire community safety partnership and the crime reduction board.

11. Digital, data and technology

Theme 11

Why is this important?

We cannot improve health outcomes and reduce health inequalities without data and technology is key to making health and care services more accessible to parts of our communities. This can be via remote and virtual care, better planning of services and enhanced sharing of patient information. Technology and data can play a core role to reduce elective backlogs, mitigating urgent care pressures, continuing to deliver responsive and timely community and primary care. Digital products can enable personalised preventative care by giving people more control over their lives by providing self-assessment, education, motivation, and monitoring to help them manage their health on their own. We must ensure any digital service is inclusive and provides for everyone's needs by listening to and designing with communities with seldom heard voices more closely.

What have we delivered in our first year 2023/24?

- Optimisation and increasing adoption of shared care record.
- Developing our patient facing digital offer and Patient Portal to provide a front door to patients under our care.
- Increased focus on levelling up digital maturity.
- Relaunching the BI and analytics service, started building the capabilities needed for population health management and aligned and standard performance and BI reporting and tools.
- Collectively refreshed technology to increase staff capacity and organisational productivity specifically unified communications, telephony and networks.

What are the priorities going forward?

- Simple, consistent experiences across all our digital services – joining up services to give people a convenient, relevant and seamless way to interact with their health and care needs. Ensuring that any digital product or service is inclusive, high quality, safe and effective.
- Scaling the use of new digital products through collaboration, prototyping, testing and learning.
- Levelling up our digital maturity – a modern and future proofed infrastructure that enables our ambition of integrated care underpinned by common standards and safe and secure systems.
- Employing technology to deliver more care out of hospital and support people to self-manage their conditions - supporting people to live independently and receive care at or near their home.
- Using data and information to enhance decision making - using intelligence, evidence and analytics to make better decisions to benefit patients, the population and operational efficiencies.
- Building the population Health Management Analytics capacity to inform service integration and redesign: deliver the necessary IG framework, a linked dataset in the MLS CSU data warehouse accessible to the ICS analytics community
- Advancing digital skills in the workforce to support care pathway improvements and enhancing capacity and capability of workforce to deliver digital transformation. Building the digital specialist skills and the digital, data and technology profession across our system.
- Working collaboratively to deliver effectiveness and efficiencies, by ensuring smart investments and improving productivity to support frontline working.

What are we measuring?

Each project measures outcomes and success, for example the number of people across our system using the Shared Care Record.

Who is accountable?

One of the ICS Programme Boards focuses on Digital, Data and Technology and brings in the ICS Digital Clinical Leads, these two groups will be responsible for setting the digital agenda and collective vision. Their work will be informed by three workstreams on digital transformation and improvement.

There are currently seven Groups and Boards focusing on the technicalities of the deliverables including Shared Care Record, Cyber and Data Security and for the Patient Portal. Based on the structures already in place in the NHS Trusts and primary care system in Herefordshire and Worcestershire, the ICB Digital Leaders will work closely with the organisation Boards and Steering Groups. There are strong links to the other five ICS Forums where digital plays a central role and vice versa Delivery teams are accountable for the outcomes they are set up to deliver.

Where can you see more detail and get involved?

There is a digital section on the ICB website

Digital innovation :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

12. Research and innovation

Theme 12

Why is this important?
As a system we recognise the importance of promoting research an innovation in the provision of healthcare. The ICB Medical Director holds the responsibility for promoting this, ensuring it is clinically led and underpins the delivery of the Joint Forward plan.

What will we deliver and when?
- **Undertake needs assessment :** We have had a system research strategy in place for the last 5 years, it is not due an update. Our individual providers have internal strategies. This year we plan to create a more formal ICB reseach and innovation startegy
- **Assets:** ICS Academy, Knowledge and research school, The Herefordshire and Worcestershire reseach Collab. Worcester University - Allied health professional school. I&I Bid – Engaging underrepresented communities. (Personalised care.) Innovation – Pods. Research network.
- **Resources:** Increase access to funding, ,E.g. NHIR and working in partnership with the academic health science network.
- **2024/25 priorities:** Development of ICS wide research strategy, building on NHS Trust research frameworks. Building out from health into broader sectors including social care and the voluntary, community and social enterprise sector. Build on innovation working out from what has been delivered to date, building innovation into improvement methodologies, including, but not restricted to digital innovation in line with the system digital strategy.

Innovation - What are we building on?
To help promote innovation across the system, the ICB has created an Innovation Hub called: The CO-LAB www.icscolab.org.uk We believe this is the first example of an ICB-led Innovation Hub. It exists both virtually and physically, located deliberately in a rural community hospitals (Kidderminster Treatment Centre), where we know innovation traditionally receives less focus, but has real chance of improving health services. Approaching it's first year operating, it has had a number of successful initiatives and adoptions of innovation, including:

New Ways of Working and developing new knowledge:
- In partnership with Warwick University's "West Midlands Health and Wellbeing Innovation Network WMHWIN", The CO-LAB ran a 5-day Agile approach for one of our Trusts to help them co-design a new Heart Failure @ Home pathway with a "User focus". The co-design event included staff, commercial innovators and patients. Outputs included a framework for staff to use if interested in this type of approach, supplemented by education webinars.
- It is regularly used as a space anyone in the ICS can use for free to re-imagine pathways and processes. For example, it's used monthly by one of the trust's Transformation guiding board as part of it's Virginia Mason Programme.

Trial and Adoption of Innovation:
- The CO-LAB hosted certified VR anti-anxiety headsets and approached teams to trial. Following a successful trial on our Pediatric Oncology wards, where they reduced anxiety in children needing cannulas, improving patient experience and reducing clinic time, a number of headsets have been purchased for long-term use on those wards and are being trialed across multiple other wards within two Trusts (one within our ICS and one in a neighboring ICS)
- As the host for the first teleconsultation pod from a French-based innovator, The CO-LAB has worked extensively with the company on feasibility, demoing and real-world testing. The pods are now being used in the South East of England and is being deployed in system as part of an NIHR bid for the ICS.

Partnerships:
- The CO-LAB has partnered with innovative organisations to understand opportunities and art-of-the-possible to highlight to workstream leads, these include:
    - ICS Partnership with Amazon Web services, where the ICB participates in their Global Healthcare Incubator.
    - Satellite Catapult, currently arranging a trial of drone technology
    - IASME, working with a local innovator to train unemployed Neurodiverse young people for employment in cybersecurity
    - Partnership with multiple Universities, including a successful partnership with the University of Manchester on a systematic review of literature on the implementation of AI in health and care

Staff and wellbeing:
Early on in the hub's life it became apparent there was a significant ask for finding and spreading innovation practice for wellbeing of staff. Initiatives have included:
- Partnering with a Hypnotherapy provider, we setup an agreement to offer the hub's use whilst closed in return for free provision of sessions to front-line staff to address anxiety, sleep deprivation and relaxation. Sessions typically have 20 attendees, with great feedback
- The Hub is provided free of charge to ICS groups who want to host staff celebration or wellbeing events. For example, it is used as part of the International staff process, providing an area for them to come together, and celebrate pre-exam.
- NHSE provided sessions for Wellbeing in Leadership Roles, is being hosted at hub for several trusts in and out of the ICS.

Herefordshire and Worcestershire Research collaborative
- Is the system wide group overseeing research in the system, we are looking to widen its brief to look at innovation too as part of the strategy refresh.
- It monitors performance / recruitment across the system, but also looks to broaden the scope of our research beyond organisational boundaries, looking at how we work with the local university as it develops

13. Greener NHS

Theme 13

Why is this important?

The climate emergency is also a health emergency.

Poor environmental health contributes to major diseases including cardiac problems, asthma and cancer. Unaddressed, it will disrupt care and affect patients and people at all stages of their lives. Climate change impacts every single person and as such we all have a duty and responsibility to do something about it.

Herefordshire and Worcestershire ICS are committed to embedding environmental and sustainable practices into all areas of our work, as an enabler for better health. We see the work of the green agenda aligned to our principles of delivering high quality care; reducing health inequalities and improving the health and wellbeing for the communities we serve.

Reducing emissions will mean fewer cases of asthma, cancer and heart disease. Many of the drivers of climate change are also the drivers of ill health and health inequalities. In the UK, air pollution is attributable for 1 in 20 deaths, making it the greatest environmental threat to health. We can all play our part in tackling climate change through reducing harmful carbon emissions, which will improve health and save lives.

Environmental health impacts are often unfairly weighted in areas of deprivation and minority ethnic groups. For example, Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.

What have we delivered in our first year 2023/24?

- **An ICS wide Sustainability Impact Assessment (SIA)**
- **Strengthened networks and coordination across the System to share best practice and learnings.**
- **Delivery of successful Healthier Action Fund initiatives for CoolSticks and Reusable theatre hats at Worcester Acute Hospital Trust.**
- **Development of a Green Champions Programmes launched across two Trusts to encourage staff engagement.**

What are the priorities going forward?

- To refresh the HWICS Green Plan.
- To increase the use of low carbon inhalers.
- To continue to strengthen our networks and connections to create greater impact.
- To develop an Adaptation Plan.
- To reduce the amount of nitrous oxide and mixed nitrous oxide used.
- To embed the SIA across the system.
- To encourage staff to utilise different travel options.

Who is accountable?

- Greener NHS SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of Trust Green Plans sit at Trust provider level.
- Collectively agreed ICS Greener NHS actions sit at ICB level, working collaboratively with Providers to deliver through their existing governance groups.
- Engagement is undertaken directly with SROs, and operational working and engagement through a system Sustainability Leads group.

Where can you see more detail and get involved?

ICS Green plan – Later years, priorities.

14. Mental Health Collaborative

Theme 14

Where we are now? – What we have achieved together

The mental health collaborative (MHC) has continued to respond to NHS mental health workforce recruitment challenges by reallocating resource and/or strengthening pathways to provide a range of interventions and support through the voluntary, community and housing sectors. This has provided the foundations for building different approaches to service delivery and engaging partners more effectively in direct service pathways, building up a "team of teams" approach to meet local need. This has also improved timely access and patient experience, creating a platform for building a new way of working going forward and is consistent with the core principle 5 agreed in the Integrated Care Strategy of "co-producing solutions with our communities and Voluntary & community sector organisations as equal partners with collective responsibility". Evaluation of these schemes to date demonstrates that this local tailoring of mental health support reaches communities that would not normally engage with local NHS services, thereby tackling mental health inequity, strengthening the competence and confidence of this wider non NHS and social care workforce to support mental health needs as well as enhancing their role in appropriately signposting to statutory services.

Where next? – Areas of focus

The top 5 priorities for Mental Health Collaborative (MHC) are directly aligned to the Integrated Care Strategy Priorities (as outlined below):

- Children and Young People's Mental Health: 0-25 service - work to develop a model is ongoing. (Providing the best start in life)
- Perinatal Mental Health – due to its role in preventing future mental ill health and strong evidence base, and its contribution to the Integrated Care Strategy priority (Providing the best start in life)
- SMI Physical Health Checks - based on principles of health inequality, parity of esteem and requirement to improve system performance. Suggestion to fund PCNs (Primary Care Networks) to increase delivery of checks. (Living, ageing and dying well)
- Suicide Prevention - a successful programme with a strong evidence base, as well as a collaborative workstream across agencies. (Reducing ill health and premature death from avoidable causes)
- Crisis Services - particular focus on CYP (Children and Young People) crisis support (likely to link with Crisis Alternatives workstream funded via SDF), while recognising existing commitment around Mental Health Response Vehicles.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital through the Community Mental Health Transformation programme, ie mental health support wrapped into Primary Care Networks:

- Including a focus on reducing inequalities, the further development of ARRS (Additional Roles Reimbursement Scheme) roles and the further expansion of the VCSE (Voluntary, Community and Social Enterprise) and housing partners in local delivery.
- The redesign of adult mental health acute and rehabilitation clinical pathways (using the GiRFT approach).
- The reduction of out of area placements.
- Focus on crisis support (likely to link with Crisis Alternatives workstream funded via SDF), while recognising existing commitment around Mental Health Response Vehicles.
- Child and Adolescent Mental Heath Services (CAMHS) – including 24/7 CYP Crisis and improving specialist CAMHS provision across Herefordshire and Worcestershire.

How we will get there? – Development steps

The structures and governance of the mental health collaborative were reviewed by all partners in Q3 of 23/24 after the decision to pause the formal delegation/transfer of functions from the ICB to HWHCT and to strengthen the current Joint Committee arrangements, building on the success to date.

The MHC governance has now set out that the MHC Executive will recommend commissioning decisions to the Joint Committee, noting that they:

- have appropriate Impact Assessments undertaken
- evidence lived experience engagement
- evidence clinical engagement
- have addressed all performance, quality and finance issues
- reflect place-based views

The MHC Committee will then expect that the decision-forming stage has followed due process (including impact assessments) and has included appropriate clinical engagement, lived experience input and is reflective of place-based views. The MHC Committee will receive assurance reports from MHC Executive on the MH work programme – to include finance, performance, quality and workforce.

During 2024/25, the Joint Committee will include Learning Disability and Autism and will receive reports from the LDA Programme Board

15. NHS Trust Collaborations

Theme 15

Where we are now?

- Wye Valley NHS Trust (WVT) has been a full member of The Foundation Trust Group since 2016.
- Worcestershire Acute Trust (WHAT) became a full member of The Foundation Trust Group from July 2023 resulting in a joint Chief Executive and Chair across the four Foundation Group Hospitals.
- WAHT and WVT has completed a service sustainability analysis, which is now being developed into a work plan. This includes, agreement to form collaborative arrangements. There is continued mutual aid for vulnerable services with WVT being lead provider for dermatology and WAHT for MaxFax.
- WAHT and Herefordshire and Worcestershire Health and Care Trust – Memorandum of Understanding signed by both Trust Boards and work programme agreed. Co-ordination of progress drive through consistent reporting to both Trust Boards and appropriate system meetings. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, stroke pathway and urgent care pathway (frailty and virtual wards).
- WAHT and University Hospitals Birmingham - maintain cancer network access and outcomes, other tertiary referrals.
- WAHT and University Hospitals Coventry and Warwickshire – MDT working on clinical services in head & neck cancer, cardiac electrophysiology, urology cancer. Work progressing on full membership of urology network. Robotic Assisted Surgery for Prostatectomy – WAHT lead provider for collaboration with WVT – service commissioned using UHCW specialist MDT. Improvement partner for Virginian Mason methodology.
- WAHT and West Midlands Cardiology network chaired by our Divisional Director in Specialist Medicine.
- S Midlands Pathology Network – board approvals received for LIMs outline business case and SM Pathology network collaborative.
- Continued member West Midlands Cancer Alliance.
- The West Midlands Mental Health and Learning Disability and Autism Provider Collaborative was informally formed in 2021 bringing together 7 Trusts in the West Midlands, including Herefordshire and Worcestershire Health and Care NHS Trust based on, Working on the greatest challenges, supporting local systems (ICSs) to improve population health outcomes, playing a critical leadership role by operating as a network of Trusts, building on best practice and developing a regional approach and common set of outcomes, developing innovative clinical and workforce solutions, Horizon scanning to maximise WM PC influence and implementation of changes, in line with delegation from NHSE there are 5 provider networks managing the delegated functions around eating disorders, LDA, perinatal ,CAMHS & forensic services.

Where next? – Areas of focus

- Acute Trusts will continue to strengthen collaborations with during 2024
- Identifying clinical services that would benefit from a collective review
- Continuing to provide mutual aid and reviewing services for closer collaboration
- Provider review of areas of opportunity around back office functions at Foundation Group, system or Place as appropriate
- Taking forward the review of options for Stroke services across H&W
- Contributing to the development of a Pathology Network across the South Midlands
- Continued joint working on sustainability of vulnerable services
- UHCW - Urology Area Network - MoU in development

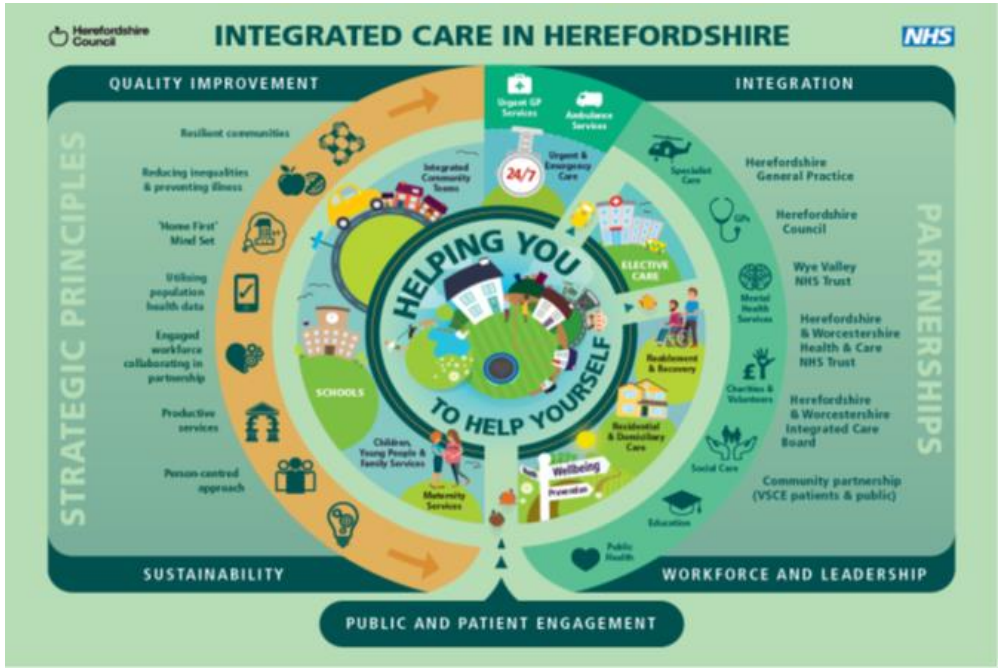
How we will get there? – Development steps

- Stratify provider collaborative arrangements based on service and population needs.
- Develop and agree an MOU between Trusts
- Chief Medical Officer / Chef Operating Officer group leading work to bring collaborative service models to maximise capacity in services with large backlogs or other critical issues
- ICB-led methodology for vulnerable services is twofold:
    - At operational level to manage existing or at risk vulnerable clinical services with identified models to support in the short term.
    - Strategically a provider led self-assessment of all clinical services to theme by sustainability / resilience and / or growth domains as part of potential collaborative service model.
- WAHT currently carrying out internal survey of existing collaborative working arrangements.
- Strategically, WAHT continue to test the validity of their clinical service strategy across vertical and horizontal pathways.

16. One Herefordshire Partnership

Theme 16

The One Herefordshire Partnership (1HP) drives the co-ordinated planning and delivery of the Herefordshire health and care system in order to deliver improvements in health and care outcomes through integrated working. 1HP partners share strategic objectives and reviews business cases, provides a forum for discussion on care pathway changes and approves the objectives set by the Primary Care networks (PCNs).



Where we are now? What have we delivered in 2023/24

- Developing strategies for key long term conditions
- Reduced secondary care referrals by 50% for patients with Diabetes through integrated PCN working
- Developed a blueprint for integrated urgent and emergency care
- Implementing a Talk Wellbeing approach to dealing with health inequalities, promoting personalisation and prevention
- Initiating programmes around the two HWBB priorities
- Launched the Community Paradigm approach
- Successfully bid for the 0-19 year old public health nursing service based on an integrated approach
- *Shortlisted for the HSJ Awards place-based partnership award*

Where next? – Areas of focus

1HP 2024/25 priorities

Fuller Delivery Plan

Integrated neighbourhood teams
Proactive care
Integrated Urgent Care model implementation

HWBB Priorities

Mental health and wellbeing
Best start in life

Planned Care

Developing a Long-Term Conditions programme that systematically supports a prevention approach
Reducing waiting lists (Making Every Referral Count)

Workforce

Seeking further opportunities for joint roles across 1H partners
Herefordshire public sector organisations joint recruitment

Working with Communities

Developing a Community Paradigm approach, co-ordinating engagement at Place and maximising the role of the VCS

How we will get there? – Development steps

- Developing a business case for integrated urgent and emergency care
- Reviewing the Place-based governance structure with the support of the LGA to better meet resident's needs
- Consolidate the approach to delegated delivery of the MOU between 1HP and ICB around the Better Care Fund

17. Worcestershire Place Partnership

Theme 17

The Worcestershire system spans many partner organisations and sectors. Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

We recognise the required shift to achieve greater integration and have been working to establish a framework for the culture within which we will work, between key partners, by agreeing and centring on our **shared vision and values** and putting people in our communities at the heart of everything we do. We understand that an **equal partnership** between NHS and health, local government and our VCSE sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:-

- Place equal value and emphasis on the **physical health and mental health** and wellbeing
- **Protect health** and focus on supporting the **conditions for good health**
- **Focus on prevention**; to prevent, reduce or delay need for care and support
- **Improve health disparities** particularly for those who are vulnerable, disadvantaged or living with a disability
- **Listen** to people who use our services and strive to improve, ensuring a **quality experience**
- Deliver **proactive and better coordinated** care to help people to stay healthy and independent**,** based on each person's needs
- Work together in an **evidence-based way** to take to **system wide approaches** to improve health across the life course
- Maximise **shared funding opportunities** to achieve **best value** (including social value)
- Develop and support our **workforce**

District Collaboratives: District Collaboratives bring together statutory health and care services, District Councils, the Voluntary, Community and Social Enterprise (VCSE) and wider partners to deliver against shared priorities with their communities. This is a new way of working and represents a shift in how communities and health and care providers work together. This should see greater local autonomy and resources directed into communities to enable greater control over addressing the underlying causes of ill health through interventions people design for themselves. There is a focus upon building strong, resilient communities, understanding and being able to optimise local assets, whilst articulating gaps and opportunities available to further improve the local offer. We are increasingly seeing that local partnerships are most effective in improving population health and tackling health inequalities.

Where next? – Areas of focus

- Priorities identified by the Worcestershire Health and Wellbeing Board: Good mental health and wellbeing, supported by (1) Healthy living at all ages (2) Safe, thriving and healthy homes, communities and place (3) Quality local jobs and opportunities
- Place based integrated performance report to drive assurance and prioritisation of activities.
- Strong integrated GP leadership across whole county and ensure full support to mature and develop
- Identification and building on local place-based assets to provide foundation for further 'left shift'
- Shared delivery plan across local NHSE Provider Alliance; shared delivery demonstrates maturity of relationship
- Support development and sustainability of VCSE Alliance as an equal partner
- Deliver agreed model of integrated urgent care and frailty action plan, further reducing pressure on ED front door and thereby supporting flow.
- Increasingly looking at shared resources, building on the work of place-based intelligence, engagement and communication cells.
- Support improvements to Stroke pathway to ensure sustainability and high-quality outcomes
- Consider wider integration with other statutory partners eg police, fire

How we will get there? – Development steps

- Developing relationships of trust through working together to deliver place priorities, as listed above.
- Develop systems thinking to enable shared understanding of challenges and solutions across providers.
- Consider implications of adopting Community Paradigm approach and how we can harness local assets to support District Collaborative objectives
- Maximise impact of the reinvigorated Place Leadership, collaboration between HWB and other place-based governance infrastructure to deliver sustainable improvements.

18. Pan system collaboration – The Office of the West Midlands Integrated Care Boards

Theme 18

The six ICBs in the West Midlands are collaborating to form an Office of the West Midlands. NHS Birmingham and Solihull ICB will host the staff performing these functions from 01 April 2023 and staff will transfer to the BSOL ICB in July 2023.

From April 2024 BSOL will also host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

Herefordshire and Worcestershire ICB will be leading a project on development and delivery of the dental access recovery plan.

The VISION:

Through at scale collaboration and distributive leadership, the Office of WM will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.

Purpose:

The core purpose is to :

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making
- To identify shared priorities and goals and clear projects and work programmes to deliver them
- To bring together in a single host ICB the shared teams and staff supporting the Office of the West Midlands and their ICBs.
- To develop distributive leadership and expertise across an agreed range of functions/teams for the benefit of all ICBs
- To provide a single coherent voice for the West Midlands ICBs where appropriate /a single point of contact/shared voice for change
- To share learning and support improvement across the ICBs
- To achieve best value and efficiency by working at scale where appropriate

Work Programme	Host ICB	Lead CEO
POD / GMaST / Complaints / Secondary Dental – Dental access recovery plan	Herefordshire and Worcestershire	Simon Trickett
Operating Model Development	Coventry and Warwickshire	Phil Johns
Collaboratives		
Integrated Staff Hub and OWN hosting	Birmingham and Solihulll	David Melbourne
Specialised commissioning		
Commissioning Support Service Review	Shropshire, Telford and Wrekin	Simon Whitehouse
NHS 111/999 Services	Black Country	Mark Axcell
West Midlands Combined Authority		
Immunisations and Vaccinations	Staffordshire and Stoke	Peter Axon

NHS
Office of the West Midlands
Partnership of Integrated Care Boards

Joint forward plan – 24/25

Appendix 3: Statutory Requirements checklist

This section includes a **cross reference to the two Health and Wellbeing strategies** for Herefordshire and Worcestershire, to identify the extent to which the JFP addresses the priorities set out therein.

The section also identifies which section of the JPF (or other documents) **show how the ICB will meet its statutory duties** as laid out in Appendix 2 of the mandatory guidance.

Final Draft: 22ND May 2024

Mapping to the Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this
Core Priority Areas	Best Start in Life For Children	• **Appendix 1, Theme 1** (Maternity and Neo-natal Care), **Appendix 1, Theme 2** (Early years, children and becoming an adult): The core focus of these two areas is directly aligned to the Health and Wellbeing priority or providing the Best Start in Life for Children.
	Good Mental Wellbeing throughout life	• **Appendix 1, Theme 6** (Learning Disability and Autism Care), **Appendix 1, Theme 7** (Mental Health and Wellbeing), **Appendix 2, Theme 15** (Mental Health Collaborative): The core focus of these three areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life.
Supporting Priorities	Improving access to local services	• **Appendix 1, All Themes** – Improving access to core NHS services is a priority running through the work programmes of all core themes, including through the development of virtual wards and an overall ambition to invest more in preventative activities and to provide best value healthcare in the right setting. • **Appendix 1, Themes 11, 12 and 13** (Primary Care Themes): Improving access for primary care services will be a specific focus through implementation of the National Access Recovery Plan. Furthermore, the ICB is responsible for commissioning Dental Services from April '23 and is prioritising work to improve access, particularly for those with greatest need. • **Appendix 2, Theme 11** (Digital data and technology): A key theme of our digital strategy is to enable greater access to service through digital platforms and to support the development of virtual wards.
	Support people to live and age well	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, All Themes** – Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities • **Appendix 2, Theme 5 (Prevention):** This sets out how NHS services will work to support local prevention strategies through specific interventions.
	Good work for everyone	• **Main Document, Workforce Section (page 13)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.
	Support those with complex vulnerabilities	• **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 6** (Learning Disability and Autism Care), These sections outline out work to support people with complex needs. Other services, particularly Primary Care also tailor their approaches to support complex needs. • **Appendix 2, Theme 4** (Health Inequalities), **Appendix 2 Theme 6** (Personalised Care), **Appendix 2 Theme 8** (Commitment to carers), **Appendix 2, Theme 9** (Support to veteran health), **Appendix 2, Theme 10** (Addressing the needs of victims of abuse): These sections outline specific local actions that will ensure that NHS partners support those people with complex vulnerabilities.
	Improve housing, reduce homelessness	• **Main Document, Population Health Management section (page 27),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes.
	Reduce Carbon Footprint	• **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.

Mapping to the Worcestershire Health and Wellbeing Strategy

Worcestershire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this	
Core Priority: Good Mental Health and Wellbeing	**Whole Population Approach**	• **Appendix 2, Theme 17** (Worcestershire Place Partnership): This section outlines how partners will work together at county and district collaborative level to put integration at the heart of our service delivery.	The core focus of these areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life: • **Appendix 1, Theme 6** (Learning Disability and Autism Care) • **Appendix 1, Theme 7** (Mental Health and Wellbeing) • **Appendix 2, Theme 14** (Mental Health Collaborative)
	Align and Support Local Strategies	• **Main Document, Population Health Management section (page 27),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 11** (Digital, Data and Technology):	
	Commitment to reducing health inequalities	• **Appendix 2, Theme 4** (Health Inequalities), • **Main Document, Population Health Management section (p27)**	
	Engage local communities over the lifetime of the strategy	• **Appendix 2, Theme 7** (Working with Communities) • **Appendix 2, Theme 8** (Commitment to Carers)	
Supporting Priorities	**Healthy Living at All Ages**	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 4** (Frailty), **Appendix 1, Theme 8** (Long term conditions): Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities. • **Appendix 2, Theme 5** (Prevention)**:** This sets out how NHS services will work to support local prevention strategies through specific interventions.	
	Quality local jobs and opportunities	• **Main Document, Workforce Section (page 13)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.	
	Safe, thriving and healthy communities and places	• **Appendix 2, Theme 7** (Working with Communities): This section outlines how we will listen to our communities and use this intelligence to make sure we focus on doing the right things. • **Main Document, Population Health Management section (page 27),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.	

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Describing the health services for which the ICB proposes to make arrangements.	**Chief Executive**	**Appendix 1, Core Areas of Service** provides an overview of the range of services that the ICB is making arrangements for. The ICB Operating Model and System Development Plan provides more detail on specific areas to demonstrate how services are organised and developed.
Duty to promote integration	**Executive Director of Strategy and Integration**	The duty to promote integration is inherent to the **design of the whole local system, as demonstrated in**: Integrated Care Strategy, JPF Main Document, JFP **Appendix 1 (Core areas of focus) and Appendix 2 (Enablers)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. Additionally, there are a myriad of other documents that outline this, including: ICB Operating Model and Organisational Structure, Better Care Fund, ICB Contribution to the Health and Wellbeing Strategies, Place Partnerships and HIPP Board, Fragile Services Framework, Clinical and Care Professional Leadership Networks
Duty to have regard to the wider effect of decisions	**Executive Director of Strategy and Integration** **Director of Corporate Services**	**The Four Pillars of Integrated Care Systems**, built up from the Triple Aim were the **basis of the strategic planning framework** that was used to develop the ICS Strategy, the Joint Forward Plan and the linkages they have to the Health and Wellbeing Strategies. The ICB Governance Design, as set out in the ICB Constitution and Governance Handbooks outlines how the Governance Structure of the ICB is designed to ensure that the ICB meets its duty to have regard to the wider effect of its decisions. The main committee for ensuring this happens is the ICB Quality, Resources and Delivery (QRD) Committee, which is supported by the ICB Quality Delivery and Oversight of System Group (QDOS), which pulls together the activities of all the ICS Programme Boards and Forums.
Financial duties	**Chief Finance Officer**	**Main Document, pages 17 - 19** outline the 23/24 Financial Plan. It also outlines arrangements for developing a Medium-Term Financial Strategy, which will be used to set out the plan for returning the system to financial balance. The ICS Finance Forum (chaired by Wye Valley NHS Trust Chairman) is the strategic group that bring finance professionals together to build consensus around the financial plan.
Implementing any Joint Local Health and Wellbeing Strategy	**Executive Director of Strategy and Integration**	**The JFP has been developed to specifically demonstrate how NHS partners will contribute to the delivery** of the Integrated Care Strategy and the two Joint Local Health and Wellbeing Strategies. The overall approach to the development of the Integrated Care Strategy and the Operating Model for the system (build around place) has been created to ensure alignment between all strategic plans.
Duty to Improve quality of services	**Executive Chief Nurse**	**Appendix 2, Theme 1 (Quality, Safety and Patient Experience)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to reduce inequalities	**Executive Director of Strategy and Integration**	**Appendix 2, Theme 4 (Health Inequalities) and Theme 5 (Prevention)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to promote the involvement of each patient **Duty to involve the public**	**Director of Operations – System Programmes** **Director of Communications & Engagements**	**Appendix 2, Theme 6 (Personalised Care)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Appendix 2, Theme 7 (Working with Communities)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Main Document, Population Health Management (page 27),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty as to patient choice	**Chief operating officer**	**Patient choice is a key focus for the ICB.** There is a plan for an accreditation process for new providers in development that will be ready in late 2023. Addition, there will be revised patient information to promote choice and support patients decisions. Progress against Patient Choice will be reported through the Elective, Diagnostic and Cancer Programme Board through the SRO for patient choice.
Duty to obtain appropriate advice	**Chief Executive, through individual Executive Leads**	**There are a myriad of different arrangements** in place for ensuring that the ICB obtains relevant advice when making decisions. This includes arrangements with a legal firm to provide legal advice, and MOU with public health to provide support for undertaking needs assessments, arrangements with the CSU for provide procurement advice etc.

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Duty to promote innovation	**Chief Medical Officer & Director of Workforce and Digital**	The Chief Medical Officer is responsible for coordinating work across the ICB for promoting Innovation and the ICB employs and Officer within the Digital Team to support this work. **Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty in respect of research	**Chief Medical Officer / LTC and Personalised Care Lead**	
Duty to promote education and training	**Chief People Officer**	**Main Document Pages 13 to 16** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Duty as to climate change	**Head of Health Inequalities, prevention and Greener NHS**	**Appendix 2, Theme 13 (Greener NHS)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of children and young people	**Director of Operations – System Programmes**	**Appendix 1, Theme 2 (Early Years, children and becoming an adult)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of victims of abuse	**The Chief Nursing Officer**	**Appendix 2, Theme 10 (Addressing the specific needs of victims of abuse)** The Director of Partnerships and Health Inequalities and Chief Nursing Officer is coordinating work to link in with external partners to ensure that the ICB fulfils across these areas, in addition to the services in place across Herefordshire and Worcestershire.

Other Recommended Content	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Workforce	**Main Document Pages 13 to 16** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Performance	**Main Document Page 12** sets out the specific short term performance trajectories that are being aimed for. Longer term trajectories will be developed as part of the new approach to Strategic and Operational Planning and will be incorporated in the first refresh of the JFP.
Digital / Data	**Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Estates	**The System Development Plan and ICS Operating Model documents** outline more detail on how the ICB and System Partners meet their statutory requirements in these areas.
Procurement / Supply Chain	
Population Health Management	**Main Document, Population Health Management (page 27),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
System Development	**Appendix 2, Theme 14 to 18** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Supporting Wider Social & Economic Development	The ICB fulfils its statutory duties through **membership of the Health and Wellbeing Boards** and engagement and contribution to the two Joint Local Health and Wellbeing Strategies, which both have a focus on tackling the wider determinants to health.
Veteran's Health	**Appendix 2, Theme 9** for detail on our approach to supporting veteran's health

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Update to Standing Orders
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Audit Ctte, Trust Board
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Draft 2024 FG Standing Orders

1. Purpose of the report

To present the updated Standing Orders (SOs) for WVT for approval prior

2. Recommendation(s)

That Trust Board approve the draft SOs for adoption across the Foundation Group and at WVT specifically.

3. Executive Director Opinion[1]

It is a requirement that all NHS bodies lay out how they will manage the business of the Trust led through the Trust Board and its sub committees. These Standing Orders have been produced for adoption by all NHS Trusts within the Foundation Group (acknowledging SWFT's 'foundation trust' status for which there are different requirements)

SOs (alongside SFIs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. The documents fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. They also provide a comprehensive business framework that is to be applied to all activities. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.

This new document has used the previous WVT's SOs. As such, there are no material changes to the previous version, with the exception that they've been adapted to be applicable to George Eliot and Worcestershire Acute. They are based on the Department of Health's 'model' SOs. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. A final summary of delegated powers (appendix 1) has not been provided given that they could be subject to change depending on feedback from Board members. It is intended to collate the delegations by job role which will make it more explicit and easier for post holders to see exactly what they are responsible for.

[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.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

George Eliot Hospital NHS Trust

Worcestershire Acute Hospitals NHS Trust

Wye Valley NHS Trust

STANDING ORDERS 2024/25

Table of Contents

Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS Trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with SOs made under Regulation 19(2).

These SOs and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The SOs, Standing Financial Instructions (SFIs), procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" SOs are:

- SFIs, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Schedule of Decisions Reserved to the Board of the Trust
- Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

These extended SOs set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

All executive and non-executive directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

INTRODUCTION

1. The George Eliot NHS Trust (GEH) is a statutory body which was established on 1st July 2009 under The NHS Trust (Establishment) Order 1993 under The George Eliot Hospital NHS Trust (Establishment) Order No 1510.
2. The principal place of business of GEH is George Eliot Hospital, College Street, Nuneaton, CV10 7DJ.
3. The Worcestershire Acute Hospitals NHS Trust (WAHT) is a statutory body established on 1st January 2000 under the NHS Trust (Establishment) Order 1990 under Order No 3473.
4. The principal place of business of WAHT is Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD.
5. The Wye Valley NHS Trust (WVT) is a body corporate which was established on 1st April 2011 under The NHS Trust (Establishment) Order 1993 (the Establishment Order).
6. The principal place of business of WVT is Trust Headquarters, Hereford County Hospital, Stonebow Road, Hereford, HR1 2ER.
7. NHS Trusts are governed by statute, mainly the National Health Service Act 2006 and the Health and Social Care Act 2012.
8. The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and Schedule 4) and in the Establishment Order.
9. As a body corporate, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role, it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee for property held by the Trust on behalf of patients.
10. The Department of Health and Social Care (DHSC) requires that Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior managers. The Code of Conduct and Code of Accountability makes various requirements concerning possible conflicts of interest of Board directors. The NHS Trusts (Membership and Procedure) Regulations 1990 requires the establishment of audit and remuneration committees with formally agreed terms of reference.
11. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.
12. Through these SOs, the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of the SOs; or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State for Health and Social Care may direct.
13. These documents, together with SFIs, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trusts' interests by ensuring, for example, that all transactions maximise the benefit to the Trust and protecting staff from possible accusations that they have acted less than properly.
14. The SOs, Scheme of Delegation document and SFIs provide a comprehensive business framework. All directors and all staff should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions to the extent required for the proper conduct of their duties.
15. **The failure to comply with SOs and SFIs can be regarded as a disciplinary matter that could result in dismissal.**

SECTION A - INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

Save as otherwise permitted by law, at any meeting the **Chair** of the Trust shall be the final authority on the interpretation of Standing Orders (SOs) on which the **Chief Executive**, guided by the **Trust Secretary**, shall advise them.

GEH, WAHT and WVT are part of a Foundation Group of hospitals along with the South Warwickshire University NHS Foundation Trust (SWFT) who share a **Chief Executive**.

The **Chief Executive** works with the **Chair** to ensure that the Board maintains its capacity and is continually developed in order to remain 'fit for purpose' in the context of a changing NHS and wider healthcare environment. In support of these responsibilities a key part of the **Chief Executive** role is a focus on the integration agenda, system leadership and partnership working.

To this end, this role involves robust engagement with stakeholders, commissioners, other health and social care providers, public, private and third sector partners, children and families, to maximise the opportunities for improved service delivery at every opportunity.

The **Managing Director** is responsible for the day to day management of the Trust on behalf of the **Chief Executive** leading the Executive Team and Chairing the Trust Management Board. This role encompasses internally and externally the development and implementation of the Trust strategy, the management of relationships, engagement with staff and stakeholders and embedding partnerships with key stakeholders to the organisation, overseeing all communications activity across the Trust, both internally and externally, and the delivery of the Board Assurance Framework.

The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act 2006
- the **2012 Act** is the Health and Social Care Act 2012
- **Membership and Procedure Regulations** are the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990)2024), as amended.

Other definitions:

- **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, it shall be the **Chief Executive**.
- **Board** means the Chair, Officer (Executive Directors) and Non-Officer (Non-Executive Director) members of the Trust collectively as a body.
- **Budget** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- **Budget holder** means a director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

- **Chair of the Board (or Trust)** is the person appointed by the Secretary of State for Health and Social Care and Social Care (delegated to NHS England (NHSE) to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
- **Chief Executive** means the Chief Officer of the Trust. The **Chief Executive** is also the Accountable Officer.
- **Chief Finance Officer** means the Chief Financial Officer of the Trust.
  Clinical Directors are specialty leads reporting to and accountable to the **Chief Executive**, with professional oversight from the Chief Medical Officer. They are ***excluded*** from the term "director" for the purposes of this document, unless specifically stated otherwise.
- **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- **Committee** means a committee or sub-committee created and appointed by the Trust.
- **Committee members** means persons formally appointed by the Board to sit on or to chair specific committees.
- **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- **Executive Director** is an officer of the Trust. Up to five will be voting members of the Trust Board, appointed in accordance with the Membership and Procedure Regulations, 1990. The remainder will not be eligible to vote on the Trust Board.
- **Funds Held on Trust** are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
- **Managing Director** means the Managing Director of the Trust and the person responsible for the day to day management of the Trust.
- **Member** means Executive Director (officer) or Non-Executive Director (non-officer) member of the Board as the context permits. Member in relation to the Board does not include its Chair.
- **Associate Member** means a person appointed to perform specific statutory and non-statutory duties, which have been delegated by the Trust Board for them to perform, and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
- **Membership, Procedure and Administration Arrangements Regulations** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
- **Motion** is a formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
- **NHS England (NHSE)** is responsible for the oversight of NHS Trusts and has delegated authority from the Secretary of State for Health and Social Care and Social Care for the appointment of the Non-Executive Directors, including the Chair of the Trust.
- **Nominated officer** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
  Non-Executive Director also is a member of the Trust Board who is not an Executive Director of the Trust and is not to be treated as an Executive Director by

virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

- **Officer** (or **staff**) means an employee of the Trust or any other person holding a paid appointment or office with the Trust. (This includes all employees or agents of the Trust, including medical and nursing staff and consultants practising upon the Trust's premises and shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust).
  Officer member means a member of the Trust Board who is either an Executive Director of the Trust or is to be treated as an Executive Director by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).
- **Senior Independent Director (SID)** means an independent non-officer member appointed by the Board to provide a sounding board for the Chair and serve as an intermediary for the other directors when necessary.
- **SFIs** means Standing Financial Instructions.
- **SOs** means Standing Orders.
- **Trust** means the George Eliot Hospital NHS Trust/Worcestershire Acute Hospitals NHS Trust/Wye Valley NHS Trust.
- **Trust Secretary** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.
- **Vice-Chairperson/Deputy Chairperson** means the non-officer member appointed by the Board to take on the Chairperson's duties if the Chairperson is absent for any reason.
- **Working day** means any day, other than a Saturday, Sunday or legal holiday
  Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.
  All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

Policy statements: general principles

These SOs and SFIs must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- Bribery Act 2010

The Trust Board will from time to time agree and approve policy statements and procedures which will apply to all, or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's SOs and SFIs.

SECTION B – STANDING ORDERS FOR THE REGULATION OF THE PROCEEDINGS OF GEH/WAHT/WVT

Part 1 – Membership

1 Name and business of the Trust

1.1. All business shall be conducted in the name of George Eliot Hospital NHS Trust/Worcestershire Acute Hospitals NHS Trust/Wye Valley NHS Trust ("the Trust").

1.2. All funds received in trust shall be in the name of the Trust as corporate trustee. The powers exercised by the Trust as corporate trustee, in relation to funds held on trust, shall be exercised separately and distinctly from those powers exercised as a Trust.

1.3. The Trust has the functions conferred on it by Schedule 4 of the 2006 Act.

1.4. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health and Social Care. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health and Social Care.

1.5. The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, which may include members participating by video or telephone. These powers and decisions are set out in the Schedule of Decisions Reserved and Standing Financial Instructions (SFIs) which are a separate document and have effect as if incorporated into the SOs.

2 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

2.1 The Chair of the Trust (Appointed by the NHSE);

2.2 The voting membership of the Trust Board shall comprise the Chair and five non-executive directors (appointed by NHSE), together with up to five executive directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent non-executive directors.

2.3 In addition to the Chair, the non-executive directors shall normally include:

a. one appointee nominated to be the Vice-Chair
b. one appointee nominated to be the Senior Independent Director
c. one or more appointees who have recent relevant financial experience

Appointees can fulfil more than one of the roles identified.

2.4 Up to five executive directors (but not exceeding the number of non-executive directors) including:

- **Chief Executive**
- Chief Finance Officer
- Medical Practitioner (Chief Medical Officer)
- Registered Nurse/Midwife (Chief Nursing Officer)
- **Managing Director**

2.5 The Board may appoint additional executive directors, in crucial roles in the Trust, and also additional non-executive directors and Associate non-executive directors to be non-voting members of the Trust Board.

2.6 The Trust shall have not more than 11 and not less than eight members (unless otherwise determined by the Secretary of State for Health and Social Care and Social Care and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

3 Appointment of Chair and Members of the Trust Board

3.1 The Chair and non-executive directors of the Trust are appointed by the NHSE, on behalf of the Secretary of State for Health and Social Care.

3.2 The **Chief Executive** shall be appointed by the Chair and the non-executive directors.

3.3 Executive directors shall be appointed by a committee comprising the Chair, the non-executive directors and the **Chief Executive**.

3.4 Where more than one person is appointed jointly to an executive director post in the Trust, those persons shall become appointed as an executive director, jointly.

4 Appointment and Powers of Deputy Chair & Senior Independent Director

4.1 Subject to SO 4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not an executive director, to be Deputy Chair & Senior Independent Director (SID), for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

4.2 Any member so appointed may at any time resign from the office of Deputy Chair and SID, by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Deputy Chair and SID, in accordance with the provisions of SO 4.1.

4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair & SID shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair & SID.

5 Tenure of office

5.1 The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements Regulations.

6 Code of Conduct and Accountability and the Trust's commitment to openness

All directors shall subscribe and adhere at all times to the principles contained in the Code of Conduct and Code of Accountability in the NHS and in the Trust's Code of Conduct (HR.93) and Managing Conflicts of Interest Policy (MF.36).

7 Functions and roles of Chair and directors

The function and role of the Chair and members of the Trust Board is described within these SOs and within those documents that are incorporated into these SO.

Part 2 – Meetings

8 Ordinary meetings of the Trust Board

8.1. All ordinary meetings of the Trust Board shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended, and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

8.2. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may from time to time determine. A minimum of six meetings shall be held each year.

8.3. The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the Trust Board's business may be conducted without interruption and disruption.

8.4. The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Trust Board resolving as follows:

"***That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public***"

8.5. Business proposed to be transacted when the press and public have been excluded from a meeting as provided in SO 8.4, shall be confidential to members of the Board.

8.6. Members and officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Trust Board meetings without the express permission of the Trust Board.

8.7. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

8.8 The Chair may invite any member of staff of the Trust, any other NHS organisation, an officer of the local council(s) or any other individual acting in an advisory capacity to attend meetings. These invitees shall not count as part of the quorum or have any right to vote at the meeting.

8.9 An annual public meeting shall be held on or before 30 September in each year for the purpose of presenting audited accounts, annual reports and any report on the accounts.

8.10 The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted.

8.11 The provisions of these SOs relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to seminars or workshops or other meetings attended by members of the Trust Board.

9 Extraordinary meetings of the Trust Board

9.1 The Chair may call a meeting of the Trust Board at any time. Directors may ask the Chair to call a meeting of the Trust Board at any time.

9.2 A meeting may be called forthwith, by the directors who are eligible to vote, if the Chair refuses to call a meeting after such a request has been presented to them, signed by at least one third of the whole number of directors who are eligible to vote (including at least one executive and one non-executive director); and has been presented to them at the Trust's principal place of business. The directors who are eligible to vote may also call a meeting forthwith if, without refusing, the Chair does not call a meeting within seven days after receipt of such request.

10 Notice of meetings

10.1 The Trust shall set dates and times of regular Trust Board meetings for the forthcoming financial year by the end of December of each year.

10.2 One third or more members of the Trust Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting. In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

10.3 A notice of the meeting, specifying the business proposed to be transacted, shall be posted before each meeting on the Trust website. The notice shall be delivered to every director by the most effective route, at least three working days before the meeting. Notice shall be presumed to have been served two days after posting and one day after being sent out via email.

10.4 Lack of service of such notice on any individual director shall not affect the validity of a meeting. However, failure to serve such a notice on at least three directors who are eligible to vote will invalidate the meeting.

10.5 Where a part or the whole of a meeting is to be open to the public, official notice of the time, place and agenda of the meeting shall be announced in public. As required by the Public Bodies (Admission to Meetings) Act 1960 Section 1(4)(a)), notice will be given by one or more of the following announcements:

a. in the local press,
b. on the Trust's internet website,
c. displaying the notice in a conspicuous place in the Trust's hospitals or other facilities
d. displaying the notice in other "central and conspicuous places".

10.6 The Trust Board may decide to limit publication to details of the items on the meeting agenda that will be considered in the part of the meeting to be held in public. A copy of the notice including the agenda may also be sent to local organisations that will have an interest in the decisions of the Trust Board. These organisations include bodies responsible for commissioning acute and community NHS services locally, patient and public representative groups and local councils.

10.6 Notice will be given at least three working days before the meeting. Failure to do so will render the meeting invalid.

11 Agenda and Supporting Papers

11.1 The Trust Board may determine that certain matters will appear on every agenda for an ordinary meeting of the Trust Board and that these will be addressed prior to any other business being conducted at the discretion of the Chair. On agreement by the Trust Board, these matters may change from time to time.

11.2 A director may request that a matter is included on an agenda. This request should be made in writing, including by electronic means, to the Chair, **Chief Executive**, or the Trust Secretary at least seven working days before the meeting, subject to SO10. Requests made less than seven working days before the meeting may be included on the agenda at the discretion of the Chair, or to the extent that this discretion is delegated to the **Chief Executive** and the **Trust Secretary.**

11.3 Notwithstanding SO 11.2, a director may with the consent of the Chair of the meeting, add to the agenda of any meetings any item of business relevant to the responsibilities of the Trust under "Any Other Business".

11.4 The agenda will be sent to directors five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda but will certainly be despatched no later than three clear working days before the meeting, save in an emergency.

12 Chair of meetings

12.1 The **Chair** shall preside at any meeting of the Trust Board, if present. In his absence, the Deputy Chair shall preside.

12.2 If the Chair and Deputy Chair are absent, the directors present, who are eligible to vote, shall choose a non-executive director who shall preside. An executive director may not take the chair.

12.3 The decision of the **Chair** of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the SOs shall be final. In this interpretation he shall be advised by the **Chief Executive** and the Trust Secretary and in the case of SFIs he shall be advised by the Chief Finance Officer.

13 Voting

13.1 It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

13.2 Save as provided in SO27 Suspension of Standing Orders and SO28 Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding i.e. the Chair of the meeting, shall have a second, and casting vote.

13.3 At the discretion of the **Chair**, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the **Chair** directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot. Unless specifically agreed beforehand, the voting record of each individual director in a paper ballot will not be made public or recorded.

13.4 The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

13.5 If a Board member so requests, their vote shall be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded.

13.6 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

13.7 An officer who has been formally appointed by the Trust to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy shall be entitled to exercise the voting rights of the executive director. An officer attending the Trust Board meeting to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An executive director's status when attending a meeting shall be recorded in the minutes.

13.8 Where the post has voting rights attached, the joint appointees will have the power of one vote; and shall count for the purpose of SO 2 as one person:

a. either or both of those persons may attend or take part in meetings of the Board;
b. if both are present at a meeting they should cast one vote if they agree;
c. in the case of disagreements no vote should be cast;
d. the presence of either or both of those persons should count as the presence of one person for the purposes of SO14 Quorum.

13.9 For the voting rules relating to joint members see SO 3.4.

13.10 Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

14 Quorum

14.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the **Chair** and members, including at least one executive director and one non-executive director is present.

14.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

14.3 If the **Chair** or executive director or non-executive director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution because of a declaration of a conflict of interest (see **Part 3 – Standards of Business Conduct**) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting shall then proceed to the next business.

15. Record of attendance

15.1 The names of the directors and others invited by the **Chair**, in accordance with Standing Order 8, present at the meeting, shall be recorded in the minutes.

15.2. If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

16. Minutes

16.1. The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

16.2. There should be no discussion on the minutes, other than as regards their accuracy, unless the **Chair** considers discussion appropriate.

16.3. Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

17 Petitions

Where a petition has been received by the Trust, the **Chair** shall include the petition as an item for the agenda of the next meeting.

18 Notice of Motion

Subject to the provision of SO20, a director of the Trust desiring to move a motion shall give notice of this, to the **Chair**, at least seven working days before the meeting. The **Chair** shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

19 Emergency Motions

Subject to the agreement of the **Chair**, and subject also to the provision of SO20, a member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The **Chair**'s decision to include the item shall be final.

20 Motions: Procedure at and during a meeting

20.1 A motion may be proposed by the **Chair** of the meeting or any member present, it must also be seconded by another member.

20.2 The **Chair** may exclude from the debate, at their discretion, any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;

- that the Trust Board proceed to next business;
- that the Trust Board adjourns;
- that the question be now put.

21 Amendments to motions

21.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

21.2 Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

21.3 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

22 Rights of reply to motions

22.1 Amendments. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

22.2 Substantive/original motion. The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

23 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

24 Motions once under debate

24.1 When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceeds to the next business
- that the question should be now put
- the appointment of an 'ad hoc' committee to deal with a specific item of business
- that a member/director be not further heard
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see SO 29).

24.2 In those cases where the motion is either that the meeting proceeds to the “next business” or “that the question be now put” in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

24.3 If a motion to proceed to the next business or that the question be now put, is carried, the **Chair** should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

25 Motion to rescind a decision of the Trust Board

25.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the **Chief Executive** for recommendation.

25.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the **Chair** to propose a motion to the same effect within six months. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee or the **Chief Executive**.

25.3 When the Trust Board has debated any such motion, it shall not be permissible for any director, other than the **Chair** to propose a motion to the same effect within a further period of six calendar months.

26 Chair's ruling

The decision of the **Chair** of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the SO and SFIs, at the meeting, shall be final.

27 Suspension of Standing Orders

27.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 14), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Trust Board are present (including at least one executive director and one non-executive director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

27.2 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the **Chair** and members of the Trust.

27.3 No formal business may be transacted while SO are suspended.

27.4 The Audit Committee shall review every decision to suspend SO.

28 Variation and amendment of Standing Orders

These SOs shall not be varied except in the following circumstances:

- upon a notice of motion under SO 18

- upon a recommendation of the **Chair** or **Chief Executive** included on the agenda for the meeting
- that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's non-executive members vote in favour of the amendment
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

29 Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board as follows:

> "***that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest***", Section 1 (2), Public Bodies (Admission to Meetings) Act l960.

30 General disturbances

The **Chair** (or Deputy Chair) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption. Section 1(8) of the Public Bodies (Admissions to Meetings) Act 1960 provides the Trust Board power of exclusion to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The public will be required to withdraw upon the Trust Board resolving:

> "***That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public***".

31 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

32 Observers at Trust meetings

The Trust will decide what arrangements and terms, conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms, and conditions as it deems fit.

Part 3 – Standards of business conduct

33 Declarations of interest

33.1 In addition to the statutory requirements relating to pecuniary interests dealt with in SO 34, the Trust's Management of Conflicts Policy (MF.38) requires directors to declare interests which are relevant and material to the Trust Board. All existing directors and decision-making staff as set out in the Policy should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and decision-making staff appointed subsequently should declare these interests on appointment.

33.2 Interests are:

- **Financial interests**, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- **Non-financial professional interests**, where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests**, where an individual may benefit personally in ways which are not linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests**, where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

33.3. Subject to the requirements stated in Standing Order 22, the interests of directors' spouses, partners, or other family members must be disclosed where these maybe in conflict with the Trust.

33.4 If directors have any doubts about the relevance of an interest, this should be discussed with the **Chair** of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

33.5 Declarations of interests should be considered by the Trust Board and retained as part of the record of each Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

33.6 If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the

director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

33.7 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports. Register of Interests

33.8 The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors and other decision-making staff. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive directors.

33.9 These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

33.10 The Register of Interests will be available to the public on the Trust's web page and at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

33.11 With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or subcommittee or group of the Trust Board; and to any member of such committee or subcommittee or group (whether or not they are a director).

34 Disability of directors in proceedings on account of pecuniary interest

34.1. Subject to SO33 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

34.2. The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to them to be in the interests of the NHS that the disability should be removed.

34.3 The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

34.4 Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

34.5 For the purpose of this SO a director shall be treated, subject to SO2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

- they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or,
- they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this SO to be also an interest of the other.

34.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

- of an interest in any company, body or person with which they are connected as mentioned in SO 34.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

34.7 This SO shall not prohibit a director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

- They have an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
- the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one hundredth of the total issued share capital of the class. This does not affect their duty to disclose the interest

34.8 This SO also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

35 Standards of Business Conduct

35.1 The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

35.2 The NHS Constitution (updated January 2021) identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

- to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies;
- to act in accordance with the terms of contract of employment;
- not to act in a discriminatory manner;
- to protect confidentiality;
- to be honest and truthful in their work;
- to aim to maintain the highest standards of care and service;
- to maintain training and personal development to contribute to improving services;
- to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity;
- to involve patients in decisions about their care and to be open and honest with them and;
- to contribute to a climate where the truth can be heard and learning from errors is encouraged.

35.3 The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

- **Selflessness**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity**: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity**: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability**: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness**: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty**: Holders of public office should be truthful.
- **Leadership**: Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

35.4 All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

- act in the best interests of the Trust and adhere to its values and this code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions;
- recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and;
- accept responsibility for their performance, learning and development.

35.5 All Directors must act in accordance with the Professional Standards Authority's 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' 2012.

35.6 All staff shall declare any relevant and material interest, such as those described in SO 33 and in the Trust's Management of Conflicts Policy (MF.38). The declaration should be made on appointment to the executive director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Management of Conflicts Policy (MF.38). The system will then add the interest to the Trust's Register of Interests.

35.7 Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the expenditure of taxpayer monies, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

35.8 If an officer becomes aware of a potential or actual contract in which they have an interest of the nature described in SO 33 and SO 34, they shall immediately advise the **Chief Finance Officer** formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed or awarded contract to which they have an interest.

35.9 Gifts and hospitality shall only be accepted in accordance with the Trust's Management of Conflicts Policy (MF.38). Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

35.10 All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy), should be declared via the Trust's online declarations of interest system. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act 2006 and the Bribery Act 2010.

35.11 In addition to SO 33, SO 34 and this Standing Order, an officer must also declare to the Chief Executive or Trust Secretary any other employment, business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be

predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part 4 – Arrangements for the exercise of functions by delegation and committees

36 Exercise of functions

Subject to SO 40 and such directions as may be given by the Secretary of State for Health and Social Care and Social Care, the Trust Board may delegate any of its functions to a committee or sub-committee or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

37 Emergency powers and urgent decisions

The powers which the Trust Board has retained to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the **Chief Executive** and the **Chair** acting jointly and, if possible, after having consulted with at least two non-executive directors. The exercise of such powers by the **Chief Executive** and the **Chair** shall be reported to the next formal meeting of the Trust Board for formal ratification.

38 Delegation to committees

The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

39 Delegation to officers

Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the **Chief Executive**. The **Chief Executive** shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

40 Schedule of decisions reserved for the Trust Board

40.1 The Trust Board shall adopt a 'Schedule of Decisions Reserved for the Trust Board' setting out the matters for which approval is required by the Trust Board. The Schedule of Reservation, Delegation of Powers and Financial Delegation Limits (Standing Financial Instructions) are a separate document and shall be regarded as forming part of these SOs.

40.2 The Trust Board shall review such Schedule at such times as it considers appropriate; and shall update the Schedule of Reservation, Delegation of Powers and Financial Delegation Limits (Standing Financial Instructions) after each review.

40.3 The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub- committee shall be subject to and qualified by the reserved matters contained in that Schedule.

41 Scheme of Delegated Authorities

41.1 The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them. The Schedule that is current at the date of adoption of these SOs is contained in Appendices 1 and 2 and shall be regarded as forming part of these SOs.

41.2 The Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendices 1 and 2 after each review.

41.3 The direct accountability, to the Trust Board, of the Director of Finance and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

42 Appointment of committees

42.1 Subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care, the Trust may, and if directed by them, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

42.2 An appointed committee may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

42.3 The SOs of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.

42.4 The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

42.5 Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

42.6 The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the Secretary of State for Health and Social Care, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

42.7 Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this SO are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

42.8 The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

43 Statutory and mandatory committees

Role of Audit Committee

43.1 In line with the requirements of the Code of Governance for NHS Provider Trusts, NHS Audit Committee Handbook (fourth edition), NHS Codes of Conduct and Accountability, and the Higgs report, the Trust Board will establish an Audit Committee, constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

43.2 The terms of reference of the Audit Committee shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board. The Terms of Reference will be approved by the Trust Board and reviewed on an annual basis.

43.3 The Code of Governance for NHS Provider Trusts, and Higgs report recommends a minimum of three non-executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

Role of Auditor Panel

43.4 The Trust Board shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

43.5 The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

43.6 The terms of reference of the Auditor Panel shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Remuneration Committee

43.7 In line with the requirements of the Code of Governance for NHS Provider Trusts, NHS Codes of Conduct and Accountability, and the Higgs report, the Trust Board shall appoint a committee to undertake the role of a remuneration and terms of service committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the **Chief Executive** and other executive directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

43.8 The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the **Chief Executive** and executive directors, including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions;
- arrangements for termination of employment and other contractual terms.

43.9 The terms of reference of the Remuneration and Nominations Committee shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

43.10 The Code of Governance for NHS Provider Trusts and Higgs report recommends the committee be comprised exclusively of non-executive directors, a minimum of three, who are independent of management.

Role of the Charity Committee

43.11 The Trust Board, acting as Corporate Trustee, shall appoint a committee to be known as the Charity Trustee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

43.12 The terms of reference of the Charity Trustee shall have effect as if incorporated into these SOs and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

44 Non mandatory committees

44.1 The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

44.2 The terms of reference of these committees shall have effect as if incorporated into these SOs. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

44.3 The membership of these committees may comprise non-executive directors or executive directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

44.4 The current non-mandatory committees in place are (March 2023):

- **Quality Committee/Quality Assurance Committee**. The purpose of the Quality Committee/Quality Assurance Committee is to provide the Board with an independent and objective review of all aspects of quality and safety relating to the provision of care and services in support of ensuring the best clinical outcomes and experience for all patients; and, to assure the Board that the Trust is aligned to the statutory quality and safety demands of existing legislation relating to all areas of the Trust.
- **Risk Management Executive/Executive Risk Committee.** The purpose of the Risk Management Executive/Executive Risk Committee is to ensure the effective implementation of the Risk Management Strategy and there are core processes in place to manage risks across the organisation. The Risk Management Executive/Executive Risk Committee reports on any issues where the Trust Board may require additional assurance or where a Trust Board decision is required.
- **Finance and Performance Executive.** The purpose of the Finance and Performance Executive is to ensure the Executive Team holds all divisions and/or directorates (as appropriate) to account for their delivery of key quality, performance, workforce and financial objectives and as required by the Trust Board and/or regulators. The overall objective is to provide assurance and support at all levels that appropriate management action (by managers and clinicians) is being exercised and that the organisation can demonstrate it is well led from “ward to board”.
- **Foundation Group Strategy Committee.** The purpose of the Foundation Group Strategy Committee is to advise the Boards of South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust, Worcestershire Acute Hospitals NHS Trust and Wye Valley NHS Trust on all matters relevant to identifying and sharing best practice at pace.

These are subject to change at the discretion of the Trust Board.

45 Joint Committees

45.1 Joint committees may be appointed by the Trust by joining one or other Trusts consisting of, wholly or partly of the **Chair** and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

45.2 Any committee or joint committee appointed under this SO may, subject to such directions as may be given by the Secretary of State or the Trust or other health

bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

46 Proceedings in committee to be confidential

46.1 There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

46.2 Committee members should normally regard matters dealt with or brought before the committee as being subject to disclosure, unless stated otherwise by the **Chair** of the committee. The **Chair** shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

46.3 A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

46.4 Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services

47 Applicability of Standing Orders and Standing Financial Instructions to Committees

The SO and SFIs of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "**Chair**" is to be read as a reference to the **Chair** of other committees as the context permits, and the term "member" is to be read as a reference to a member of other committees also as the context permits.

48 Duty to report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SOs to the **Chief Executive** as soon as possible.

49 Terms of reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the SOs.

50 Delegation of powers by committees to sub-committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

51 Approval of appointments to committees

The Board shall approve the appointments to each of the committees, which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

52 Appointments for statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

53 Proceedings in committee to be confidential

53.1 There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act 2000 and there is no legal justification for non-disclosure.

53.2 Committee members should normally regard matters dealt with, or brought before the committee as being subject to disclosure, unless stated otherwise by the **Chair** of the committee. The **Chair** shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

53.3 A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

53.4 Regardless of this SO, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

54 Election of Chair of committee

54.1 Each committee shall appoint a **Chair**; and may appoint a Deputy Chair from its membership. The terms of reference of the committee shall describe any specific rules regarding who the Chair should be. Meetings of the committee will not be recognised as quorate, if the Chair, or Deputy Chair, or other suitably qualified, nominated member of the committee is not present to undertake the role.

54.2 Each committee shall review the appointment of its Chair, as part of the annual review of the committee's role and effectiveness.

55 Special meetings of committee

The **Chief Executive** shall require any committee to hold a special meeting, on the request of the **Chair**, or on the request, in writing of any two members of that committee.

Part 5 – Custody of seal and sealing of documents

56 Custody of seal

The common seal of the Trust shall be kept by the **Trust Secretary** in a secure place.

57 Sealing of documents

57.1 The Seal of the Trust shall only be attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has first been approved in accordance with these Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authorities.

57.2 The seal shall be affixed in the presence of the signatories in accordance with Paragraph 33 of Schedule 4 of the 2006 Act:

> ***"33 Instruments etc. (1) The fixing of the seal of an NHS trust must be authenticated by the signature (a) of the chairperson or of some other person authorised (whether generally or specifically) by the NHS trust for that purpose, and (b) of one other director."*** 31. Bearing witness to the affixing of the Seal

57.3 A recommended wording for the witnessing of the use of the Seal is "The Common Seal of the George Eliot Hospital National Health Service/Worcestershire Acute Hospitals National Health Service/Wye Valley National Health Service Trust was hereunto affixed in the presence of…."

57.3 The seal shall be affixed in the presence of two executive directors, and not from the originating department, and shall be attested by them.

58 Bearing witness to the affixing of the Seal

A recommended wording for the witnessing of the use of the Seal is "*The Common Seal of the George Eliot Hospital National Health Service/Worcestershire Acute Hospitals National Health Service/Wye Valley National Health Service Trust was hereunto affixed in the presence of….*"

59 Register of sealing

The **Trust Secretary** shall keep a register in which they will make an entry of every sealing, numbered consecutively in a book provided for that purpose. The entry shall be

signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

60 Signature of documents

60.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the **Chief Executive** or any executive director, unless any enactment requires or authorises otherwise.

60.2 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Delegation. This will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

Part 6 – Waiver of Standing Orders made by the Secretary of State for Health and Social Care

61 Power of the Secretary of State to make waivers

Under regulation NHS (Membership and Procedure) Regulations, there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

62 Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of SO 80 (below), the "relevant Chair" is:

a. at a meeting of the Trust, the Chair of that Trust
b. at a meeting of a Committee:
   - in a case where the member in question is the Chair of that committee, the Chair of the Trust;
   - in the case of any other member, the Chair of that committee.

63 Application of waiver

63.1 A waiver will apply in relation to the disability to participate in the proceedings of the Trust because of a pecuniary interest. It will apply to a member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

- services under the National Health Service Act 1977; or
- services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

63.2 Where the 'pecuniary interest' of the member in the matter, which is the subject of consideration at a meeting at which, they are present:

a. arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
b. has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

- are members of the same profession as the member in question,
- are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

64 Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

a. the member must disclose their interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;
b. the relevant **Chair** must consult the **Chief Executive** before making a declaration in relation to the member in question pursuant to SO 80.2b, except where that member is the **Chief Executive**;
c. in the case of a meeting of the Trust:
   - the member may take part in the consideration or discussion of the matter, which must be subjected to a vote, and the outcome recorded;
   - may not vote on any question with respect to it.
d. in the case of a meeting of the Committee:
   - the member may take part in the consideration or discussion of the matter, which must be subjected to a vote, and the outcome recorded;
   - may vote on any question with respect to it; but the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Perinatal Services Safety Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Associate Director of Midwifery, Amie Symes
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To provide Board with a quarterly update in line with Trust, local and national reporting requirements for perinatal services.

2. Recommendation(s)

Board is asked to consider this new style report and pursue any key lines of enquiry.

3. Executive Director Opinion[1]

The report has been developed to ensure we meet all internal and external reporting requirements in line with contracting and CNST requirements. The report has been reviewed and discussed at Quality Committee with no requirement to escalate any matter for Board attention.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement	***Sustainability***
☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***	☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***
☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***	☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***
☐ ***Work with partners to deliver the improvement plan for Children's services***	☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***
Digital	***Workforce***
☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***	☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***
☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***	☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***
☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***	☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***
Productivity	***Research***
☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***	☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***
☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***	☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***
☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	

[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.

Perinatal Services Safety Report

1. INTRODUCTION

1.1 Since 2016 the spotlight has been on maternity services to work towards achieving a national target of reducing stillbirths, neonatal deaths and intrapartum brain injuries by 50% by 2025. The Maternity Safety Report considers and meets the requirements set out within the NHS Resolution Maternity Incentive Scheme (CNST) Year 6, the Maternity Self-assessment Tool, and embeds the NHSEI Perinatal Quality Surveillance Model (PQSM). The information in this report provides an update on key maternity and neonatal safety initiatives against locally and nationally agreed measures, to support WVT to achieve the national ambition.

1.2 This Maternity Safety Report is utilising a new format and template with an improvement in how, and the pace at which the service gathers data. For this reason, the monthly reporting requirements feature data from March and April 2024 in this report. Quarterly elements will cover Q4 (Jan-Mar24). This report will be shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board.

2. PERFORMANCE

2.1 Activity

2.1.1 There were 150 births in March and 124 in the month of April. These are stable rates in keeping with our annual trends.

Midwife to birth ratio (<1:24)	1:23

2.1.2 Red flags

Red flags are outlined within CNST standards and are all subject to an incident report and MDT review. The red flags in March and April are recorded as:

			March	April
Red Flags	WVT	Delay in Induction >2hrs	3	0
	WVT	Delay in Catagory 1 C-Section >30mins	0	2
	WVT	Delay in administering medication	0	0
	WVT	Delay in starting syntocinon/ARM >30mins	1	0
	WVT	Delay in Suturing >60mins	0	0
	WVT/PQSM	Unable to provide 1:1 care in labour	0	0
	WVT	Delay in Triage >30mins	0	0
	WVT	Community midwives on call covering maternity unit	0	1
	WVT	Any movement of midwifery staff from any area to provide midwifery cover	10	3
	WVT	Delayed recognition of and action on abnormal vital signs	0	0
	WVT	DSC lost - supernumerary status	0	0

There were 3 delays in IOL>2 hours during March and no delays during April; and one delayed commencement of Syntocinon for IOL. On all occasions where decisions are needed to delay care, they are subject to a Consultant review and receive a wellbeing assessment. If the woman is high risk we explore mutual aid options from neighbouring trusts. The delays are reflective of high acuity on the unit at the time. There are no patient safety concerns with any of the delayed cases.

There were 2 cases in April where the CS took more than 30mins. The first was 33mins and the delay was to administer magnesium sulphate, which supports neuro-protections in a premature baby, a Saving Babies Lives recommendation. This is managed on an individual risk basis and the MDT review team were satisfied with the care provided. The second was 34mins and also delayed to provide magnesium sulphate, with the MDT team in agreement that care was appropriate. No harm was caused in either case.

2.1.3 **RCOG Obstetric attendance**

CNST requires compliance with the RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. Our performance is noted as:

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	1	100%	
Caesarean birth for women with BMI>50	1	100%	
Caesarean birth <28/40	0	N/A	
Premature twins (<30/40)	0	N/A	
4th degree perineal tear repair	0	N/A	
Unexpected intrapartum stillbirth	0	N/A	
Eclampsia	0	N/A	
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	3	66%	1 instance where the Consultant was not called and learning has been shared with the individual.

3. SAFETY

3.1 **Incidents**

To provide Board oversight and assurance, this report aligns to the PQSM Minimum Data Set requirement and provides detail on incidents graded moderate or above; including incidents reported to MNSI (formerly HSIB), NHS Resolution Early Notifications/Claims. Whilst we transition to improved ways of working under PSIRF, this report also provides detail on cases determined as a PSII and any cluster reviews under the PSIRF umbrella.

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee; a forum where scrutiny and assurance are gained.

3.1.2 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
March	1	0	0	0	0	0	0
April	0	0	0	0	0	0	0

3.1.3 **Cluster Review**

The service has noted a higher than average number of Postpartum Haemorrhage over 1500mls. This has been ongoing for over a year, with some service improvement planned by the Consultant Midwife. The governance team have devised an audit tool to review incidents of PPH which enables identification of any care issues. The information gathered from this enables the team to undertake a thorough thematic review and devise consequent actions.

This has been reported to Patient Safety Panel where the outcomes and learning will be further shared. Ten cases have been selected at random for the initial phase and outcomes and action plans will be shared in the next quarterly report.

3.1.4 PMRT compliance

CNST requires the service to provide a quarterly PMRT report. The below cases are a summary of the reportable cases, specified by MBRRACE criteria (late fetal loss (between 22+0 and 23+6 weeks), stillbirths, early neonatal death (from 20 weeks gestation), late neonatal deaths or cases joint with another hospital). In line with CNST Safety Action 1, the report includes details of the deaths reviewed, highlights themes identified and the consequent action plans. The report evidences that the PMRT has been used to review eligible deaths and meets the required standards of a) notification of all eligible deaths, b) seeking parents' view of care and c) reviewing the death and completing a review within specified timeframes.

Internal

MBRRACE Case ID	Category of loss	Date of birth	Gestation at birth	Parents view's sought (if no, why)	Date of notification	Date review started	Date of LMNS MDT review	Grading of care	Date report published	Actions plan
90775/1	Stillbirth	08/12/23	32+3	11/12/23	11/12/23	12/12/23	12/04/24	A, A	01/05/24	None identified
92535/1	Stillbirth	25/03/24	31+4	11/04/24	25/03/24	05/04/24	Outstanding	Outstanding	Outstanding	Outstanding
93213	Stillbirth	05/05/24	32+3	07/05/24	08/05/24	14/05/24	Outstanding	Outstanding	Outstanding	Outstanding

External

MBRRACE Case ID	Category of loss	Date of birth	Gestation at birth	Parents view's sought (if no, why)	Date of notification	Date review started	Date of LMNS MDT review	Grading of care	Date report published	Actions plan
Unknown	Stillbirth	07/05/24	35+4	By Glangwilli Hospital	By Glangwilli Hospital	By Glangwilli Hospital	Outstanding	Outstanding	By Glangwilli Hospital	Outstanding

3.1.5 PMRT thematic review and action

Between December and May this year we have identified 3 cases with similarities. All 3 patients received midwifery care in Powys and attended WVT reporting reduced fetal movements. On assessment, in all 3 cases the babies were found to have died in utero. Joint discussions have been held with PUTHB midwifery leaders to identify areas of learning. There have been some delays in Powys attending the PMRT, however this has been escalated and is expected to resolve.

Actions include:

- PUTHB to identify if women are provided with sufficient information regarding Reduced Fetal Movements
- WVT to ensure RFMs are discussed with women from Powys who book at WVT
- WVT to refer learning to LMNS as there is a wider campaign planned by the LMNS, we will ask for support with ensuring PUTHB women are included.

3.2 Claims Scorecard

There is a requirement to share the Trust Claims Scorecard, and for this to be reviewed by the Maternity Safety Champions. The Associate Director of Midwifery and the Perinatal Quality and Safety Matron have met with the Claims and Inquest officer and undertaken an initial review. A more detailed review is planned at the end of May and this will enable the information to be shared in detail at the June Safety Champions meeting. A summary of findings and subsequent actions will be shared in the next Perinatal Safety Report.

4. PATIENT EXPERIENCE / SERVICE USER FEEDBACK

4.1 The data presented within the section of the report relates to maternity services only.

4.1.1 Concerns and Complaints

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is patient identifiable and is therefore contained in detail within the Minimum Data Set shared with private Board, allowing us to summarise the numbers of concerns, complaints and compliments in this section.

	Concerns	Complaints
March	1	0
April	3	1

The service currently has one open complaint; a historic complaint from July last year. The complaint is complex as those who had been allocated and investigating, have since left the organisation and the case has had to be reallocated. There is a plan in place for an MDT meeting in early June, and a follow up meeting with the family.

4.1.2 Friends and Family Test

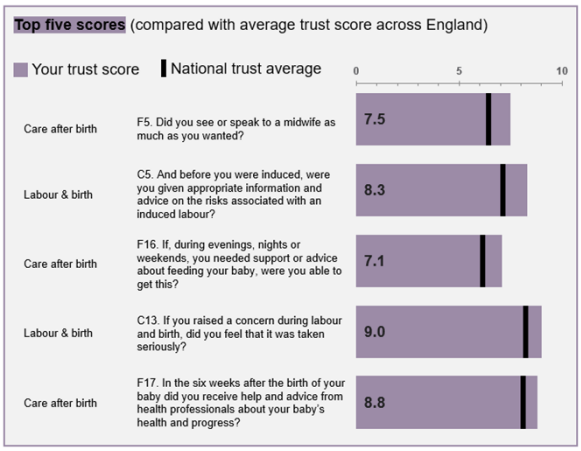
The service uses Friends and Family Text messaging to gather service user feedback. This information is collated through Envoy and is presented as:

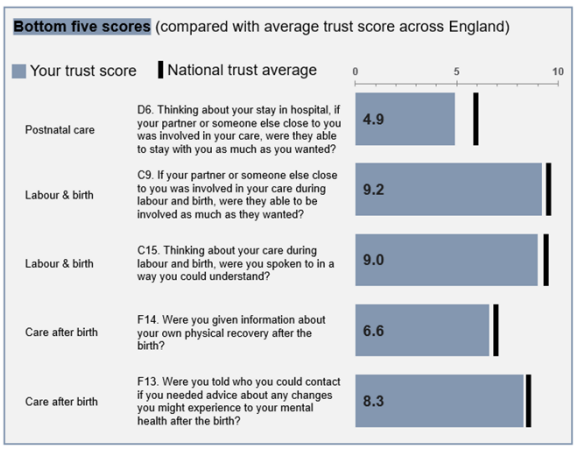
	March	April
Delivery Suite	Positive: 100.00% Negative: 0.00% Ratings 23% Response Rate	Positive: 96.88% Negative: 3.13% Ratings 28% Response Rate
Maternity Ward	Positive: 92.00% Negative: 8.00% Ratings 17% Response Rate	Positive: 100.00% Negative: 0.00% Ratings 16% Response Rate
Outpatients	Positive: 100.00% Negative: 0.00% Ratings 7% Response Rate	Positive: 93.33% Negative: 6.67% Ratings 14% Response Rate

The learning from patient feedback is covered within the Triangulation section (5) of this report.

4.1.3 CQC Survey Results

The CQC Maternity Survey results were published in February of this year. We were pleased to see that WVT scored in the Top 5 Trusts regionally, in each of the 8 categories. Furthermore, there were no decreases in score in any area in comparison to the findings from 2022. The summary of the findings identified:





Actions to further improve patient experience is included within the Triangulation section (5) of this report.

4.1.4 MNVP

The MNVP undertook a 15 steps visit on the 23rd April. The 15 steps brings together those who use maternity services, providers and commissioner within local maternity and neonatal systems to review together where and how maternity care is provided, considering:

- Is it welcome and informative?
- Is it clean and safe?
- Is it organised and calm?
- Is it friendly and personal?

We were fortunate to share the 15 steps with a number of service users who we extended our thanks to for their time and support. We were also accompanies by a Safety Champions and a number of midwifery students.

Following the walk around, the key highlights include:

Celebrations:	Consideration:
➢ Delivery suite calm and relaxed ➢ Clear signage for Triage ➢ Introduction of BSOTs improved ➢ Welcome board in outpatients ➢ Friendly staff ➢ Clean ➢ Good website / informative	➢ Improve window coverings in Delivery Suite ➢ No hand gels in each cubicle in Triage ➢ Notes out on show in some areas ➢ Posters out of date ➢ Reception area hidden behind screen ➢ Risk of tailgating onto ward

5. TRIANGLATION

5.1 The service uses all of its knowledge from safety information and service user feedback to determine key learning and actions. This informs the improvement initiatives taken across the service.

5.1.1 **Immediate Action**

- Educated the team regarding movement of staff across the service and the reporting of this due to over reporting
- Feedback to middle grades and co-ordinators around when to call a Consultant in line with RCOG requirements
- Work with Clinical Lead anaesthetics to support ward round improvements
- Install hand gels in each cubicle in triage
- Immediate feedback from 15 steps shared with team to include security risks from tailgating and Information Governance Breech risks from records
- Link with LMNS and WAHT to learn from Induction of Labour incidents

5.1.2 **Short Term Action (3 months)**

- Review the Claims Scorecard and associated cases to identify any thematic or individualised learning to be imbedded
- Present Claims Scorecard to Safety Champions
- Complete the PPH thematic review and generate action plan
- Undertake a deeper review of the Friends and Family Feedback to identify learning

5.1.3 **Long Term Actions (6+ months)**

- Develop an LMNS Perinatal strategy around partners staying / communication plan
- Review the training for Maternity and Neonatal teams around communication with families; to include counselling for informed decision making, delivering difficult news and not over optimistic in outcomes. This must also include training around documentation.

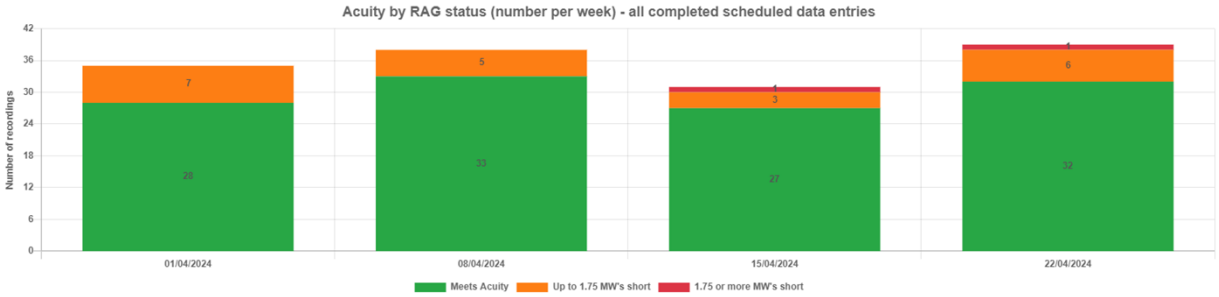
6. WORKFORCE

6.1 **Safe Staffing - Midwifery**

A monthly submission to Board outlining how safe staffing in maternity is monitored will provide assurance. Safe staffing is monitored by the following:

- Completion of Birthrate plus acuity tool
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags, also monitored for CNST compliance
- Shift fill data
- Daily SitRep reporting
- Sickness absence, vacancy and turnover rate

6.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 85.1% of the expected intervals, which is a good reliability factor. A review of the data demonstrates when staffing met or did not meet acuity. This demonstrates that acuity has been met 84% of the time. For 15% of the time the service has been short by up to 1.75 midwives and for 1% of the time the service has been more than 1.75 midwives short.



6.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 33 instances of staff being redeployed internally to cover acuity, for example from another clinical area to Delivery Suite. In a small service, this is reasonable as it demonstrates flexibility within the service to meet acuity needs. There was 1 occasion where community was redeployed to support Delivery Suite acuity which has been a considerable decrease since 2023. There were 4 occasions where specialist midwives have supported clinical acuity and this is a positive practice in that they all participate in a standby rota which supports them to retain clinical skill whilst meeting the needs of the service. There were 8 occasions where acuity was escalated to the manager on call for support.

Number & % of Management Actions Taken

From 01/04/2024 to 29/04/2024

MA1	Redeploy staff internally	33	67%
MA2	Redeploy from community	1	2%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	2%
MA5	Staff stayed beyond rostered hours	1	2%
MA6	Specialist MW working clinically	4	8%
MA7	Manager/Matron working clinically	1	2%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	8	16%
MA11	Maternity Unit on Divert	0	0%
	Total	49	

6.1.3 The Antenatal and Postnatal ward Birthrate plus acuity tool is currently under maintenance and therefore data is currently not available. However, it is noted that 2 midwives are retained for minimum safe staffing on the maternity ward at all times.

6.1.4 There were 3 incidents related to midwifery staffing. These have all been reviewed and no harm has been caused, appropriate management of staffing and acuity has taken place in all cases. There were 4 red flags for the period; 3 were reported for delays in Induction of Labour (IOL) of >1 hour; 1 was reported for a brief suspension of homebirth after community midwives had used their on call hours to attend one, and could not facilitate a second homebirth in the same shift. Red flags are covered in more detail further in the report.

6.1.5 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November. The number of midwifery bank shifts in maternity has decreased over the last 6 months, with some bank still being required to cover maternity leave vacancy and short notice sickness. There has been an increased in demand for support worker bank shift, attributable to significant sickness rate and vacancy factor.

	Fill Rate %					
	MW contracted	**MW extra hrs**	**MW bank only**	**MSW contacted**	**MSW extra hrs**	**MSW bank only**
AN clinic/DAU	80.36%	0 hrs	0 hrs	59.52%	11.9%	8%
Community	80.46%	4.29%	0hrs			
Delivery Suite	103.89%	1.29%	1.03%	79.4%	0 hrs	13.9%
Maternity Ward	102.08%	2.5%	0 hrs	88.75%	0.83%	4.58%
Triage	95%	3.75%	2.5%	70%	0 hrs	25%
DS Co-ordinators	100%	0 hrs	0 hrs	0 hrs	0 hrs	0 hrs

Maternity workforce sickness:

Unit	Grade Type Category	Contracted Hours	Episodes	Sickness Days	Sickness Hours	
Maternity - Clinics - W01000353	Registered Midwives	723.00	3	43	140.1	19.38%
	Support	160.71	-	-	-	-
	Unregistered Nurses	471.43	2	53	204	43.27%
	Total:	**1,355.14**	**5**	**96**	**344.10**	**25.39 %**
Total:		**1,355.14**	**5**	**96**	**344.10**	**25.39 %**
Unit	**Grade Type Category**	**Contracted Hours**	**Episodes**	**Sickness Days**	**Sickness Hours**	
Maternity - Community - W01000350	Registered Midwives	2,302.93	6	54	223.9	9.72%
	Unregistered Nurses	505.71	-	-	-	-
	Total:	**2,808.64**	**6**	**54**	**223.90**	**7.97 %**
Total:		**2,808.64**	**6**	**54**	**223.90**	**7.97 %**
Unit	**Grade Type Category**	**Contracted Hours**	**Episodes**	**Sickness Days**	**Sickness Hours**	
Maternity - Ward/Delivery Suite - W01000355	Estates and Ancillary	471.21	-	-	-	-
	Registered Midwives	8,809.07	11	105	504.8	5.73%
	Unregistered Nurses	2,691.43	-	-	-	-
	Total:	**11,971.71**	**11**	**105**	**504.80**	**4.22 %**
Total:		**11,971.71**	**11**	**105**	**504.80**	**4.22 %**

Maternity clinics has the highest rate of sickness in both midwives and support staff. This area has a small workforce and therefore % rates can often appear inflated. Staff in the clinic area are supported by managers, HR colleagues and occupational health where indicated.

Community midwifery also sits above Trust target. Maternity ward and delivery suite have a lower rate, a slight rise from last month, but all staff continue to be managed and supported in line with best practice and Trust policy.

6.2 **Obstetric workforce**

The obstetric rotas have been covered throughout April as outlined below.

During April, we recruited 1 long term locum consultant for 12 months, an experienced consultant; this is to cover a sabbatical of a substantive consultant. We have also recruited a second locum for 3 months to provide support until our newly appointed substantive cons joins us in September.

We have also recruited a locum for 1 months to cover sickness, this post may be extended if possible.

	Substantive fill	Substantive fill rate%	Substantive extra fill	Sub. extra fill rate %	Locum fill	Locum fill rate%
Consultant: hot week	120/220	54.55%	30/220hrs	13.64%	70/220hrs	31.82%
Consultant: on call	306/522hrs	58.62%	201/522hrs	38.50%	15/330hrs	4.55%
Consultant: cold week	64/104hrs	61.54%	32/104hrs	30.77%	8/104hrs	7.96%
Consultant: antenatal clinic	44/48hrs	91.67%	0hrs	0%	0hrs	0%
Middle Grade: delivery suite	189/189hrs	100%	0hrs	0%	0hrs	0%
Middle Grade: antenatal clinic	189/189hrs	100%	0hrs	0%	0hrs	0%

6.3 **Anaesthetic workforce**

The anaesthetic rotas have been covered throughout April as outlined below. The rota gaps were filled by existing members of staff with cover provided 100% of the time.

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	29	97%	27	90%
Anaesthetist extra hours	1	3%	3	10%

6.4 **MDT ward rounds**

MDT ward rounds take place at 08:30 and 20:30 daily. Medical staff attendance is expected 100% of the time, however due to high acuity for example, this may not always be possible. Attendance has been escalated to the CD and CL for Obstetrics, and also to the CL for anaesthetics. They have been asked to provide assurance more closely on a monthly basis, with an action plan for improvement. This will be reported next month.

	08:30	20:30
Anaesthetist	80%	83%
Obstetric Consultant	90%	97%
Ward round completed	100%	100%

6.5 **Neonatal Nursing**

The Neonatal Nursing workforce is outlined as:

Nursing position	Budgeted WTE	Contracted WTE	Maternity leave	Long term sickness
Band 7	**1**	**1**	**0**	**0**
Band 6	**5.16**	**6.07**	**0**	**0**
Band 5	**10.5**	**9.75**	**0.92**	**1.22**
Outreach	**1.26**	**1.26**	**0**	**0**

Sickness remains a challenge this month within the band 5 workforce, being managed in line with trust policy. Cover provided by additional hour's bank staff and ID medical agency staff.

Date	Qualified in Specialty workforce (expected standard 70%)	Qualified in Specialty on shift
April 2024	**48%**	**100%**

Mitigation to reduce the issues with QIS – 3 staff to commence QIS course from September 2024.

There were no unit closures during April 2024 and bed occupancy was relatively low.

6.6 **Staff Survey**

The Perinatal Quad (Associate Director of Midwifery, Clinical Lead for Obstetrics, Clinical Lead for Neonates and the General Manager for Women's and Childrens) have participated in the NHSE Perinatal Culture Club. This saw the roll out of the SCORE survey across maternity service staff. The findings from this will be shared with the Trust at the end of May and will be utilised to formulate an action plan. This will be reported by exception in the June report.

7. COMPLIANCE

7.1 **TRAINING**

CNST standards (Year 6) require compliance with training to be at 90% in all staff groups by 1st December 2024. Compliance is on track for all staff groups and there is no concern that the targets will not be met.

Maternity Support Workers were not initially required to be a part of the CNST Standards, therefore the speciality has been added to the training agenda from 2023 onwards. A staggered approach has been taken to ensure safe staffing in the clinical environment, and this group is on trajectory to meet the target of 90% by December 2024.

PQSM		Progress in achievement of CNST /10	10	10
PQSM	%	Training compliance in PROMPT: Midwives	92%	95%
PQSM	%	Training compliance in PROMPT: Obstetric Consultants	88%	100%
PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	100%	81%
PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	100%	100%
PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%
PQSM	%	Training compliance PROMPT: Maternity Support Workers	67%	60%
PQSM	%	Annual NLS update compliance: Paediatric Consultants	100%	*
PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	*	*
PQSM	%	Annual NLS update compliance: Paediatric Juniors	*	*
PQSM	%	Annual NLS update compliance: Midwives	92%	95%
PQSM	%	Annual NLS update compliance: Neonatal Nurses	90%	*
PQSM	%	Fetal Wellbeing update day: Obstetrics	100%	100%
PQSM	%	Fetal Wellbeing update day: Midwives	99%	99%
PQSM	%	Midwifery update day (Core Competency): Midwives	91%	93%
PQSM	%	Midwifery update day (Core Competency): Support Staff	76%	76%

Some data is missing from the paediatric training, this will be provided as a verbal update at the meeting.

7.2 **Saving Babies Lives**

Saving Babies Lives v3. was launched in March 2023 with an update to the previous 5 elements and introduction of a 6th element to cover maternal diabetes. Under CNST standards, Trusts are required to demonstrate compliance with the use of the nationally approved toolkit, which WVT are fully compliant with. The trust progress is also quality assurance checked by the LMNS on a quarterly basis. The latest quarterly review for Q4 took place in May and the current progress is reported as:

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	86%	Partially implemented	80%	CNST Met

The service has action plans to address each of the key areas. CNST year 6 requires full implementation by March 2024, however where this has not been met compliance can still be achieved if the ICB confirms it is assured best endeavours and sufficient progress has been made. The LMNS have confirmed that they are satisfied with efforts and progress to date.

7.3 **CNST MIS Year 6**

CNST launched Year 6 on the 2nd April. The maternity leadership have reviewed each of the 10 safety actions to ensure that compliance can be achieved again this year.

Whilst the service starts to pull evidence for each of the relevant sections it is not possible to share progress in a visual format as almost all actions are 'in progress' status. The NHS Futures Platform offers a tracking tool this year and the team are currently working to embed this into their governance, and this will enable sharing of the progress in future reports.

7.4 **ATTAIN**

The Term admission rate had, for some time been consistently below the National average rate of 5%. In March this year, the rate rose to 5.6% and in April, it rose further to 6.1%. All cases undergo MDT review however, we are not able to provide an ATTAIN report and action plan at this time and this will come as an exception to June Quality Committee.

7.5 **SINGLE DELIVERY PLAN**

The Single Delivery Plan, published in March 2023, is a three year plan which aims to make care safer, more personalised and more equitable embedding actions across 4 key themes. The perinatal team are working closely with the LMNS to deliver against the themes and there are no areas for current escalation and this work remains on track and in progress.

Theme	RAG Progress
Theme 1; Listening to women and families	
Theme 2; Growing, retaining and supporting workforce	
Theme 3; Culture of safety and learning	
Theme 4; Safer, more personalised care	

7.5 **SAFETY CHAMPIONS**

Maternity Safety Champions work at every level – trust, regional and national – and across regional and organisational boundaries. They develop strong partnerships, can promote the professional cultures needed to deliver better care, and play a key role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.
CNST Safety Action 9 requires all Trusts to have visible Maternity and Neonatal Board Safety Champions who are able to support the perinatal leadership team in their work to better understand and craft local cultures.

A safety walk round took place on the 3rd April, three safety champions were present and an external Non-Executive Director also joined for shadowing and oversight. Areas that were visited included Maternity Triage, Theatre and Recovery, SCBU and Antenatal Clinic. All areas visited were clean, tidy and no safety concerns were identified. During the walk round the Safety Champions had discussions with staff working in maternity triage, concerns were raised around the delay in scanning of patient paper documents onto the EPR.

The maternity leadership team were aware of this issues and had been working with the IT department to understand why the printers were not allowing all staff to log in for use. This issue, as well as a vacant ward clerk post were contributing to a backlog in scanning of documents. The Safety Champions advised to add the issue to the risk register, which has been completed. Since the walk around the issue has been resolved and is no longer an ongoing risk.

During April's Safety Champions monthly meeting the MNVP advised that some service users had shared they were not offered the telemetry CTG during labour when birthing in the pool environment. Now, the leadership team during their manager on call days ensure that the machine is ready to use and staff feel confident to use it, this will hopefully improve patient experience and improve options during labour and birth.

SCBU were congratulated after successfully achieving BFI accreditation.

SCBU MNVP explained that they are in partnership with SCBU leaders and service users review the visiting times to ensure the times are appropriate and in line with what the service users require.

REPORT ENDS

APPENDIX – PQSM Dashboard

	Area	Dashboard	Framework	Indicator Description	March	April
Intrapartum	Deliveries	LMNS/PQSM	Contractual	Total births (deliveries)	150	124
	Delivery Method	LMNS/PQSM	LMS	% Vaginal births (deliveries)	42.7%	36.3%
		LMNS/PQSM	Contractual	% Ventouse & forceps births (deliveries)	11.3%	14.5%
		PQSM		% Induction of Labour	35.3%	33.9%
	C-Section Deliveries	LMNS/PQSM	LMS	RG*1 having a caesarean section with no previous births	6	2
		LMNS/PQSM	LMS	RG*1 Deliveries	30	13
		LMNS/PQSM	LMS	RG*1 % C-section deliveries	20.0%	15.4%
		LMNS/PQSM	LMS	RG*2 having a caesarean section with no previous births	12	20
		LMNS/PQSM	LMS	RG*2 Deliveries	26	35
		LMNS/PQSM	LMS	RG*2 % C-section deliveries	46.2%	57.1%
		LMNS/PQSM	LMS	RG*5 having a caesarean section with at least one previous birth	24	20
		LMNS/PQSM	LMS	RG*5 Deliveries	27	25
		LMNS/PQSM	LMS	RG*5 % C-section deliveries	88.9%	80.0%
	Births	LMNS/PQSM	LMS	Stillbirths	1	0
		LMNS/PQSM	LMS	% Stillbirths	0.7%	0.0%
	Red Flags	WVT/PQSM		Unable to provide 1:1 care in labour	0	0
Neonatal	Risk Management	LMNS/PQSM	Integer	Neonatal deaths	0	0
		LMNS/PQSM	%	% Neonatal deaths	n/a	0.0%
		LMNS/PQSM	Integer	Neonatal brain injuries	0	0
		LMNS/PQSM	%	% Neonatal brain injuries	n/a	n/a
Postnatal	Risk	LMNS/PQSM	LMS	Maternal deaths	0	0
	Insight	PQSM	Integer	Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0
		PQSM	Integer	New HSIB SI referrals accepted	0	0
		PQSM	Integer	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0
		PQSM	Integer	Coroner Reg 28 made directly to Trust	0	0
	Workforce	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0
		PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	*/	4
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0
		PQSM		Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	10	6
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	4.7	6.2
		PQSM		Datix related to workforce (service provision/staffing)	10	3
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%
	Involvement	PQSM		Service User feedback: Number of Compliments (formal)	12	13
		PQSM		Service User feedback: Number of Complaints (formal)	0	1
		PQSM		Staff feedback from frontline champions and walk-abouts (number of ther	1	1
	Improvement	PQSM		Progress in achievement of CNST /10	10	10
		PQSM	%	Training compliance in PROMPT: Midwives	92%	95%
		PQSM	%	Training compliance in PROMPT: Obstetric Consultants	88%	100%
		PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	100%	81%
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		PQSM	%	Midwifery update day (Core Competency): Support Staff	76%	76%

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Patient Experience Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director Quality Governance
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update Board on the progress in key areas for improving patient experience, supporting the delivery of the updated Trust quality priority for 2024-25; *Improve responsiveness to patient experience data*.

2. Recommendation(s)

Board is asked to note the content of the report and the role of the Patient Experience Committee in overseeing improvements in patient experience.

3. Executive Director Opinion[1]

It is pleasing to note the proportion of positive responses received through family and friends text messaging service. Divisions are to be commended on progress being made to address the backlog of overdue complaints and the standard of responses that are leading to less comebacks (dissatisfaction with the response). The plan to focus on strengthening patient engagement is welcome and we look forward to working with Health watch on the culture of listening project.

[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.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Patient Experience Report

Introduction

The report provides an update on patient experience key metrics and areas of improvement in support of the Trust Quality priority for patient experience.

Headlines

- The patient experience quality priority has been updated for 2024-25 to; Improve responsiveness to patient experience data.
- Comparative data of the past 2 financial years shows a 28% decrease in reopened complaints Trust wide, suggestive of improved satisfaction of complainants with their initial response.
- Data shows the Trust perform better at meeting complaint deadlines agreed with the complainant than achieving the 30 day KPI.
- Areas of good practice identified that contributed to the improved position in complaint response times in Q4.
- 3 clear themes that were consistent with all overdue complaints resulting in delays to processing times have been identified through discussion with divisions.

Quality Priority 2024-25

Our quality priority for 2023-24 was broad; 'Improve patient experience'.

Whilst survey and FFT responses have shown improvement in some aspects of patient experience, our responsiveness to feedback is inconsistent and failing to meet national and local targets. This limits our ability to generate widespread sustainable improvement.

Therefore to provide focus on this the priority has been updated for 2024-25; ***Improve responsiveness to patient experience data.***

For the year ahead this report will provide a quarterly update on patient experience metrics and in addition will highlight improvement work underway to deliver the quality priority. The aim being to see an improvement in the following areas;

- Evidence use of FFT feedback to generate improvement (projects/ case studies)
- Improvement in national patient survey results
- Evidence use of survey feedback to generate improvement (projects/ case studies)
- Reduction in complaints and concerns
- Improved response times to complaints and concerns
- Reduction in overdue responses to complaints and concerns
- Reduction in comebacks or re-opened cases
- Increased patient engagement and collaboration on improvement projects

Friends and Family Test (FFT)

The Trust is now using a text messaging services to receive feedback in line with the national Friends and Family test programme.

FFT text message service rollout

The text messaging service is now live in the following services;

- All inpatient areas (inc. community beds)
- All outpatient departments (last report only Oxford Suite rolled out)
- Maternity

Outstanding are the following services below;

- Community Services
- Paediatrics

The roll out of the service has not progressed since the last report due to capacity with the Informatics team in developing the data in the format required and providing this to Envoy.

The Trust has now added an additional method for patients/ families/ carers to leave feedback via the Trust website. This will feed responses directly into the Envoy system and be included within the reporting established. This method will be offered to patients who wish to provide feedback about their experience in Radiology. Adding Radiology to the text messaging service was not a viable option due to the risk of patients receiving too many messages and disengaging/ choosing not to respond.

FFT Results

Below is the FFT results data from January 2024 – March 2024.

Headlines

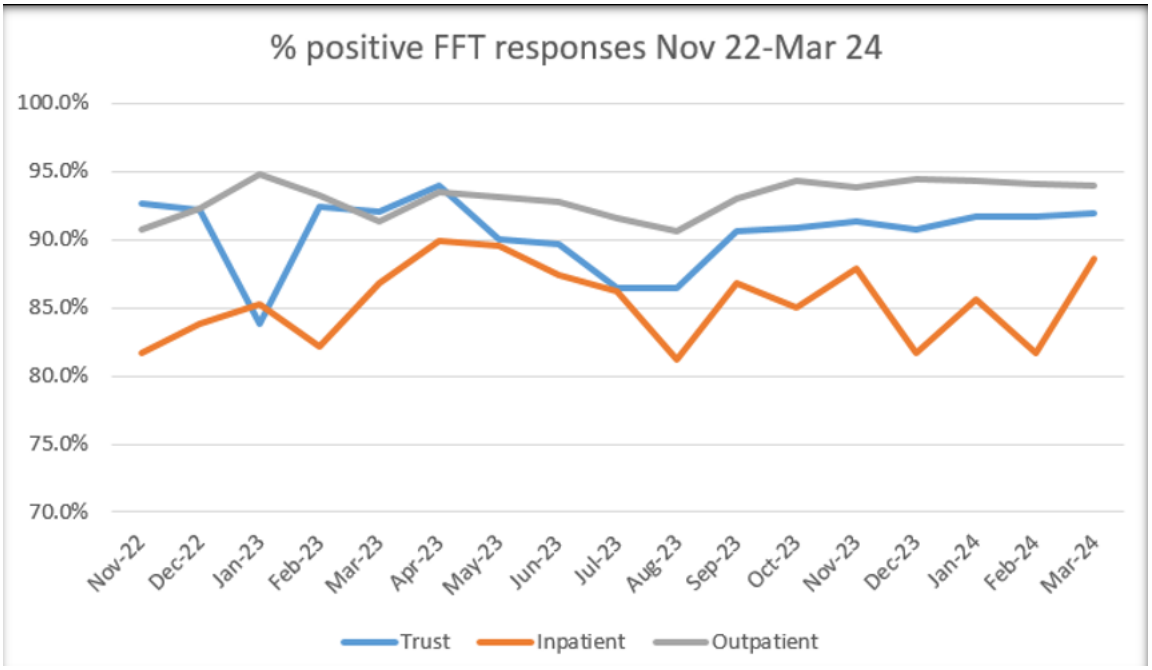
Between January 2024 – March 2024;

- The Trust has sent 65891 messages for feedback.
- 15294 responses were received (18% response rate overall)
- 91.79% of our patients have given positive feedback.
- 15.28% patients gave further comments in regards to how they scored their experience.

Quantitative Data

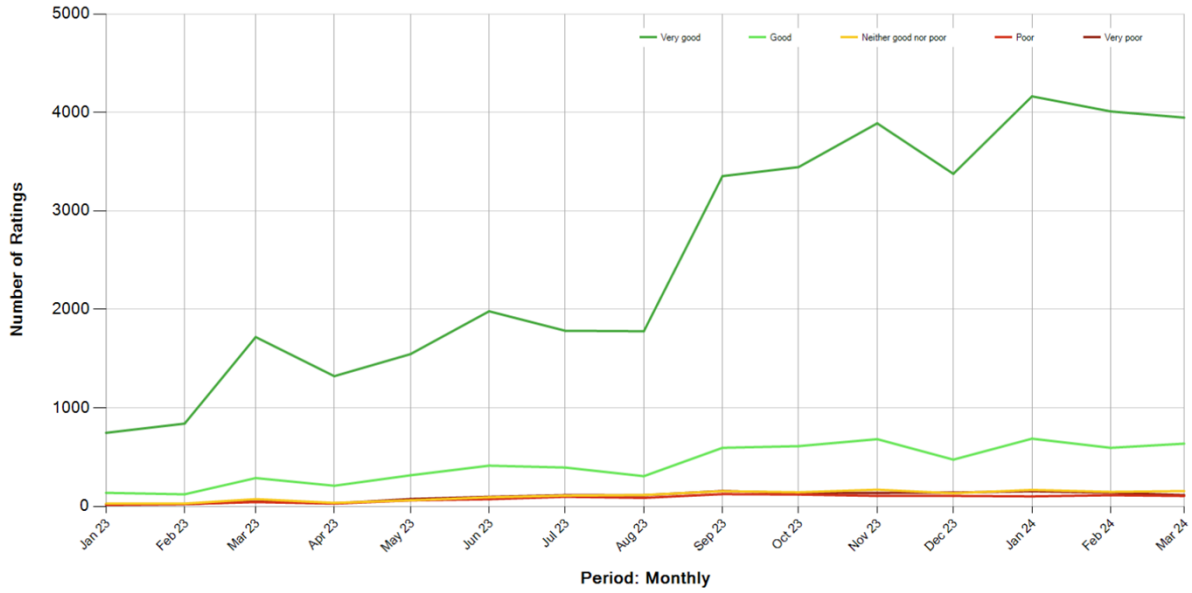
Our latest results in the table and chart below, are the percentage of responses that scored their experience positively (recommendation rate).

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	92.6%	92.2%	83.8%	92.4%	92.0%	93.9%	90.0%	89.7%	86.5%	86.4%	90.63%	90.88%	91.29%	90.74%	91.74%	91.66%	91.99%
Inpt	81.7%	83.8%	85.3%	82.2%	86.8%	89.9%	89.6%	87.4%	86.2%	81.2%	86.75%	85.0%	87.91%	81.71%	85.65%	81.67%	88.63%
OP	90.7%	92.3%	94.8%	93.2%	91.3%	93.5%	93.1%	92.8%	91.6%	90.6%	93.02%	94.34%	93.80%	94.42%	94.32%	94.13%	93.91%



Overall, we continue to see the highest satisfaction ratings in outpatients, at a consistent level each month, inpatients shows a fluctuating picture in comparison but beginning to show an upward trend in positive responses during Q4.

The chart below shows the actual response received by patients and overwhelmingly the most popular response continues to be 'very good' month on month, increasing significantly in proportion of response since August 2023.



For the 17 months since implementing the text messaging service, the Trusts average response rate is 20%, a slight decrease from 21% in the previous report. However this has declined in the last quarter to 18.3%, the lowest quarterly response rate since commencing with the service. A breakdown by service type is shown in the table below.

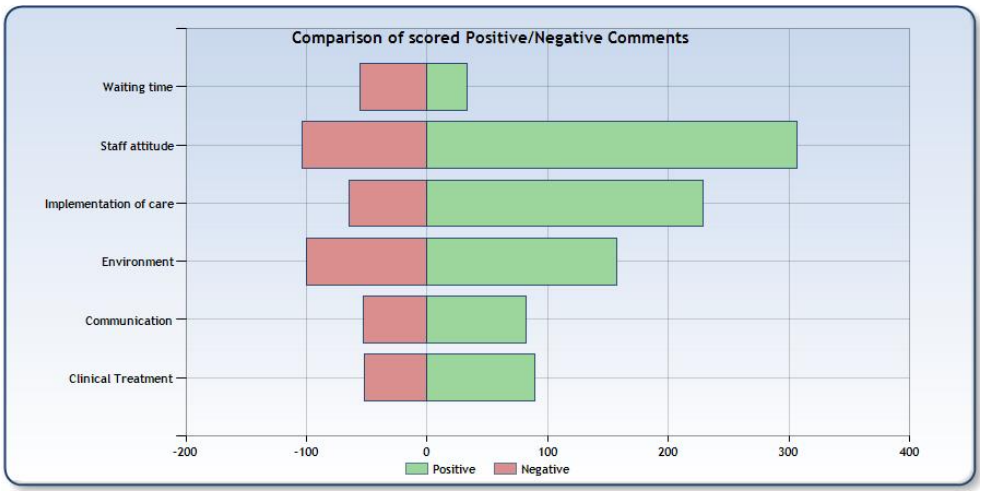
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	19%	18%	24%	22%	23%	21%	21%	21%	21%	21%	20%	20%	19%	18%	18%	18%	19%
Inpatient	15%	15%	21%	20%	21%	19%	19%	19%	17%	15%	16%	15%	15%	15%	18%	16%	17%
Outpatient	23%	18%	22%	21%	22%	20%	20%	20%	22%	21%	20%	20%	18%	18%	17%	18%	19%
Day case	20%	19%	28%	24%	26%	25%	24%	24%	24%	26%	24%	23%	24%	22%	24%	23%	25%

Qualitative Feedback

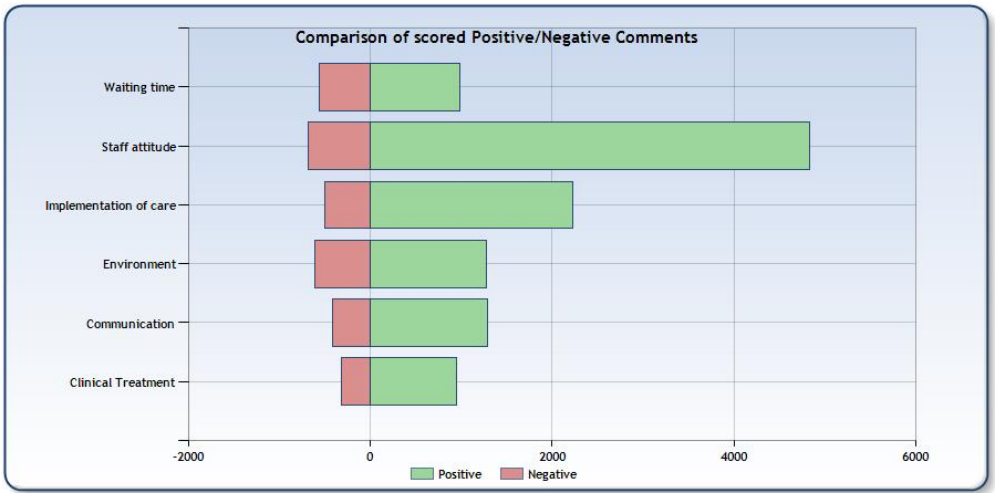
After patients have answered the initial FFT question, they are asked for comments. The free text comments message provides a wealth of qualitative data. The Envoy systems allows themes to be identified and categorises the qualitative feedback thematically and by the negative or positive nature of the comment.

The charts below show the top 6 themes broken down by inpatient and outpatient responses for this quarter.

Inpatient responses



Outpatient responses



Overall outpatient areas have the most positive feedback. However in both inpatient and outpatient areas, for each theme, the positive feedback outweighs the negative. In particular relating to staff attitude.

Divisions undertake the same analysis of this data and identify areas of good practice and areas for improvement. Divisional reporting at Patient Experience Committee (PEC) has commenced, triangulating FFT feedback with other sources of patient experience data.

Surveys

Since last reporting there were no national survey reports published. The Quality Committee asked that divisions shared improvement plans generated from the national survey reports for oversight at PEC and Quality Committee. To date PEC have received the improvement plan in response to the Cancer Patient Experience Survey (CPES) and the surgical division response to the national inpatient survey. Reporting on improvement plans will be incorporated into divisional reporting to PEC throughout the year.

Complaints

This section of the report provides;

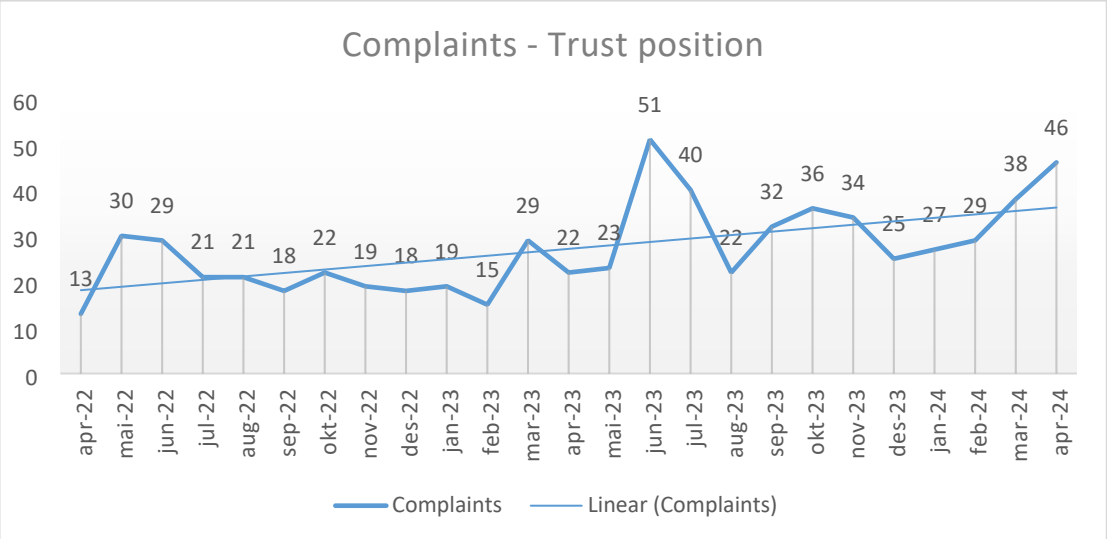
- KPI data update
- Analysis of complaints position by Division.
- PHSO model complaint guidance

Complaints position

(New complaints only)

KPI	Jan	Feb	Mar
Number of complaints 2023	19	15	29
Number of complaints 2024	27 (↑42%)	29 (↑93%)	38 (↑31%)

A comparison of Q4 data between 2023 and 2024 shows a significant increase in the number of new complaints received, with the chart below showing an increasing year end trend for the past 2 financial years.



When also considering the number of complaints that are reopened ('comebacks') that Divisions also respond to, this increases the total number of complaint responses required. Comparative data of the past 2 financial years shows a 28% decrease in reopened complaints Trust wide, suggestive of improved satisfaction of complainants with their initial response.

Type	2022-23	2023-24
Total new complaints	254	379 ↑49%
Total reopened complaints	36	26 ↓ 28%
Total complaint responses	290	405 ↑40%

Overdue complaints

A data snapshot at the end of Q4 showed us there were 56 open complaints that had not been processed within 30 days.

Division	Overdue Complaints Jan 24	Overdue Complaints Feb 24	Overdue Complaints Mar 24	Div. Total Q4	Div. Total Q3	% difference Q3/Q4
Medical	15	10	15	40	105	↓62%
Surgical	49	39	38	126	168	↓25%
Integrated Care	0	0	0	0	9	↓100%
Clinical Support	1	0	0	1	0	↑100%
Corporate	5	5	3	13	18	↓28%
Trust Total	70	54	56	180	300	**↓67%**

This is a considerable improvement in the Q3 position, with a 67% decrease in the Trust position by April. Given that the new complaints received have increased significantly in the same period this demonstrates a concerted effort to resolve outstanding complaints, whilst maintaining quality responses as suggested by the reduced number of reopened complaints.

During April and May, the Quality & Safety Matron met with Medical and Surgical Divisions to review the complaints position.

There were some areas of good practice identified that contributed to the improved position:

- Timely engagement with complainants to understand the issues and desired outcome
- Allocation of dedicated resource to manage complaints in the Surgical Division
- Weekly review of complaints position
- More detailed Divisional reporting

Complaint response times

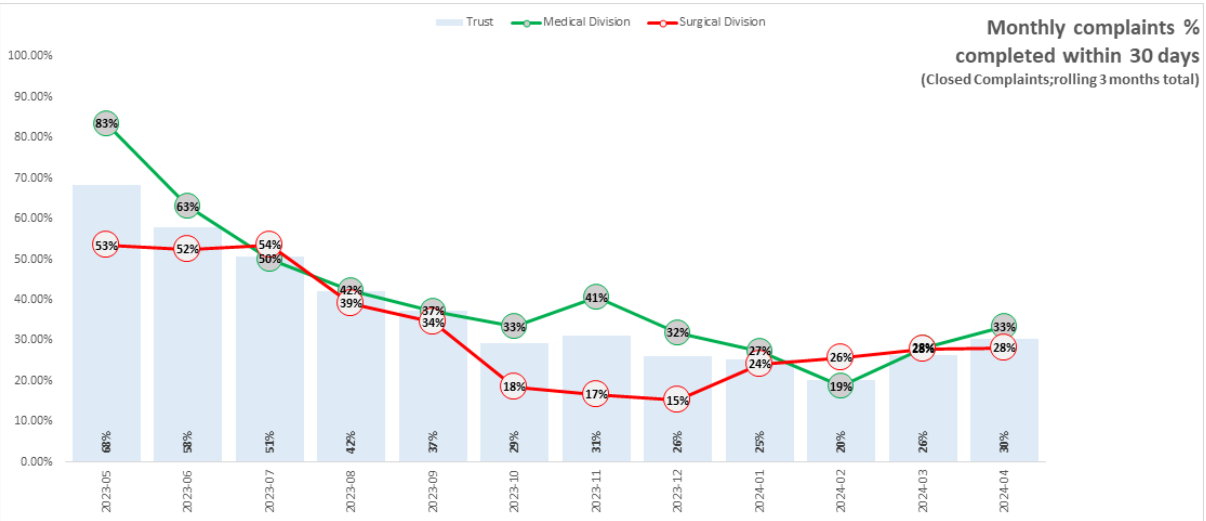
Complaint response times remain consistently below the 30 day target across all Divisions.

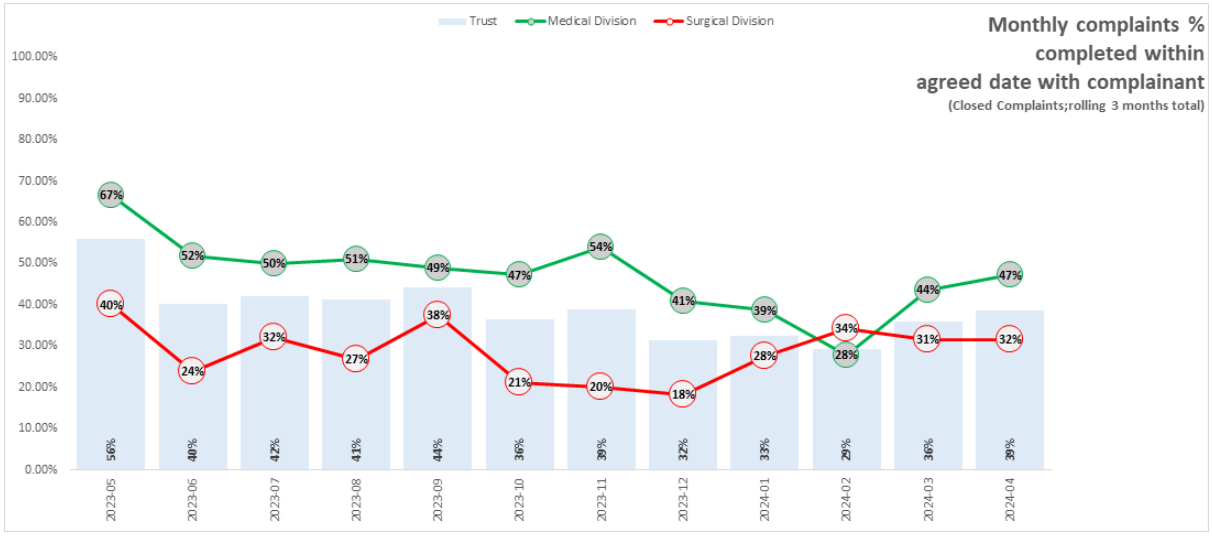
The Trust position at the end of Q4 shows us that the average response time was 67 days, with the last 50 closed complaints having an average processing time of 109 days. This is reflective of the increased effort to close older complaints.

Whilst the KPI reports on a 30 day processing compliance, this figure does not account for complaints where a response timeframe has been agreed with the complainant that is in excess of 30 days.

By using a 3 month average of closed complaint totals to reduce the monthly variation and make the trend clearer, the following charts show 12 months data of closed complaints that have been processed within 30 days, and the compliance with the date agreed with the complainant. Due to the small numbers received, Integrated Care and Clinical Support have been included in the Trust totals, but excluded from the run charts.

Both metrics show that we are consistently failing to meet complaint deadlines, though on the whole the individualised response times performs better than the 30 day KPI.



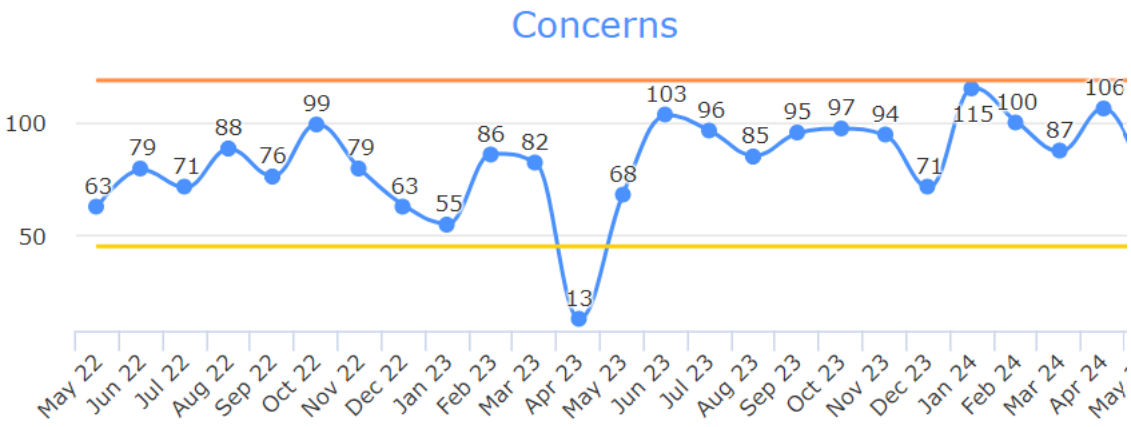


There are some data quality issues noted with May-Aug 2023 with the agreed date figures due to the change in question fields in InPhase – this has been rectified from September and informatics are working on a retrospective adjustment.

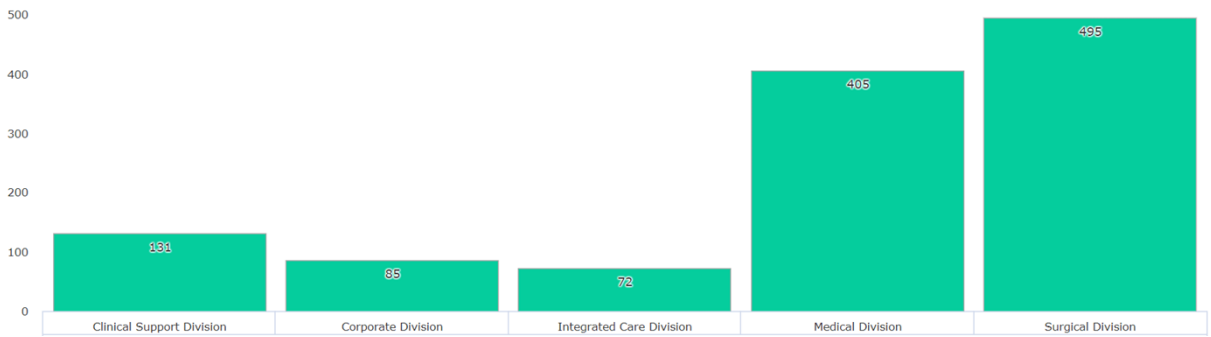
The number of complaint responses that are considerably overdue will impact the average calculation, and we expect an improved picture next quarter with an increased focus on the closure of these.

Concerns

The number of concerns reported in Q4 remained high as shown in the chart below, seeing an upward trend in numbers since May 2023 (dip in April due to introduction on Inphase and switchover).

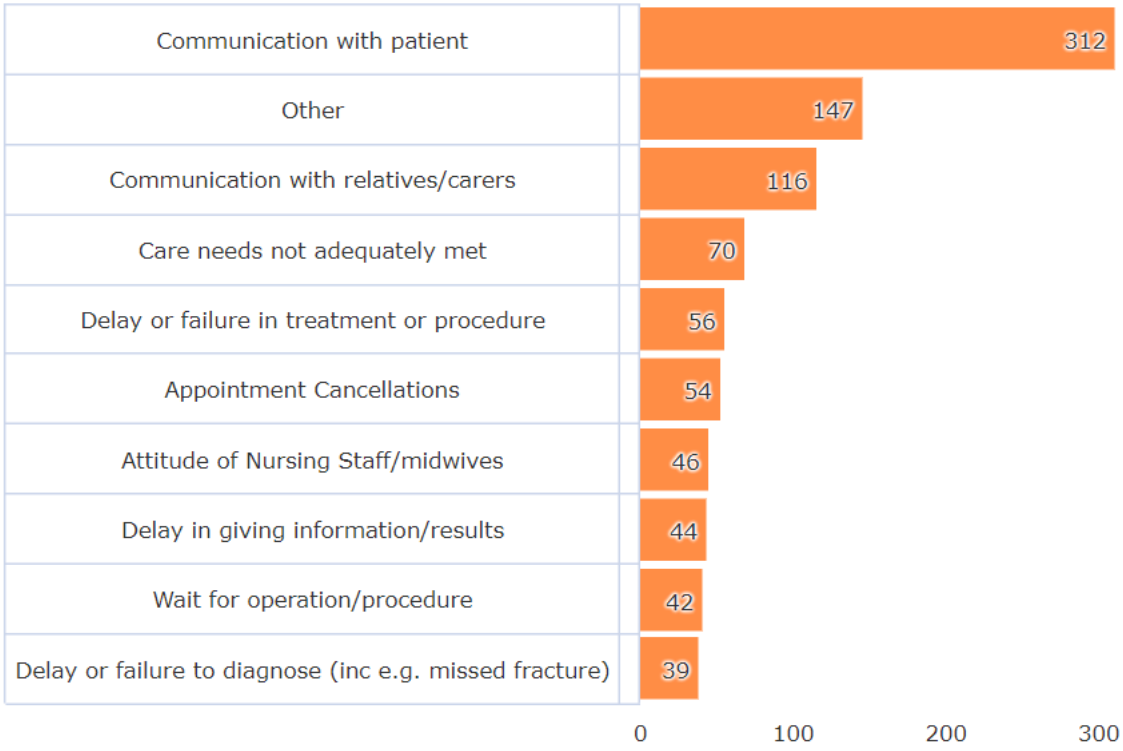


Over the last 12 months concerns have been reported for each division as follows;



Version 2 25/03/2024

Similarly to complaints, the majority of concerns relate to medical and surgical division. Themes of concerns are also seen in complaints as shown below. In Q4 storage of personal possessions was also a theme.



Divisions will now report concerns information into PEC triangulating with wider patient experience data sources. Divisions have reported that concerns have become increasingly complex and require cross-divisional input.

Discussion at PEC centred on whether we have the process right for managing complaints. There is an approach to concerns that they must be directed to PALS to be addressed. This is thought to be two-fold; staff not feeling confident to manage concerns directly and the Trust 'requirements' to log all concerns centrally and monitor how they are responded to. How to manage concerns effectively will be addressed as part of the quality priority for the coming year recognising the central processes for concerns management requires urgent review.

Model Complaint Guidance

The Public Health Service Ombudsman (PHSO) have published model complaint guidance that advocates for several key changes in current complaint handling processes.

In practical terms, adopting these changes would require the following agreement:

1. 'Concerns' that can be answered at ward level by the end of the next working day are not monitored or recorded by PALS, but signposted to the service to deal with as an 'everyday conversation'
2. Verbal complaints that can be resolved by the end of the next working day to be managed as point 1 and do not need to follow the complaints procedure.
3. Written complaints that are suitable for 'early resolution' should be responded to on a form by agreed departmental staff within 5 working days and do not need to be approved at Divisional/THQ level (formally logged and monitored by Complaints).
4. Timescales for complaints processing to be agreed with the complainant.
5. Lead Trust to be nominated to coordinate multi-organisation responses

Version 2 25/03/2024

These recommendations have been discussed at Patient Experience Committee for feasibility, and a working group is being formed to fully map the guidance against current processes, define what is positive change, what processes would look like in practice and what associated monitoring is required.

Patient Engagement

There is a renewed focus on patient engagement through the existing group and actively seeking opportunities to engage patients in our existing work streams and structures; for example in the 12 month rolling plan for PLACE and 15 steps audits. In addition the Trust is proactively engaging with partners across the system in engagement projects such as launching the Culture of Listening project with Healthwatch. This is a project driven by Healthwatch who sought out the Trust to support this new initiative. The aim of the project is to get patient feedback on their healthcare journey and not focussing on one particular interaction or admission. Additionally, the patient experience team are engaging with system partners on innovative projects designed to use the role of volunteers to improve areas of patient experience already known to be of concern such as a volunteer befriending service to support patients in the community and avoid the need for readmission.

Conclusion

There is an appetite across the Trust to improve responsiveness to patient feedback, in particular systematically reviewing our processes for responding to complaints and concerns. Divisions are undertaking work within their areas to improve responsiveness and learning will be drawn from this where there is opportunity to support efforts across all divisions. The working group for implementation of the PHSO best practice guidance will be the focal point of this work.

Despite increasing numbers of complaints in the quarter, response times improved across the Trust. Good practice was noted and analysis of barriers to improving response times identified and are being addressed proactively.

The reduction in ‘comebacks’ suggests the quality of complaint responses is improved, and our ability to respond to bespoke patient deadlines for complaints is more reliable than meeting the KPI. However as work progresses it is hoped the Trust can achieve both.

FFT data continues to provide a wealth of feedback, and a focus on how this is being utilised to drive improvement is important to demonstrate how we listen to patients. Case studies and projects will be requested to showcase this.

Actively seeking feedback through patient engagement, rather than waiting for a complaint, concern or survey response, is a crucial part of the process for improving patient experience and will be a crucial to achieving our quality priority aim for the year ahead.

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Policy Panel Update
Status of report:	☐**Approval** ☒**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Policy Panel, Trust Board
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on those policies that have been presented to and approved by the Policy Panel plus to provide assurance on the overall provision of policies within WVT.

2. Recommendation(s)

To note those policies approved by the policy panel, on behalf of the WVT Board, since it last reported to Board in December 2023.

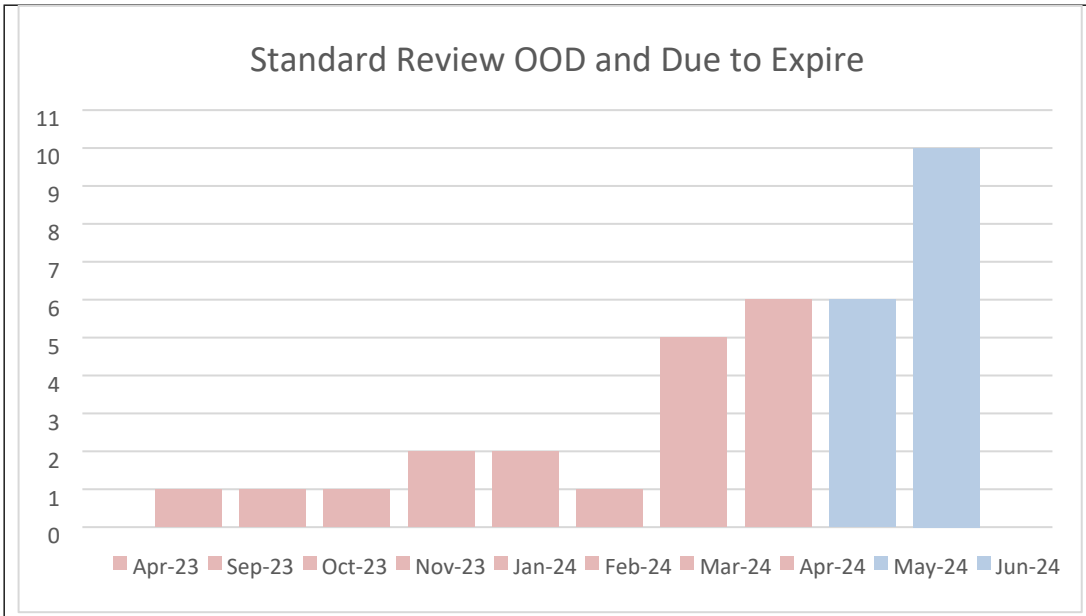
3. Executive Director Opinion[1]

The Trust's Policy Panel, chaired by the Managing Director: ratifies policies and provides the Board with a summary; approves related documentation; ensures that documentation is presented in the Trust format and has been catalogued on the Trust database; and, monitors the adherence to the developmental processes to maintain the quality of documentation.

The table below provides an overview of the trust's position with the provision of policies.

Total # of Policies being updated (within 6 months of expiry)	Total # of Policies: Out of Date	Total # of Policies: About to Expire (within 60 days)
34 (increase of 10 since Dec 2023)	**18 (increase of 8 since Dec 2023)**	**16 (decrease of 2 since Dec 2023)**

[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.



The panel has approved the following policies (linked to the Trust intranet) since it last reported to Board in December 2023:

PR.44 - Critical Care Operational Policy
PR.74 - Safe Sedation Policy
HR.14 Recruitment & Selection Policy
HR.14a Recruitment & Selection Guidance Policy
HR.40 Special Leave Policy
MF.19 Fraud and Bribery Policy and Response Plan
IG.S.01 - National Data Opt Out SOP
HR.S.08 - Overpayment of Salary SOP
PR.198 - Blood Culture Policy
IG.61 Images and Recording Policy
PR.S.34 EDS issue SOP
PR.S.05 Entonox Administration SOP
PR.138 Potassium Policy
HR.79 Clinical Excellence Award Policy
EP.01 - Major Incident Policy
EP.04 - EPRR Trust Wide Policy
PR.112 e-Rostering Policy
HR.S.07 - Recruitment and Selection of Consultant Medical Staff
HS.05 Incident Management Policy
PR.114 - Provision of Continence Pads in the Community
PR.S.33 The management of long term indwelling abdominal drain (LTAD) for patients with non-malignant ascites due to end stage liver disease
PR.S.02 Management of Nasogastric Tubes (NGT) in patients with suspected / confirmed bowel ileus or obstruction
PR.123 Discharge lounge operational policy
PR.55 Patient's Own Drug Policy
IG.19 IT Equipment and Digital Disposal Policy

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Board Assurance Framework (BAF) and Divisional Very High Risk Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Associate Director of Corporate Governance / Company Secretary
Documents covered by this report:	1) BAF as at 31st May 2024 2) Very High Risks 15+ as at 31st May 2024

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WVT's strategic objectives for 2024/25 and a review of the current operational Very High Risks (rated 15 and above).

2. Recommendation(s)

The WVT Trust Board is invited to note:

- The risks to delivery of WVT's strategic objectives 2024/25; and,
- The operational Very High risks (rated 15 and above) being carried by divisions within the Trust.

3. Executive Director Opinion[1]

The BAF is a live document which currently details the risks of achieving the Trust's 2024/25 strategic objectives utilising the Incident and Risk Management system, InPhase. This document is continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives.

As requested at the Board meeting in July 2023, the BAF now also reflects the direction of travel: the consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.

The Board Assurance Framework has now been aligned to the Trust's new strategic objectives for 2024/25 and are now presented to the Board for review.

The Trust's very high risks are also provided and are reviewed bi-monthly by the Executive Risk Committee, with a deep dive of each divisions' risk registers taking place on a rotational basis.

[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.

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

Quality Improvement

☒ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***

☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***

☒ ***Work with partners to deliver the improvement plan for Children's services***

Digital

☒ ***Implement an electronic record into our Emergency Department that integrates with other systems***

☒ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***

☒ ***Maximise the functionality of EMIS with 1H partners and the shared care record***

Productivity

☒ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***

☒ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***

☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***

Sustainability

☒ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***

☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***

☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***

Workforce

☒ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***

☒ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***

☒ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***

Research

☒ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***

☒ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Risk Title	Risk Type	Risk detail	Review date due	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
BAF 2024/25 Ability of system to manage flow across the urgent and emergency care pathway	Strategic	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.	04-Jun-24	Andy Parker	20	4	4	16	8	•Trust Capacity meetings allowing visibility of the issues and escalation. •Investment in additional ward discharge coordinator capacity. •Escalation and Surge Plans in place •System wide silver meetings • Winter Plan 2023/24 - Discharge to Assess Board - Valuing Patient Time Board - ICS Urgent and Emergency Care Board	•Ability for out of area partners to respond to the repatriation of patients. •Gaps in Homefirst provision and Discharge to Assess settings. •Shortfalls in staffing at ward level creating delays in discharge planning. • Additional financial burden as a result of inability to mitigate additional activity at the 'front door'. • Inability for Powys to respond to discharge pressures in a timely manner - Continued use of Boarding on acute wards to maintain flow	07-May-24	•System wide silver and gold calls. •Finance and performance executive reporting •Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board. Standardization of discharge processes and planning of admission across patient settings. Ward Based Dashboards Better Care Fund oversight by both One Herefordshire Partnership and Integrated Care Executive. Winter Plan and capacity bridge analysis.	System oversight of discharge delays and capacity.	→
BAF 2024/25 Delivery of the Digital Strategy	Strategic	There is a risk of a delay to the delivery of benefits and the future capital funding of the Digital Strategy due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.	28-May-24	Katie Osmond	16	4	4	16	8	•Trust and Foundation Group and ICB Digital Strategies •Programme Team •IT Project Managers •Clinical Systems Governance Board provides clinical acceptance and engagement in any proposed solutions or changes •Monthly review of programme progress against plan. •Clinical Systems Group has been established to manage systems in BAU. •Engagement with the national frontline digitisation programme.	•Change management training of staff •Staff engagement. •Work pressures and availability of staff to be released to attend training. •Lack of resilience in resource plans. •Impact of the introduction of digital strategies across all stakeholders. •Uncertainty in national priorities for delivery of digital strategies. Uncertainty in availability of Front-line Digitalisation funding to progress strategy	30-Apr-24	•Capital Planning and Equipment Ctte. •Bi-monthly Board paper to Trust on digital progress. •Internal audit reviews •NHS England participation in governance forums •Digital programme board with overview of projects to determine critical path, overlap and staff impact. •Clinical Systems Group - maintenance and monitoring of BAU. •Reporting to the national frontline digitisation programme. Trust membership of ICB Digital Data and Technology Forum (DDAT)	Uncertainty around NHSE Frontline Digitisation funding for existing solutions based on historic Procurement concerns.	↑
BAF 2024/25 Risks to productivity and operational capacity plans and delivery	Strategic	There is a risk that the Trust will not be able to achieve its productivity and activity plans as a result of factors due to: vacancies; pace of productivity improvements; access to outsourced capacity; and, sub-optimal urgent care pathway. This may severely impact on the delivery of productivity and operational capacity plans that deliver safe and timely elective, emergency and urgent care. All factors, either individually or collectively, could significantly decrease the level of available capacity and productivity.	04-Jun-24	Andy Parker	25	5	3	15	10	•Recovery and Restoration plan (under regular review) •Escalation and surge plan •Ringfenced elective pathways •Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. •Group and system-wide mutual aid •Activity plans. •Clearly documented value for money assessment of additional flexible capacity options as part of business case process. - GIRFT Faster Further 40 programme in place across region.	•Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. •Potential impact of ongoing industrial action. •Productivity plans based on GIRFT faster further programme	07-May-24	•Daily reporting and escalation. •Monthly division check and challenge reviews. •ICS restoration and recovery oversight group •Productivity Board •Finance and Performance Executive reports. •Integrated Performance report to Board. •Local and regional value-weighted activity is above 100% of 2019/20 levels. - GIRFT Further Faster 40 meetings - monthly	Elective Surgical Hub final theatre template and recruitment	→
BAF 2024/25 Availability of Capital Funds to meet Trust's Strategic Objectives	Strategic	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivering of key estates and investment being made on Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to an ability to procure essential equipment resulting in adverse impacts on healthcare delivery.	26-Jun-24	Alan Dawson	15	3	4	12	9	•Capital planning and prioritisation of key schemes and equipment •Holding contingency funds for adhoc emergency requirements •Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	•Ability to determine emergency capital spend requirements •Approval of capital fund applications •Capital funding provided is not sufficient to meet whole requirement	08-May-24	•Project teams and programme board structure in place for major schemes. Capital Planning and Equipment Committee •Trust Management Board •Financial reports to Board Operational Planning Process Capital Programme Board	None	↑
BAF 2024/25 Clinical and support staff recruitment and retention	Strategic	There is a risk to achieving the Trust's strategic objectives due to staff shortages and being unable to recruit to clinical, nursing and support staff vacancies, resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	02-Jul-24	Geoffrey Etule	20	4	3	12	8	•Recruitment and retention initiatives: plan for clinical staff; international recruitment; 'golden hello' for hard to recruit role; TRAC recruitment system; flexible working policy; career and pay progression framework. •Allocate Project Plan (which oversees implementation of innovative job planning) to allow adaptive use of existing workforce negating the need for recruitment by making best use of resources •Workforce and OD Strategy and Leadership Development Programme - developing skills and competencies of managers to enable improved recruitment and retention. •'Deep dives' and analysis into areas of high turnover, vacancies, exit interviews and new starter surveys. •Contract management and monitoring data of Master Vendor and Direct Engagement use. including monitoring of agency price cap. •Mutual Aid opportunities within the ICS and/or Group. National NHS workforce to inform WVT 5 year 'grow our own' workforce plan now in place	•Clear medical workforce plan that addresses opportunities within ICS. •Full implementation of e-rostering in clinical areas. •Temporary Staffing engagement and deployment policy. •Enhanced workforce planning and development support for managers. •National shortage of clinical staff both Medics and Registered Nurses. • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes. • Uncertainty of the impact of industrial action. • Cost of living impact on recruitment and retention.	07-May-24	•HR Directors weekly ICS meeting. •F&PE reports •E-rostering project board to deliver against plan. •JNCC and Equalities group receive quarterly update on workforce issues. •Staff recruitment and retention working group. •Integrated Performance Report to Board •MARP and NARP (reinstated in August 2022). •Weekly MD-led vacancy review panel - reviews all non-clinical recruitment. •Health and Wellbeing Group to review and assess effectiveness of health and wellbeing initiatives to support recruitment and retention.	• Limited assurance that the master vendor contract will meet required agency fill rates which leads to use of higher cost tiers within the contract and other agencies - due to ongoing National shortage of clinical staff. • Expediency of ICS-wide initiatives.	→

**BAF 2024/25 **Fragility of Histopathology Service: Lack of sufficient consultant histopathologists	Workforce	There is a risk of patient harm due to insufficient local histopathologist which will lead to a lack of 100% MDT cover, some urgent cases having to the outsourced and delays or lack of local 2nd opinions and hence diagnostic delays.	20-Jun-24	Chizo Agwu	20	4	3	12	8	• Locums employed in the department • Suitable work sent to backlogs or bank • Support from Worcester/SWFT/UHCW • 2 WTE Histopathologist's appointed to and due to start 05/08/2024 Fortnightly meetings with Managing Director / Chief Medical Officer and Chief Operating Officer with equivalents at Worcester Acute to discuss all current concerns around fragile services	• Locums not always available • A lot of work is not suitable for sending to backlogs	20-May-24	Monitoring of staffing levels regularly by management team - Assessment daily within Histology of suitability for sending samples to backlogs/bank - turn round times and cancer escalations monitored regularly	Staff availability for Monitoring - availability of backlog resource	**NEW BAF RISK**
** BAF 2024/25 - **Inability to identify resource to 'left shift' and/or maintain financial flow into Herefordshire		There is a risk of inability to move funding sources across providers within Herefordshire due to the funding arrangements across primary and secondary care which could lead to an inability to achieve left shift in all cases	02-Jul-24	Jon Barnes	12	3	4	12	3	Able to subcontract using standard NHS contracts for some services and maintain income flows, counting activity as Trust based.	Other than subcontracting, no contracting mechanism identified to allow the movement of work and funding without a loss of income to Herefordshire	31-May-24	One Herefordshire Partnership	Need to better understand available opportunities	**NEW BAF RISK**
** BAF 2024/25 - **Risk of reputational damage to Wye Valley NHS Trust in relation to the strength of partnership working arrangements in the context of the inadequate rating for local children's services	Strategic	There is a risk that relationships are insufficiently developed between Health and Social Care partners which could lead to ineffective arrangements for children and young people	10-Jun-24	Lucy Flanagan	16	4	3	12	8	Multi-agency policies relating to children and young people - Local authority improvement plan and associated committee meeting attended by statutory partners.	Inconsistencies in practice of Multi-agency teams working with children and young people	10-May-24	Community Paediatrics Performance Review meeting - SEND - children and young people Partnership - Quality committee - One Herefordshire Partnership - children and young people Safeguarding Partnership - Local authority improvement Board	OFSTED report findings - Progress against improvement plan not met expected timescales for delivery	**NEW BAF RISK**
** BAF 2024/25 - **Fragility of the Haematology service at Wye Valley	Clinical Care	There is a risk of not providing clinical care to Haematology patients under the care of WVT due to all substantive consultants leaving the Haematology department. This could lead to increased waiting times for routine and urgent patients, delays in cancer patient pathways, and lack of oversight and clinical leadership to progress lab results. All of which will result in poor patient experience and timely health outcomes.	18-Jul-24	Chizo Agwu	25	5	2	10	5	• 2.6 locum consultant secured • Band 7 trainee ACP in post • Lab supporting agreed with Coventry/ Warwick • Out of hours urgent films when on call virtual process agreed with Worcester • Out of hours on call filled • In hours on call filled • Some treatment patients at other trusts, most back at WVT • Insourcing available if needed • Heam/SACT navigator in post 'Golden Hello' incentive approved to aid recruitment	• Locum contract only requires one week notice • Unsuccessful recruiting to all substantive posts • Competency restraints • Blood bank cover - which impacts surgery, maternity and emergencies, needed named consultant to authorise out of hours • 3.6 WTE consultant vacancies and 1 WTE AS long term sickness • All substantive consultants have resigned	26-Apr-24	• Audit of waiting lists • CSD monthly governance meeting • Limited number of incidents relating to risk • Adverts for posts advertised • F+PE CMO/COO meeting with ICB and WAHT Fortnightly Fragile Services meeting with Worcester Acute	• ICB options not agreed • National shortage of qualified staff	**NEW BAF RISK**
** BAF 2024/25 **Difficulties in delivering on the Equality, Diversity and Inclusion agenda (part of CQC Well Led)	Strategic	There is a risk of failing to deliver on the Equality, Diversity and Inclusion (EDI) agenda both from a strategic and operational perspective due to lack of dedicated specialist role and resources within the Trust, which will lead to falling further behind in responding to national/leg requirements and results in negatively impacting staff attraction, engagement and morale.	02-Jul-24	Geoffrey Etule	15	3	3	9	6	Limited support through the fixed-term ICS EDI role. Maintaining the staff networks in WVT. Regular communications and updates across the organisation. Workforce Race Equality for WVT Workforce Disability Equality Standards for WVT Equality Delivery System 2 for WVT Cultural Ambassadors. Continuation of engagement with Staff Networks EDI delivery plan Some support on EDI programmes from the SWFT EDI lead Working closely with FTSU Guardian and Staff Side Chair on EDI actions	Funded establishment of WVT EDI role - There is no dedicated resource for the Trust to specifically focus on this work which means that we will not be able to move forward more progressively. Future provision of ICS or Group EDI role.	07-May-24	TMB - 6 monthly reports that the Trust is meeting its obligations under WDES, WRES, EDS22 and meeting the delivery plan. CQC Inspection. WVT Equality Diversity and Inclusion Group monitoring the delivery plan. ICS engagement forums on EDI matters. CPO Board reports	Lack of dedicated EDI resource for WVT to pro-actively focus on the agenda.	**NEW BAF RISK**
**BAF 2024/25 ** Fragility of Medical cover for Stroke pathway	Clinical Care	There is a risk of harm to patients due to the loss of substantive stroke consultants. This could result in no stroke specific consultants at Wye Valley Trust which in turn may result in poor decision making and poor clinical care.	27-May-24	Chizo Agwu	15	3	3	9	3	1. Stroke locums extended until October 2024 Update 44 hours p/w + on call. 2. Develop non medical workforce model - now designed and waiting financial approval 3. Locum consultants providing virtual ward rounds at weekends and on-call for thrombolysis Sat & Sun 0900-1700. 4. Trust Registrar appointed 5. ACP appointed Jan '24 6. Contingency paper written for cover; currently with Execs for approval. 7. Fortnightly discussion meetings with Managing Director / Chief Medical Officer / Chief Operating Officer with equivalents at Worcester Acute Hospital to discuss all fragile services	1. Locum does not stay at WVT. Further recruitment has been successful but turnover is very high 2. unsuccessful recruitment of substantive ICS joint appointment Consultant 3. Non-medical workforce model is not approved or recruitment into posts is unsuccessful 4. Weekend additional rounds are costly and not a sustainable financial model 5. ACP not backfilled from CNS rota.	29-Apr-24	SSNAP performance monitoring SQL data and local dashboard ICB Programme Board (monthly) Inphase incidents Harm reviews Operational meeting (Monthly) Transformational meeting (Quarterly)	SSNAP data is retrospective released quarterly Dashboard is monthly pull which can change due to lock down date vs discharge date Lack of clinical lead impacts effectiveness/championing of WVT issues, concerns and mitigation plans	**NEW BAF RISK**
** BAF 2024/25 - **Failure to gain system support for agreed Herefordshire Integrated Care Model	Strategic	Risk that the procurement process will find a solution that identifies an appropriate out of hours general practice service but one that does not support the agreed integrated urgent care model for Herefordshire.	30-Jul-24	Jon Barnes	9	3	3	9	3	Revision of the blueprint for integrated urgent care by One Herefordshire Partnership	No current formal agreement across the ICS to support the integrated urgent care model for Herefordshire	30-May-24	One Herefordshire Partnership Trust Board	No current formal agreement across the ICS to support the integrated urgent care model for Herefordshire	**NEW BAF RISK**

** BAF 2024/25 - **Inability to fund the required resource to achieve maximum functionality of EMIS	IT	There is a risk that we will be unable to make the required improvements to both EMIS Community and EMIS GP due to lack of financial resource and the complexity of the underlying problems. Which would prevent the required improvements in functionality and intra-operability. Resulting in missed opportunity to improve support to community and general practice teams.	30-Jul-24	Jon Barnes	9	3	3	9	3	Project support identified to scope the potential for improvement and resources required	No dedicated IT support identified	31-May-24	One Herefordshire Partnership Trust Board - work programme updates for information	Unclear at present extent of opportunities / issues with EMIS and MAXIMS	**NEW BAF RISK**
BAF2024/25 One Herefordshire delivery of responsibilities contained within the MOU	Strategic	There is a risk that One Herefordshire will be unable to make improvements to 'working in a more integrated way' due to an inability to achieve consensus. This includes being unable to realise the potential benefits of the MOU (containing new responsibilities for the Better Care Fund) between the ICB and One Herefordshire.	28-Aug-24	Jon Barnes	9	3	2	6	6	• Terms of Reference for ICE to provide oversight of delivery of the MOU. • Availability of shared data Discharge to Assess Board commenced 2023/24 BCF Operational Group commenced Autumn 2023	• Finalised and signed MOU for 2024/25	31-May-24	• Monthly reports to ICE • One Herefordshire agreement of the MOU, enabling consensus. MOU finalised and signed (ICB and 1HP) in place for 2023/24	• Defined reporting mechanism to assure delivery against the MOU.	
BAF 2024/25 Delivery of Academic Programme to improve our Research Profile	Strategic	There is a risk that WVT may be unable develop an effective academic programme in order to improve our research profile due to a lack of resources including finance, manpower and delivery models required to achieve improvements to patient care.	21-Jun-24	Chizo Agwu	10	2	3	6	4	Project oversight in place: Executive lead; Research and development lead; Associate CMO for Research Narrowed scope in place focusing on the research strategy Research strategy was approved at TMB and Quality Committee - Scope agreed	Workshop in April 2024 for discussion around partner relationship working in order to increase our chances of meeting our objectives.	26-Apr-24	Reviewed under normal research meetings Workshop in April 2024 planned Quality Committee Trust Management Board	None	

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115	Inadequate Allied Health Professional Specialist Support to Critical Care	Workforce	There is a risk of critically ill patients not receiving specialist allied health professional support, due to the lack of funded baseline establishment within the intensive care unit budget. This has the potential to lead to intermittent rehabilitation programs, and results in delays to patient recovery. The unit also becomes unable to provide mandatory NHSE CQUIN data due to the lack of AHP support.	Surgical Division	20	5	3	15	5	• 0.6 funded critical care pharmacist support, and on call pharmacist • Direct referral process to dietetic service • Direct referral process to OT service • Direct referral process to SLT • Direct referral to Physiotherapy, and emergency weekend cover • Weekly Rehabilitation MDT meeting for critical care	• Gap of 0.2 WTE critical care pharmacist support • Gap of 0.8 WTE and no dietetic cover at weekends • Gap of 1.84 WTE and no OT cover at weekends • Gap of 0.8 WTE and no SLT cover at weekends • Gap of 2 WTE Physiotherapy, including 24/7 respiratory on call • Attendance is reliant on goodwill • The current service spec for clinical psychology does not incorporate critical care • Delays in weaning pathway • No defined training pathway for AHPs working in critical care e.g. lack of specialist knowledge such as implementation and use of speech valves.10. No cover for AL or sickness absence for AHPS • Limited understanding of the actual demand • In times of staff shortages ICU patients may not be prioritised from the general pool of therapy support	• Incident reports for gaps in individualised patient care Workforce business planning	• Cluster review - corporate that this is aspirational • Workforce business planning - consistently rejected. • Incident reporting is inconsistent and only demonstrates a failure in controls

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687	Lack of health psychology	Clinical Care	There is currently no provision at all for health psychology for children and young people who have long term health conditions. It is well recognised the impact that a diagnosis of a life limiting condition can have on a young person and currently there is no specialist psychology to support them. This has a significant impact on their well-being in their short term and long term care. There is a risk of harm to the patients in the longer term.	Surgical Division	16	4	4	16	8	• NICE Guidance NG61: End of life care for infants, children and young people with life-limiting conditions • NG206 Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management	• Lack of funding available for service development opportunities • There is no Health psychology service currently commissioned. • CAMHS will not see these patients as they do not have a mental health condition.		• No service provision • No identified assurance as no service provision Children and Young People Board
788	Long Waiting Times	Clinical Care	There is a risk of harm to patients due to the long waiting times for appointments in the gynaecology service New routine patients are currently waiting up to 43 weeks for a 1st appointment Urgent general gynaecology patients are now waiting up to 43 weeks for a first apt. Due to the long wait for these services there is a risk that a patients condition may worsen and their health may deteriorate and harm therefore may be caused.	Surgical Division	20	4	4	16	8	• Additional clinics are being undertaken in colposcopy, general gynae and hysteroscopy. • Nurse hysteroscopist/CNS pessary clinic requested in business planning - awaiting approval • Nurse and registrar being trained to deliver colposcopy service - takes 18 months • Outsourcing hysteroscopies to health harmonie • Exploring more robust nursing cover to implement super Saturday's in Oxford Suite.	• There is a lack of workforce to manage the current size of the waiting list. • The change to the 1:9 rota reduced the amount of elective work from each consultant. • 1 consultant vacancy - currently be filled by locum, substantive appointed commence in Sept 2024 • 1 consultant on long term sick • Awaiting agreement of business plan, new consultant included in business planning.	• The clinical team are committed to undertaking additional clinics to try and reduce the long waiting times.	• The size of the waiting list is such that it is challenging to reduce waiting times without additional workforce

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789	Risk of adverse patient events due to long stay within ED resulting in overcrowded department	Clinical Care	There is a risk of long patient stays in ED, due to poor flow within the urgent care pathway, which leads to an overcrowded department. This has, could, will lead to patient harm, (falls, pressure area damage, delirium, poor patient experience, suboptimal care; food, fluids, observations, medication and escalation of the ill patient) and privacy and dignity. It also leads to increased delays in ambulances offloads. Due to the congestion in ED and high levels of boarders on the wards, patients in ED are now being cared for in inappropriate areas forcing staff to work outside of SOPs. This is evidenced by increasing numbers of InPhases showing near misses. Although national evidence links long stays within ED to increased mortality, there is no evidence that this is occurring in WVT currently. Achieving the UEC challenge of minimum 76% on the 4 hour target by March 2024 would markedly lower this risk.	Medical Division	20	4	5	20	4	• Colour coded identification on Symphony of patients in department in excess of 6, 12, 18 and 24 hours. • Pressure area damage; Risk 1788 Repose mattress toppers on trolleys Ability to utilise hospital beds (space permitting) Anderson tool on Symphony High risk patients highlighted to site team for ward bed transfer Comprehensive nursing handovers within ED Senior nurse checklist completed Howard Wright trolleys introduced within ED, providing 48 hour pressure relief. • Delirium / Mental Health / Learning Difficulties Level of frailty determined at triage. Frailty SDEC opened to reduce length of time patients stay in main ED. Autism Care Pathway work led by DGM Plan for sensory room Mental Health Assessment Room Enhanced education for MCAs for ED Nursing and Medical staff. Security team at WVT Multi agency roundtables occurring following moderate harm incidents • Sub-optimal care Senior nurse checklist Staff huddles Sodexo catering provided for patients 4+ hours within department • SDEC Medical SDEC; working well Surgical SDEC; engagement and initial walk rounds undertaken with surgical division	• ECIST review of SNCT data – Awaited • Inconsistent use of existing tools • Surgical SDEC; when opened should reduce number of patients waiting within ED • Involvement with T&O • Virtual ward; under utilisation and lack of surgical input preventing surgical patients to be admitted to virtual ward. • Internal professional standards; productive meetings held with medical division & surgical division. • Additional ED trolley's with pressure relieving qualities. • Lack of workforce plan relating to ED and Acute medicine consultants. • Use of acute physician SPA time to manage ED outliers impacts on time to implement improvements. • ED Matron pulled operationally impacting on implementation of improvements • Overall Demand & Capacity model work up & ECIST feedback review required by Clinical Director + GM A&E. • UEC QIP; In process of being written, but not agreed/implemented. • 12 hour waits in the Emergency Department be tracked as part of monitoring the risk as we are still a national outlier. • Inconsistent use of existing tools - Improvement of ED processes through ratified and implemented SOPs in relation to triage, streaming and ambulance handovers. New ED dashboard implemented.	• Monthly ED Mortality meetings • Directorate Tri • Directorate Risk Meeting • Tri to Tri • Divisional Quality Governance Meeting • Quality walkabouts by Divisional Tri F&PE • Executive Risk Meeting • Quarterly update to Quality Committee; standardised agenda item in medical division report. • All unexpected deaths added onto Inphase and reviewed by Division • All moderate harm and above pressures ulcers reviewed at PUP with engagement from B7 sisters. • Visible leadership from B7 sister • Senior Nursing Review checklist • 6 hourly checks reflective of intentional nurse rounding. • Operational meetings - gaps in staffing • Twice daily ED huddles • Wisdom Wednesday & Feedback Friday • Engagement from Mental Health colleagues	• Resilience within the multidisciplinary workforce. • Ward implementation of agreed Ward Standards; • Promotion of flow and reduce congestion within ED. • Professional standards agreed, but inconsistently implemented. • Junior nursing workforce and clinical skills. • Confirmation from ECIST re; nursing establishment.

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										Frailty SDEC; Opened 13/09/23 • Medical cover of patients awaiting inpatient beds in ED Re-deployment of staff across the division and within the directorate Use of acute physician SPA time to manage ED outliers			
1317	Risk of patient harm due to Pharmacy Service reduced capacity/staffing	Workforce	There is a risk of harm to patients due to the lack of registered pharmacy staff nationally including agency staff. This is currently resulting in reduced ability to maintain/develop medicines related policies and procedures and maintaining governance processes including audit across the Trust (specifically controlled drug storage audits). Delays in the processing of medicines orders including inpatient, discharge and outpatient supplies. Inefficiencies due to all dispensing taking place within the pharmacy dispensary instead of ward based where possible.	Clinical Support Division	20	4	5	20	4	• Prioritisation of clinical service at ward level and technical services to reduce risk to patients and maintain capacity. • Searching for two locum pharmacists but not appointed yet. • Flexible working requests considered for all roles.	• Insufficient pharmacist numbers to cover all ward areas and maintain policy and procedure development for Divisions/Directorates • No readily available additional cover (locum or bank). • Medium to long term threat of pharmacy staff shortage due to expansion in services in all sectors.	• Pharmacy staffing reviewed weekly by COO and CMO with Division Lead and CD of Pharmacy. • Incident reports completion for medicines related incidents, complaints and PALs concerns. • Rota indicating all areas are covered adequately if possible. • Completion of medicines reconciliation at ward level, turnaround time KPIs. • Staff overtime records and sickness records and turnover. • Staff concerns and wellbeing issues raised. • Bi monthly report to Patient Safety Committee/Quality Committee on risk status via the Medicines Safety escalation report	• None

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1473	Single Lead Orthodontics Service has become fragile and unstable.	Clinical Care	There is a risk to patient care due to the Orthodontics service being a single lead service coupled with the Consultant retiring in March 2022 and a National shortage of Orthodontic specialists. This has lead to the Orthodontics service becoming fragile and unstable in its entirety and has resulted in significant waiting times for both Herefordshire and Powys patients and has the potential to result in the service being unable to be being provided as of the 1st April 2022 in Herefordshire, this could cause potential harm to patients and the Trust. Following return of consultant following retirement he is not currently available for work. We have no employed medical staff available, are unable to recruit and their are no agency locums.	Surgical Division	20	4	4	16	4	• Contract with insourcing in place until end of September 2024 to ensure capacity plan is achieved. • Additional 2 consultants provided by Portland to maximise capacity. • Additional capacity for clinics now being offered to ensure patients are seen in a timely manner. • Long term Issue being led at ICS level - meetings held fortnightly. • Joint clinics have at Worcester to commence in June 2024	• No substantive staff currently available. • Reliability of insourced consultants. • Clinics only running on weekends - limited induction and training and support.	• Contract with Portland confirmed until end of September 2024. • Provision of service being transferred to Worcester from September 2024. • Worcester providing joint clinics for more complex patients • Contract with commissioners has been extended.	• No clear plan on service provider from September 24 onwards.

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1682	Industrial Action	Emergency Planning	There is a risk that Wye Valley Trust (WVT) will not be able to provide safe and effective care to patients during periods of industrial action. There is also a risk to the health and well-being of staff who are not taking industrial action because of the increased likelihood of stress and moral injury from this incident and the pressure to provide safe services. Winter UEC pressures, protracted strike action and levels of participation by Junior Doctors.	Corporate Division	20	4	4	16	12	• The Trust receive 2 weeks notice of industrial action in accordance with section 234A of Trade Union and Labour Relations (Consolidation Act 1992) enabling contingency planning. In preparation for Industrial Action Clinical teams are asked to: 1. Review the resources available to staff services over the strike period. 2. Development of comprehensive plan outlining the type and duration of the Industrial Action and its likely effects on delivery of patient care. Central to the plan is the mitigation through governance, preplanning, operational activities, recovery phase. Underpinning the plan is organisational three levels of response (strategic, tactical and operational) providing emergency coverage, including rotas detailing staff coverage during the Industrial Action. 3. Focus the resources available on delivering urgent and emergency care and covering inpatients. In some but not all cases there will be sufficient staff available to provide elective care, but it is possible that any staff not needed for emergency care might be needed by other divisions. 4. Any staff member not planning to take industrial action should be deployed at their usual shift times - it is unacceptable to roster staff members not participating in industrial action for night shifts. Staff members may be deployed to different activities in the interests of patient safety.	• Whilst Industrial Action Plans endeavour to cover every eventuality, inevitably gaps in patient care coverage may appear: • Union(s)/ organisation(s) orchestrating the industrial action, and which staff members are participating in the industrial action and the level of participation. • Those participating in Industrial Action do not have to announce their intention to participate until the day of the Industrial Action, therein creating a level of unknown of service delivery impact until the actual day. • The union or specialisation participating in the Industrial Action may hinder possible mitigation, for example Consultants are able to 'act down', however there is no mechanism in place to cover for Consultants should they elect to take industrial action. • Some IA notices give notice not to derogate any services nationally or locally, whereas some have some accommodation to provide derogation which assists in managing associated IA risks. • Wide spread Industrial Action may impact the ability of staff members to attend their place of work, requiring extraordinary support to maintain patient delivery services. Wide spread Industrial action may impact fuel availability, public transportation, deliveries and supplies. • Based on the Industrial Action being taken, that there is sufficiently skilled and competent staff are available to provide safe and effective care to patients at all times and across the	• Reporting to Tactical Operations Group, • Incident Coordinating Centres (Strategic, Tactical and Operations), • Industrial Action Preplanning meetings and Integrated Care Board enabling regional support as appropriate.	•

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										5. Staff members may be deployed to support emergency and inpatient care in the absence of striking staff, however skills and supervision must be assessed and appropriate. Non-medical staff will expect to be paid for any additional hours they do during the industrial action 6. In the interests of patient safety planned study leave will be cancelled but for staff wellbeing will honour pre-booked annual leave, unless the member of staff has volunteered to work during the industrial action. 7. Consultants with SPA / teaching sessions will be deployed to help cover urgent and emergency care. 8. For consultants who act down outside of their normal working hours will be paid acting down rates as per our existing policy and NHS employers guidance. 9. In all cases the organisation (union) calling for a shrike will put in place derogation's, whereby certain activities are protected or if they fall below a stipulated level of service creating a condition whereby the Trust is unsafe then staff can be asked to return to work through their organisations (union). This validation process of coverage takes place first thing each morning, and where shortfalls are confirmed then formal notification is sent to the ICB onto the organisation calling for the IA detailing the shortfall in coverage (normally below christmas day cover).	Trust. • Concurrent IA.		

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1704	Delivery of Financial Plan and improving underlying position	Financial	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) required; impact of inflationary pressures; and, risk to achieving the full income target. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and shortfall in cash to meet obligations.	Corporate Division	20	4	5	20	12	• CPIP devolved as part of divisional budgets for identification and delivery. • CPIP targets agreed by divisions. • Established process for identification and monitoring of CPIP delivery. • Action plans in place for MARP and NARP. • Activity Plan implementation. Enhanced financial controls. • Deficit plan submitted for 24/25 agreed by NHSE.	• National inflationary pressures. • Process of early identification and capture of full CPIP plan. • Trust policies and processes require strengthening to ensure compliance. • Lack of recurrent efficiencies within the programme. • Lack of medium term financial plan.	• Productivity Board routine monitoring of activity plan. Monthly F&PEs review of CPIP delivery. • MARP and NARP routine review of action plan and compliance with controls. • Integrated performance report to Board. • CPIP Audit Report • ICS Finance Forum - NED-led to oversee system financial performance. • System Investment and Expenditure Ctte - Management-led oversees adherence to the enhanced financial controls	• Trust policies and processes require strengthening to ensure regular monitoring and reporting. • CPIP plans not fully identified to meet targets.
1720	Emergency Alarm activation in theatres	Health & Safety	There is a risk with the current system of summoning aid in the event of an emergency which must be available at all times and quickly identifiable.	Surgical Division	25	5	3	15	5	• Theatre co-ordinators react and immobilise all theatre staff on activation of the alarm.	• When numbers are low in theatre i.e. anti-social hours • No central communication base within theatres department to assist	• Monitor effectiveness of controls via incident reporting	• Specification of proposed system unknown. • Incident reporting data inconsistent
1762	Replacement of 4 Aseptic Isolators	Compliance with standards	There is a risk of our Technical Services Department not being able to manufacture aseptic products (inc. Chemotherapy) due to the unreliability of the current cabinets. 4 of the cabinets are approximately 15 years old and frequently breakdown requiring an engineer to come out and repair the cabinet. Due to the age of the cabinets, they are beyond full repair and	Clinical Support Division	20	4	4	16	4	• Regular maintenance • Quarterly external checks • Daily Internal checks including air pressures, air flow, microbiology • Approved procedures in relation to aseptic production • Contingency/capacity plans	• Exceeded life cycle by 8 years resulting in more regular failures • Downtime	• Annual Regional Quality Assurance Inspection (IQAAPS) • Incident Reporting via Inphase	• No gaps

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			the some of the parts that are required to fix the cabinets are no longer produced by the manufacturer (ENVAIR). The potential impact on the production of aseptic products is catastrophic - particularly affecting cancer services.										
1803	Serious harm, death or injury due to backlog of maintenance/servicing on medical equipment	Clinical Care	There is a risk of serious harm due to the large number of medical devices which may be overdue maintenance or servicing. Due to lack of access, equipment relocation (e.g. during COVID), data quality, asset management system incompatible with clinical functions (no longer fit for purpose), recent significant turnover and sickness within EBME team, historic low WTE per device ratio, lack established process (SOP) for new equipment registration. If equipment is not up to date with maintenance/servicing there is a potential for patient or staff harm. The harm may be caused by a range of factors including, for example, electrical shock, incorrect medication (dosing), incorrect diagnosis, incorrect readings etc. The results from the failure in medical	Corporate Division	15	5	3	15	5	• Risk stratification of devices to focus on areas of greatest concern • Training of EBME staff	• Poor information • Lack of coordination with departmental (non EBME) managed service contracts • New equipment not being registered with EBME	• No known trends in terms of incident reporting relating to medical equipment • Frequency of escalation from Departments if equipment overdue	• Lack of Medical Devices Committee clinical input and yet to establish sufficient reporting • Insufficient trained resource to meet quantum of work required

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			equipment can be catastrophic for patients. For example a patient not receiving the correct dosage of critical medication or babies with life changing disability through lack of medical gases if resucitaire not working correctly.										
1828	Central storage area network (SAN) end of life and unsupported	IT	There is a risk that due to exceeding their planned replacement cycle the recently obsolete SAN in Plough Lane (Trust primary data centre) will not be able to be updated should new cyber vulnerabilities be identified. This may expose the Trust to cyber attack and lead to non-compliance with the DSPT. The risk of unplanned outages due to failure and availability of replacement parts is also heightened.	Corporate Division	15	3	5	15	3	• Hoople are monitoring the situation. • The Trust has newer equipment in its backup data centre.	• Manufacturer support has ended • Lack of spare capacity is causing reporting issues in Information	• Capacity, reliability and security are reported regularly by Hoople to the Trust through formal meetings (e.g. Infrastructure Programme Board)	• Funding has not been allocated yet and remains a problem into 24/25. • Hoople are no longer able to provide assurance.

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1845	Dexa reporting	Clinical Care	There is a risk of patients with Osteoporosis being misdiagnosed due to information contained within the current Dexa report being incomplete, misleading and that there are inadequate comparisons. Which could potentially lead to over/under diagnosis or no treatment being provided to patients with Osteoporosis and result in adverse patient outcomes including delays to cancer treatment.	Clinical Support Division	16	4	4	16	4	• Currently we have stopped producing reports directly from the Dexa scanner until configuration issues have been addressed - as agreed at Dexa round table with CMO and Execs. • Previous reports to be audited when new, more accurate configuration agreed and implemented - cancer reports to be prioritised on review • Previous scan reports will be re-reported when configuration agreed and if clinically needed. • Multi disciplinary meetings being held weekly to discuss	• Delay with Dexa reporting as currently reports not being produced	• Fuji, Rheumatology and Radiology working together to ensure adequate resolution • Monitored at weekly meetings	• Time delays in finding resolution meaning delays with patient pathways
1851	Waiting times for colposocopy appointments	Workforce	Current challenges with seeing patients with 14 days for their 2ww appointments, urgent patients who should be seen at 6 weeks are being pushed out further past their see by dates to accommodate the 2ww patients. Alongside delayed follow ups, MDT patients are prioritised pushing follow ups out further past their see by dates. There has been an increase in referrals - we have had 149 more referrals than the same period last year - the same number of clinics have been delivered.	Surgical Division	16	4	4	16	2	• Additional clinics are being undertaken. • Review and prioritisation of follow up waiting list is being undertaken by DGM and colposcopy lead • Recruitment of colposcopist • Long term training of nurse colposcopist	• Do not have full establishment of colposcopist • Not able to run sufficient clinics to manage demand due to the following: lack of clinic space. lack of nursing staff available to run weekend clinics (not in budget) .	• The 2ww patients have been prioritised due to them being the most urgent cohort of patients.	• There needs to be a higher number of additional clinics done to clear the backlog and reduce the waiting time.

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1890	Medicines Related Guidelines Expired	Compliance with standards	The medicines related guidelines (MRGs) 90% are out of date. The risk due to these being out of date is that they may be being followed with incorrect advice. This potentially could impact on patient care which could lead to incorrect treatment.	Clinical Support Division	16	4	4	16	4	• Chief Pharmacist aware as well Clinical Quality Improvement manager. • Highlighted as Trust wide risk. • MSO will liaise with authors to prioritise the MRGs to extend dates or re submit by May.	• There may be capacity issues with the authors and time restraints.	• MSO will provide assurance as has a tracker of MRGs to allow for this to be updated clearly. • The Quality Improvement team are also aware and will be meeting with MSO on a weekly then fortnightly basis to keep track of this.	• None
1894	Reduction in provision of paediatric endocrinology services	Clinical Care	There is a risk of delay in the diagnosis, management and treatment of children and young people with endocrine issues due to the paediatrician with an expertise in endocrinology leaving the department. This will lead to delays in children being seen in clinic and delays in answering parent/professional queries	Surgical Division	20	4	4	16	8	• CMO to continue to do 1 clinic per month seeing paediatric endocrinology patients. • Discussions with tertiary team regarding need for increased support. • Urgent referrals to be seen in general paediatric clinics and discuss with tertiary • endocrinology Some follow ups to be put into general paediatric clinics Consultant on call to review parent queries • Consultant to sit in on endocrinology clinics with tertiary endocrinologists • Locum post out to external agencies • Permanent post on NHS jobs	• No-one available from external agency. • Permanent advert still out for applications	• Review of patient waiting for out-patient appt to see if can be seen in a general paediatric clinic. • Discussions with tertiary service for extra support. If complex patients referrals redirected to tertiary service	• No-one available to triage referrals. Not meeting • National guidance if patients with thyroid problems are seen in a general paediatric clinic.
1909	Risk of delay of renal replacement therapies due to unreliability of machines.	Clinical Care	Currently within ICU we have 4 Baxter Prismax machines which are utilised to deliver renal replacement therapy. However, these machines have become unreliable and have on times been out of action due to faults and failures. Despite a paid annual maintenance and service contract with Baxter engineer reviews and repairs have been delayed resulting in using a loan machine from	Surgical Division	15	3	5	15	3	• 4 machines in fleet • Paid annual service and maintenance contract with Baxter • Loan machine from Baxter dependant on availability • Arranged regular Baxter Rep involvement in relation to concerns	• 4 machines " style="overflow: hidden visible; color: rgb(68, 68, 68); width: 100%; background-color: transparent;">1. Poor contract service from Baxter • Potential limited availability of loan machine from Baxter • Potential high patient renal requirement needs >4 machines	• Incident reporting to monitor controls efficacy • Internal audit/log of issues	• inconsistent incident reports

Risk Id	Risk Title	Risk Type	Risk detail	Division	Initial Risk Rating	Current Consequence	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
			Baxter which is dependent on availability.										

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Monthly Mortality Report - May
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Medical Officer**
Author:	Chris Beaumont – Mortality Lead
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

This monthly report aims to provide an update on the progress of implementation for the mortality strategy. The report includes performance in relation to mortality rates, focussing on trends and variation identified, which includes the number of mortality reviews undertaken for the previous month with key learning.

2. Recommendation(s)

The Board are asked to note:

- Latest nationally reported **SHMI** (*NHS Digital*) from January 2023 to December 2023 shows an encouraging reduction of 1.1 to **101.7** for Wye Valley NHS Trust. A similar positive position is reflected in the provisional HES-based SHMI, which for the 12 month period from February 2023 to January 2024 is **98.4**.

- In regards to our key **mortality outlier groups**, there has been several significant reductions in the latest SHMI data, most notable in pneumonia with a reduction of 5.2 to 97.4. Our heart failure mortality rates have also reported a welcomed reduction to 112 in the latest NHS Digital data, and now sits back within 'as expected' ranges. The #NOF mortality rates remain at 'higher than expected' levels with the latest NHS Digital SHMI (*Jan 23 – Dec 23*) at 146. The #NOF mortality lead will be providing feedback at the May Learning from Deaths Committee, which will include the findings from the current mortality audit and proposed actions.

- The latest **Clinical Coding KPI's** (*February 2023 – January 2024*) indicate a continued strong and improving performance for our co-morbidity scores for live and deceased patients, both of which remain above our peer and the National means. In addition, the number of cases with a 'sign or symptom' coded as their primary diagnosis has significantly reduced. This improvement has been in response to Clinical Coding conducting a monthly reconciliation review of all deaths with a sign or symptom in their primary diagnosis, upon review they seek out the clinical teams involved with the aim of identifying an appropriate diagnosis.

- **Crude mortality** rate for April 2024 was **1.68%** for all admissions, which includes both planned and unplanned admissions to the Trust, equating to 79 deaths. Please note that this does not include any deaths occurring in the Emergency Department deaths.

- The **extended perinatal mortality** and **stillbirth** mortality rates remain unchanged since the last reported with the latest data indicating both rates are at **2.38 deaths** per 1000 live births.

- This month will be our first Learning from Deaths Committee, at which there are a variety of updates from teams across Trust, including #NOF, Legal, and Medical Examiner service.

3. Executive Director Opinion[1]

4. Please tick box for the Trust's 2023/24 Objectives the report relates to:	
Quality Improvement ☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes*** ☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)*** ☐ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care*** ***Digital*** ☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy*** ☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways*** ***Productivity*** ☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations*** ☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	***Sustainability*** ☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff*** ☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process*** ***Workforce*** ☐ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☐ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

[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.

Wye Valley NHS Trust Mortality Report

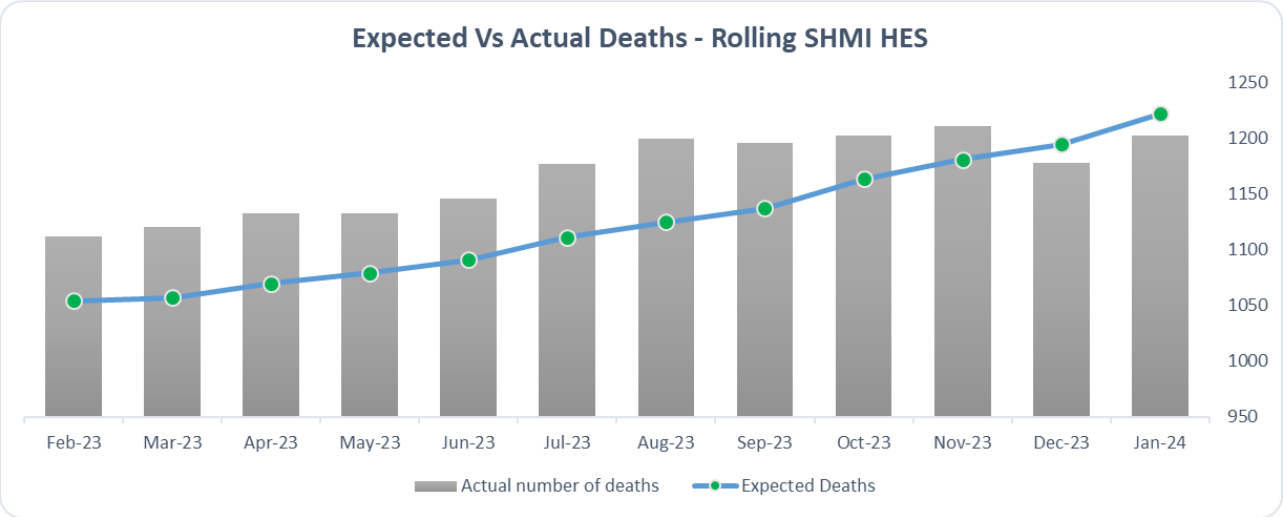
Introduction:

This report is designed to provide the Wye Valley NHS Quality Committee with assurance of the surveillance mechanisms in place to proactively monitor our mortality rates at Wye Valley NHS Trust. This will include an outline of the response and actions taken to address any areas of concerns or that require further investigation.

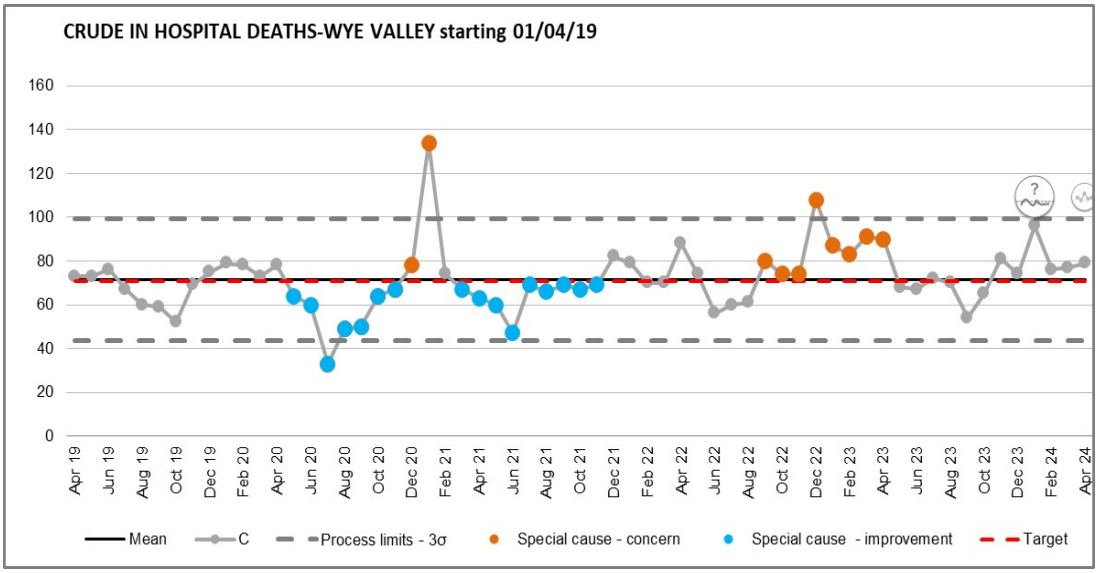
Data Summary for the Key Mortality Indicators:

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Jan 23 - Dec 23	101.7	1.1

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Feb 23 - Jan 24	98.4	-0.3
SHMI (in hospital)			92.7	-0.4
SHMI (out-of-hospital SHMI)			111.5	-0.05



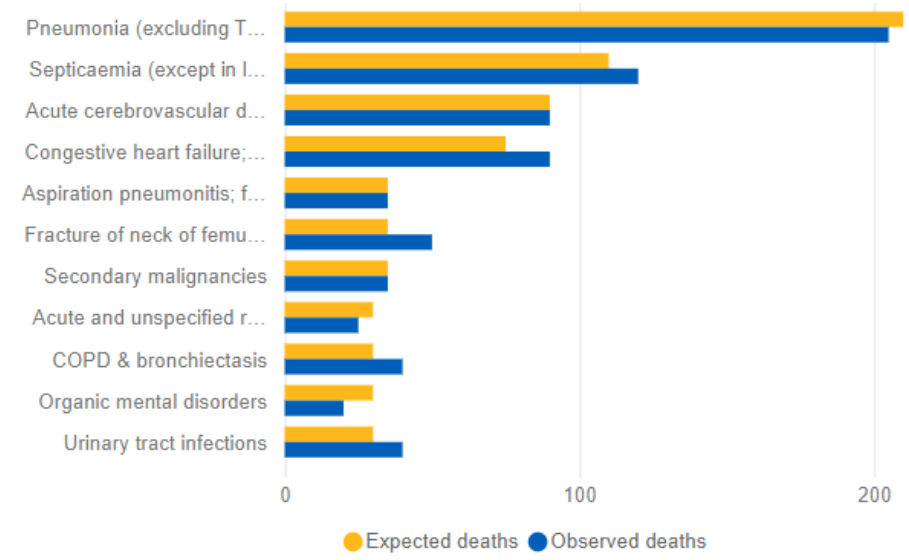
In-Hospital Crude Mortality:



Indicator - Latest Static	Description/Notes	Data month	Month Actual	Deaths in Month
Crude Mortality-All	% of Deaths by Discharges	Apr-24	1.68%	79
Crude Mortality-Emergency	% of Deaths by Emergency Discharges		5.93%	78

Outlier Update: *NHS Digital SHMI – January 2023 – December 2023*

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Pneumonia (excluding TB/STD)	73	1,285	205	210	0.9746	As expected
Septicaemia (except in labour), Shock	2	440	120	110	1.1074	As expected
Acute cerebrovascular disease	66	560	90	90		
Congestive heart failure; nonhypertensive	65	535	90	75		
Aspiration pneumonitis; food/vomitus	77	100	35	35		
Fracture of neck of femur (hip)	120	430	50	35	1.4671	Higher than expected
Secondary malignancies	30	150	35	35	0.9883	As expected
Acute and unspecified renal failure	99	240	25	30		
COPD & bronchiectasis	75	465	40	30		
Organic mental disorders	42	235	20	30		
Urinary tract infections	101	590	40	30	1.4361	As expected



Clinical Coding:

Indicator	Description	Data month	Wye Valley	Peer Mean	National Meen
Depth of Coding - Deceased Patients	Avg Depth of coding	Jan-24	13.62	13.92	15.52
Depth of Coding - Live Patients			6.71	6.73	6.88
Co-morbidity Scores - Deceased Patients	Calculated according to the Charlson Co-morbidity index.		16.07	15.46	15.55
Co-morbidity Scores - Live patients			5.89	5.76	5.07
Palliative Care Coding - Deceased Patient	Use of Z515 code		0.16	0.33	0.43
Palliative Care Coding - Live Patient			0.01	0.01	0.01
Supportive Care Coding - Deceased	Use of Z518 code		0.57	0.24	0.15
Supportive Care Coding - Live			0.00	0.00	0.00
Signs and Symptoms - Primary Diag - Deceased	Used for cases where no more specific diagnosis code is available.		0.01	0.02	0.03
Signs and Symptoms - Primary Diag - Alive			0.13	0.11	0.11

What do the charts show?

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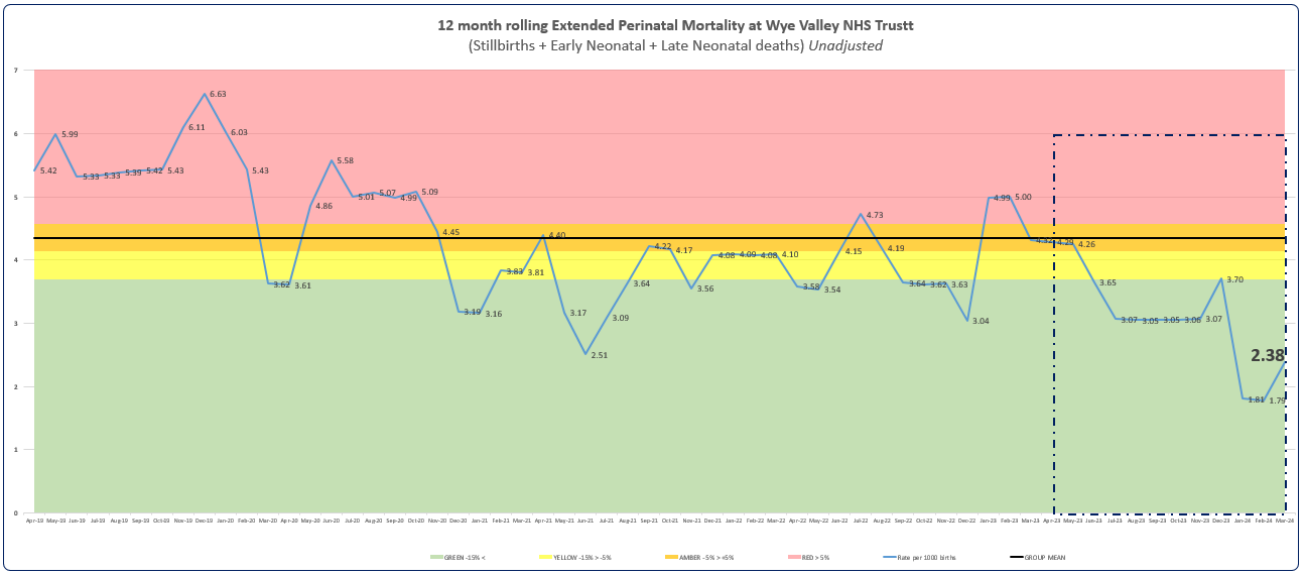
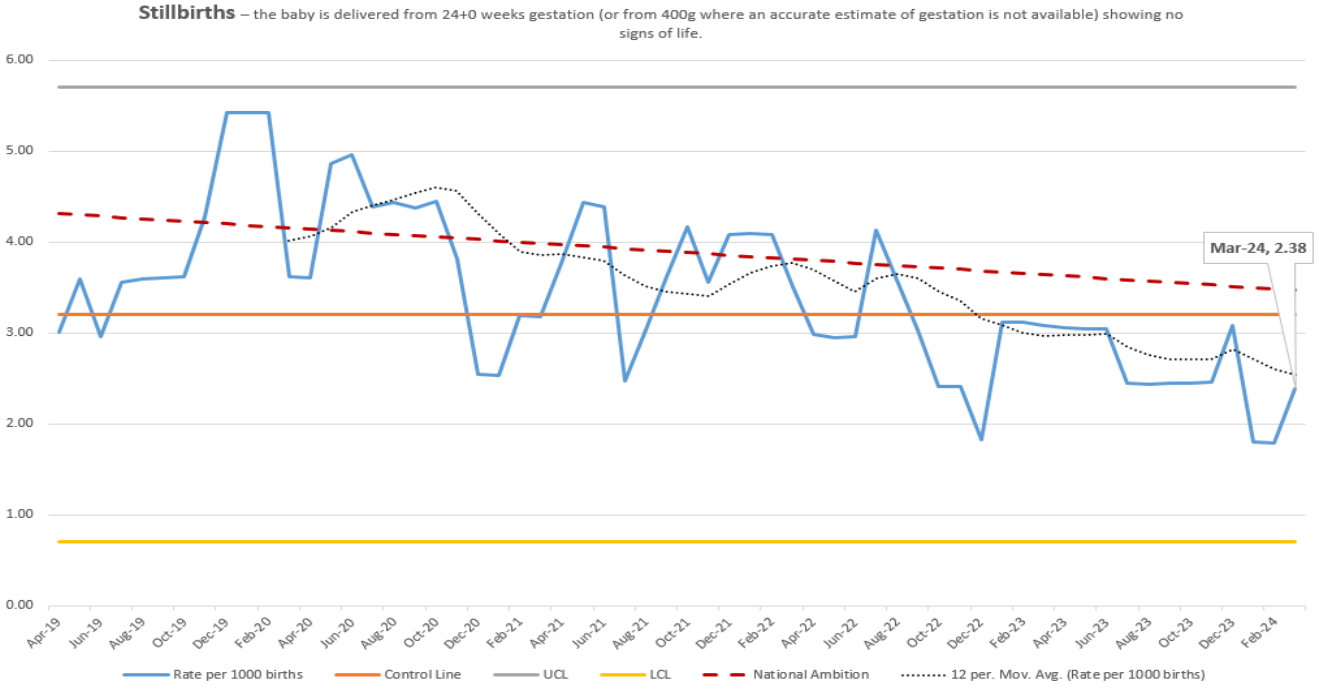
Perinatal Mortality:

Extended Perinatal Mortality Rate: *April 2023 – March 2024* **2.38 deaths** per 1000 live births.



Stillbirth Rate: *April 2023 – March 2024* **2.38 stillbirths** per 1000 live births.



Learning From Deaths:

During April, there were 91 in-hospital and ED deaths. The Medical Examiner Service reviewed 100% of cases, of which 10 cases were highlighted as requiring further in-depth specialty review. The reasons included:

- Concerns with care raised by next of kin;
- Potential delays in treatment;
- End of life planning and family discussions.

The themes of findings from the Medical Examiner scrutiny's included:

- Delay in administering medication;
- Unwitnessed falls on wards;
- Carer concerns – specifically around communication;
- Delayed referral to ITU.

In addition to the above acute cases, there have been 53 community deaths reviewed by the Medical Examiner Service during April 2024. Primary care leads have been approached to develop an appropriate route to feedback learning, key themes, and / or potential issues in care.

In the coming months we aim to develop our reporting systems, which capture all the information from the Medical Examiner and Structured Judgement Reviews, to provide a more in-depth analysis of the findings. Our new In-Phase system has been designed to structure the data that we capture, ensuring information is reportable, and more significantly we are able to identify key themes amongst larger cohorts of cases.

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Thursday 2 May 2024 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group Boards. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present:

Russell Hardy	(RH)	Group Chairman
Charles Ashton	(CA)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(AC)	Managing Director SWFT
Stephen Collman	(SC)	Managing Director WAHT
Richard Colley	(RC)	NED SWFT
Neil Cook	(NC)	Chief Finance Officer WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Catherine Free	(CF)	Managing Director GEH
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WHAT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Helen Lancaster	(HL)	Chief Operating Officer WAHT
Vikki Lewis	(VL)	Chief Digital Information Officer WAHT
Kim Li	(KL)	Chief Finance Officer SWFT
Anil Majithia	(AM)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Simon Murphy	(SM)	NED and Deputy Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Simon Page	(SP)	NED and Vice Chair SWFT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED GEH
Naj Rashid	(NR)	Chief Medical Officer GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED SWFT
Nicola Twigg	(NT)	NED WVT
Sue Whelan Tracy	(SWT)	NED SWFT
Umar Zamman	(UZ)	NED GEH

In attendance:

Sarah Assinder	(SA)	Deputy Chief Operating Officer WVT (deputising for Chief Operating Officer WVT)
Jon Barnes	(JB)	Chief Transformation and Delivery Officer WVT
Julian Berlet	(JBe)	Deputy Chief Medical Officer WAHT
Rebecca Bourne	(RB)	Head of Communications WAHT

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Thursday 2 May 2024 at 1.30pm via Microsoft Teams

Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
Oliver Cofler	(OC)	ANED SWFT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Laura Gibson	(LG)	Associate Chief Operating Officer GEH (observing)
Phil Gilbert	(PGi)	NED (Non-Voting) SWFT
Jeanette Halborg	(JH)	Deputy Chief Nursing Officer GEH (deputising for the Chief Nursing Officer GEH)
Richard Haynes	(Rha)	Director of Communications WAHT
Erica Hermon	(EH)	Associate Director of Corporate Governance WVT and Company Secretary WVT/WAHT
Oli Hiscoe	(OH)	ANED SWFT
Alison Koeltgen	(AK)	Chief People Officer WAHT
Rosie Kneafsey	(RK)	ANED GEH
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KL)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Tom Morgan-Jones	(TMJ)	Deputy Chief Medical Officer WVT (deputising for Chief Medical Officer WVT)
Jo Newton	(JN)	Director of Strategy and Planning WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Gertie Nic Philib	(GP)	Chief People Officer GEH/SWFT
Richard Oosterom	(RO)	ANED WAHT
Barti Patel	(BP)	ANED SWFT
Mary Powell	(MP)	Head of Strategic Communications SWFT
Jackie Richards	(JR)	ANED GEH
Sue Sinclair	(SSi)	ANED WAHT
Robin Snead	(RS)	Chief Operating Officer GEH
James Turner	(JT)	Head of Communications and Engagement GEH
Jules Walton	(JW)	Deputy Chief Medical Officer WAHT

There were four SWFT Governors, and three guest observers in attendance. There was one member of the pubic in attendance.

MINUTE		**ACTION**
24.032	**APOLOGIES FOR ABSENCE** Apologies for absence were received from: Paul Capener, ANED GEH; Paramjit Gil, Nominated NED SWFT; Sophie Gilkes, Chief Strategy Officer SWFT; Natalie Green, Chief Nursing Officer GEH; Mark Hetherington, ANED GEH; Julie Houlder, NED and Vice Chair GEH; Simone Jordan, NED GEH; Zoe Mayhew, Chief Commissioning Officer (Health and Care) SWFT; David Moon, Group Strategic Financial Advisor; Dame Julie Moore, NED WAHT; Andrew Parker, Chief Operating Officer WVT; and Jo Rouse, NED WVT. **Resolved – that the position be noted.**	
24.033	**DECLARATIONS OF INTEREST**	

MINUTE		ACTION
	The Group Chairman declared that his son had been made the Director of Strategy for GB UK Group Limited. **Resolved – that the position be noted.**	
24.034	**PUBLIC MINUTES OF THE MEETING HELD ON 7 FEBRUARY 2024** Mr Lappin (ANED WVT) noted that his title was incorrect and needed amending to be Associate Non-Executive Director of WVT. **Resolved – that the public minutes of the meeting held on 7 February 2024 be confirmed as an accurate record of the meeting subject to the amendments above and signed by the Group Chairman.**	
24.035	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.035.01	Foundation Group Performance Report (minutes 23.058, 23.080.01 and 24.007.02 refers) The Managing Director for GEH confirmed that the cancer diagnosis following Emergency Department (ED) attendance data had been received. She shared this with the Foundation Group Boards and explained that GEH was an outlier. The next piece of work was to understand why GEH were an outlier and where any adjustments needed to be made. The Group Chairman requested that the action remain open and the Managing Director of GEH provide an update on the progress of GEH next time. **Resolved – that the GEH cancer diagnosis from ED attendance update be provided at the August 2024 meeting.**	**CF**
24.035.02	Deep Dive into Additional Performance Measures – Theatre Productivity (minutes 23.060 and 24.007 refers) The Chief Operating Officer for GEH confirmed that Theatre Productivity was being worked through as part of the Deep Dives schedule of the Chief Operating Officers. He assured the Foundation Group Boards that Theatre Productivity would be picked up at the August 2024 meeting as a deep dive. **Resolved – that the Chief Operating Officers look into recording Theatre Utilisation data by cost per minute rather than by a percentage.**	**COOs**
24.035.03	Equality Update – NHS Equality Delivery Scheme (EDS) (minute 24.013 refers) The Chief Operating Officer for SWFT/GEH confirmed that the EDI leads were working through the EDS assessment work and acting as peers for each other. As part of the work, they were ensuring that the EDS report captured citizens from Groups which were harder to reach.	

MINUTE		ACTION
	Resolved – that the position be noted.	
24.036	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chairman provided an overview of the discussions from the Foundation Group Workshop. He highlighted the four sessions that made up the Foundation Group Boards Workshop which included guest speaker, Sir Jim Mackey, Chief Executive Newcastle Upon Tyne Hospitals NHS Foundation Trust and National Director of Elective Recovery. The Group Chairman explained that Sir Jim Mackey's update included encouraging the Foundation Group to continue sharing best practice at pace with a particular focus on integration at place and productivity. The Group Chairman continued that there had been an update on the Foundation Group's approach to being a flexible employer, followed by an update on Warwickshire's Discharge Front Runner Programme and Herefordshire Better Care Fund. He took the time to highlight the importance of Flow and the work taking place across the organisations to minimise length of stay. The Group Chairman concluded that the Foundation Group Boards Workshop ended with a session from Partners at Weightmans LLP on the four Boards legal responsibilities individually and as a collective. **Resolved – that the position be noted.**	
24.037	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director for WVT provided an update on WVT's key performance data. She highlighted that Theatre Productivity was a concern despite being an improving picture. Theatre Productivity had improved from seventy-five percent to eighty percent, however productivity needed to be eighty-five percent to meet the National standard. The Managing Director for WVT explained that Theatre usage had become a focus as well as productivity and improvement was being seen. The Managing Director for WVT noted that sickness levels at WVT were the lowest they had been at four percent however this was being monitored with a focus on health and wellbeing to ensure they stayed low. The Managing Director for WVT informed the Foundation Group Boards that she was most proud of Cancer performance, with WVT having met the February and March 2024 Faster Diagnosis Standard. This had exceeded the National target for March 2025. She then confirmed that WVT were on track to exceed the 62-day performance target nationally of seventy percent by March 2025, meaning sustainable improvement in Cancer pathways for the Trust. The Managing Director for SWFT provided an update on SWFT's key performance data. He focused initially on SWFT's ED performance highlighting how 300 attendances in a day used to be unheard of but had now become routine. He explained how this demonstrated the immense increase in demand on services. However, the Managing Director for SWFT celebrated how the ED	

MINUTE		ACTION
	teams had coped, with SWFT ending March 2024 as one of the top performing Trusts nationally for four-hour performance and ambulance handover times. This supported the approach SWFT had taken to address flow across the hospital to support pressures in ED. The Managing Director for SWFT informed the Foundation Group Boards that SWFT should be able to access a portion of capital funding for being a top performing Trust but also for the improvement seen between January and March 2024. He took the time to thank the Operational Teams and the Chief Operating Officer for SWFT. The Managing Director for SWFT explained that he was closely monitoring Cancer and Diagnostics waits across the Trust. He explained that SWFT were slightly below the trajectory for the 62-day standard for Cancer performance, and they were below the desired position for Diagnostic waits. He explained that this was mainly due to particularly high referral numbers seen in the last twelve months, and performance in non-obstetric ultrasound. The Managing Director for SWFT continued that despite this, both had seen real improvement in recent months, partly due to investment in staffing and would remain an area of focus to ensure that improvement was maintained. The Managing Director for SWFT informed the Foundation Group Boards that he was most worried about Orthodontics and Orthodontic waits. The Trust had done well to reduce long waits across all services and had no patients waiting longer than 65 weeks at the end of 2023, apart from in Orthodontics. He continued that there was a national issue for recruitment to Orthodontic Services and SWFT had been working with the Integrated Care Board (ICB) and NHS England (NHSE) for support due to the lack of capacity to get through their waiting list. The Managing Director assured the Foundation Group Boards that the Trust had been informed that there were providers who were willing to support the Trust, and therefore improvement should be seen in coming months. The Managing Director for GEH provided the Foundation Group Boards with an update on GEH's key performance data. She highlighted that GEH had exceeded the 76 percent standard for four-hour performance, however this was under challenging conditions and flow remained a challenge with delays for patients waiting admission still high. The Managing Director for GEH added that ambulance performance had improved in to April 2024. She took the time to thank the Operational teams for delivering the standards that they had been given despite the pressures. The Managing Director for GEH informed the Foundation Group Boards that both mortality figures, SHMI (Summary Hospital-Level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratios) were within expected range, and SHMI had reduced further since the report had been published. She highlighted that it was pleasing to see both mortality figures in expected range for the first time in a while. The Managing Director for GEH explained that she was pleased to report an improvement in the Cancer 28-day Referral to Diagnostic Confirmation Standard which the Trust had been struggling to achieve. She added there had also been an improvement in the 62-days for treatment figure, however there was still work to do. The Managing Director for GEH continued that the Referral to Treatment (RTT) figures were improving, with the Trust hoping to eliminate patients waiting 65-weeks or longer by the end of May 2024. She concluded by highlighting the work that GEH were doing on Theatre Utilisation, and this had	

MINUTE		ACTION
	been aided by opening two new wards to co-locate surgical services together, meaning patients were able to recover on wards and not in operating theatres. The Managing Director for WAHT provided an overview of WAHT key performance areas. He explained that ED had seen improvements in similar areas to the rest of the Foundation Group Trusts, which was pleasing, but particularly there had been an improvement in Handover delays which had been an issue for WAHT for a while. The Managing Director for WAHT explained that there had been a high-risk number of attendances through the ED department, especially walk-ins, and therefore the Trust was completing an attendance audit with the ICB. In terms of Cancer Performance, the Trust had had over 400 patients waiting over 62-days, and this had now been reduced to under190 for which the Trust had received a letter of thanks from the National Cancer Team. The Managing Director for WAHT highlighted WAHT work around RTT 78-weeks breaches, which had been reduced from 150 to 27. He added that there was a plan in place to eliminate 78-week-waits completely by the end of July 2024. The Managing Director for WAHT thanked WVT for their work with WAHT around fragile services to put more robust plans in place. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive started by celebrating WAHT's improvement achievements, particularly around Cancer and their letter from the National Cancer Team. He expressed the importance of Theatre Utilisation, highlighting that the theatre start time analysis in the Foundation Group Performance report indicated that the majority of theatre lists were not starting on time. The Foundation Group Chief Executive explained that often it was about not having the first bed availability for the first patient as this would inevitably delay theatre starting. He expressed the need to ensure robust plans were in place to prevent this happening and therefore maximising Theatres capacity to drive down waiting lists. **Resolved – that the Foundation Group Performance Report be received and noted.**	
24.038	**DEEP DIVE INTO URGENT AND EMERGENCY CARE (UEC)** The Chief Operating Officer for GEH presented the Deep Dive into UEC to the Foundation Group Boards. He explained that as a group the Chief Operating Officers from across the Foundation Group work together on a range of topics to share best practice and learnings. The Chief Operating Officer for GEH added that the Chief Operating Officers had focused on Same Day Emergency Care (SDEC), Attendance Avoidance, Admission and Discharge Pathways and Virtual Wards as part of their deep dive into UEC. The Chief Operating Officer for GEH highlighted that WAHT appeared to have a higher overall attendance compared to the rest of the Trusts in the Foundation Group, however their data included Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital. The Chief Operating Officer for GEH provided an overview of activity	

MINUTE		ACTION

across the Group in each focus area, which highlighted key focus areas moving forward. He explained that when you looked at the data broken down in different ways, for example by type one (more unwell) attendances per 1000 population, all hospitals in the Foundation Group were largely similar but WAHT had the lowest figure despite having the highest overall attendance rate. He highlighted that looking at the data in different ways had helped the Chief Operating Officers have an overall picture and determine future focus areas. The Chief Operating Officer for GEH also presented the Virtual Wards comparison data which showed that the only Virtual Ward service that each Trust had in common was the Intravenous Outpatient (IV OPAT) service. This showed the extent that the Foundation Group could learn from each other, by using pre-existing pathways and standard operating procedures to quickly set up services elsewhere in the Foundation Group.

The Chief Operating Officer at WAHT presented the key issues, drivers, and improvements for each organisation. Key challenges across the Foundation Group were mainly around overcrowding in ED, sedate flow, bed capacity and intelligence conveyancing. The Chief Operating Officer for WAHT presented the Foundation Group Boards with the common opportunities across the Foundation Group and these included SDEC, improving Length of Stay (LoS), Single Point of Access developments, OPAT expansion, Consultant Connect learning, and developing the Virtual Ward offer. She continued by explaining the next steps which included plans to hold a Foundation Group Debrief Winter Planning Summit to identify any sharing of best practice or implementation of plans, and early preparation for next winter, to develop an SDEC Community of Practice, and to focus on Demand and Capacity on Bed Modelling and Population.

The Group Chairman invited questions and perspectives, and of particular note were the following points.

The Group Chief Executive thanked the Chief Operating Officers for their presentation, and highlighted how interesting it was to see their joined-up approach to working and continued improvement. He noted the Virtual Wards slide and emphasised that the challenge would be establishing how big Virtual Wards capacity was or could be. Therefore, the demand and capacity work within the future work plans of the Chief Operating Officers was important to provide the answer, but also to determine whether the current services offered on Virtual Wards were the right services to maximise capacity.

The Group Chairman took the time to remind the public of the current pressure faced by the NHS and in particular ED departments. He expressed the need for members of the public to do their part in looking after themselves, however assured them that if they needed to attend Accident and Emergency (A&E) then the NHS teams were there to look after them.

A discussion took place on A&E attendances and the need to discharge patients quickly if they could be seen elsewhere.

MINUTE		ACTION
	Resolved – that the Deep Dive into UEC be received and noted.	
24.039	**SAFE STAFFING OVERVIEW** The Chief Nursing Officer for SWFT presented the Safe Staffing Overview to the Foundation Group Boards. She explained that the purpose of the Safe Staffing Overview was to ensure the right number of staff with the right skills were deployed to the right place to meet the demand at the time, but this had to be balanced with the need of the staff as well. The Dashboard showed all Trusts in the Foundation Group were fairly consistent with their Nurse Staffing Key Performance Indicators (KPIs), however there was one area for SWFT that she was looking into which was vacancy rates. The Chief Nursing Officer for SWFT highlighted that there was a joint risk across all Trusts, and that was the need to stop using off-framework agency companies. The Chief Nursing Officer for SWFT highlighted that this was the right thing to do however, it did pose a risk particularly around Paediatrics which was an incredibly hard speciality to recruit into. The Chief Nursing Officer for SWFT highlighted that SWFT's agency and bank spend had improved, particularly around Nurse agency spend. She concluded by informing the Foundation Group Boards that she was Chair of Project 1000 which was a project in the Coventry and Warwick System to recruit and retain 1000 more nurses over the period of three years. The Chief Nursing Officer for WVT presented WVT's overview to the Foundation Group Boards and explained that the position was largely similar to quarter three (Q3) given the winter period. She highlighted the Trust's strong vacancy position, however noted that this would deteriorate slightly in quarter one (Q1) due to the changing of the Nurse staffing establishments in line with acuity reviews. The Chief Nursing Officer for WVT explained that previously WVT was an outlier with its time-out provision and this was now aligned to the rest of the Foundation Group. She added that sickness performance had improved and WVT had ended the financial year with an improvement on agency spend, however this remained a focus area. The Chief Nursing Officer for WVT explained that she was concerned about Pressure Ulcers, and whether WVT were reporting these in the same way as the rest of the Foundation Group, and she would be working with SWFT to improve these. The Deputy Chief Nursing Officer for GEH presented GEH's overview to the Foundation Group Boards highlighted a very similar position to the rest of the Trusts in the Foundation Group. She explained that agency spend had improved significantly, with GEH already below the national target, and this would continue to be reduced over the course of the year. The Deputy Chief Nursing Officer for GEH highlighted the successful recruitment of International Nurses, and informed the Foundation Group Boards that all International Nurses were now at GEH and would be included in Nurse Staffing figures by July 2024. She explained that the Trust's current vacancy position may deteriorate in Q1 following the acuity reviews and increasing capacity with the opening of two extra wards which would need staffing. The Deputy Chief Nursing Officer for GEH expressed that she was most concerned about the	

MINUTE		ACTION
	continued challenge to recruit Registered Nurses, and also like WVT GEH were showing as an outlier for Pressure Ulcers which were being investigated. The Chief Nursing Officer for WAHT echoed the other Chief Nursing Officer's overviews and added that WAHT were also reducing our off-framework agencies where possible but were having to use them still for specialist 1:1 care. The Chief Nursing Officer for WAHT celebrated the incredibly low rates of harm despite the challenges around capacity currently faced in each of the Trusts within the Foundation Group. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive thanked the Chief Nursing Officers for their commitment to reducing agency spend across the Foundation Group. He explained that acuity reviews often highlighted the need for recruitment, and he queried whether prior to recruiting the experience of staff was taken into consideration. The Chief Nursing Officer for SWFT assured the Group Chief Executive that experience was not considered however the overall functioning of a ward and their likelihood of recruitment was factored into any decisions before recruiting. The Managing Director for WVT queried whether 1:1 specialist care was benchmarked across the Foundation Group. The Chief Nursing Officer for WAHT explained that they were not currently benchmarked, however they were incredibly low numbers. Despite this, it was something that they would be looking into to ensure a sustainable approach across the Foundation Group. **Resolved – that the Safe Staffing Overview be received and noted.**	
24.040	**IMPLEMENTATION OF THE SEXUAL SAFETY CHARTER** The Chief People Officer for GEH/SWFT presented the Implementation of the Sexual Safety Charter to the Foundation Group Boards. She explained that the Sexual Safety Charter was launched in 2023 and built on the Domestic Abuse and Sexual Violence Programme. The Sexual Safety Charter set out clearly its principles and these aligned to to each Trusts' values; that sexual harassment, inappropriate behaviours and misogynistic behaviours had no place in the organisations. The Sexual Safety Charter sets out a zero-tolerance approach to unwanted and inappropriate sexual behaviour and misogyny and set the ten principles for how to create a safe and supportive environment for all staff. The Chief People Officer for GEH/SWFT informed the Foundation Group Boards that the 2023/24 staff survey was the first year to have a question on unwanted sexual behaviour and this was included in the report for information. However, it demonstrated that across the NHS, one intwelve staff members had experienced unwanted sexual behaviour from members of the public and one in twenty-six staff members from other members of staff. The 2024/25 priorities set out that each NHS organisation should sign up to the sexual safety charter and the Chief People Officer for GEH/SWFT assured the Foundation Group	

MINUTE		ACTION
	Boards and members of the public that all four organisations in the Foundation Group had signed up. The Chief People Officer detailed the work that was being undertaken on the Implementation of the Sexual Safety Charter, including work on the Behaviour Value Frameworks, Communication Campaigns, Working with FTSU Guardians, improvements in terms of Sexual Safety Policies, Dignity at Work and Safeguarding Policies and support and sign posting for colleagues. Work also continued to eradicate inappropriate behaviour. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chairman drew attention to the impactful numbers of the report and how horrific they were. He highlighted that it was important to not normalise them. The Group Chairman expressed the need to ensure the Foundation Group were doing all they could to support staff and members of the public in a safe way. A discussion took place around national schemes and safe words and the Group Chairman requested that the Chief People Officers take the discussions and ideas away and discuss further. **Resolved – that** **A) the Chief People Officers discuss ways to further support staff and members of the public with national schemes and safe words, and** **B) the Implementation of the Sexual Safety Charter be received and noted.**	**CPOs**
24.041	**ANNUAL REVIEW OF BOARD COMMITTEE TERMS OF REFERENCE** The Company Secretary for WAHT/WVT presented the Annual Review of Board Committee Terms of Reference to the Foundation Group Boards. She explained that the Quality Committees' terms of reference needed more work before they could be standardised so were not included in the Report. Moving forward there was also a plan to look at standardising other documents including Trust Management Boards terms of references and Finance and Performance Committee's terms of references. The Foundation Group Boards approved and ratified the combined Foundation Group terms of reference for the Audit Committee, Appointments and Remuneration Committee and Foundation Group Strategy Committee. The Foundation Group Boards received and noted the combined Foundation Group terms of reference for Charity Trustee. The Foundation Group Boards received and noted the update on the terms of reference for the Clinical Governance Committee, Quality Assurance Committee, Quality Committee and Quality Governance Committee for the individual Trusts in the Foundation Group.	

MINUTE		ACTION
	The Foundation Group Boards received and noted the update on the Foundation Group combined Terms of Reference for the Trust Management Board and Finance and Performance Executive. **Resolved – that the Annual Review of Board Committee Terms of Reference be approved and ratified as detailed above and received and noted as detailed above.**	
24.042	**GROUP DIGITAL TRANSFORMATION UPDATE** The Chief Digital Information Officer for WAHT presented the Group Digital Transformation Update to the Foundation Group Boards. She explained that the report came off the back of the update that went to Foundation Group Strategy Committee in February 2024 and pre-dated the most recent update to the Committee in April 2024, hence some of the timelines in the paper needed to be revisited. The Chief Digital Technology Officer for WAHT explained that there was a need to lean into technology and avoid technology silos to maximise productivity and improve efficiency, whilst also improving patient and workforce experience. She explained that Doctor Tim Ferriss had recently been welcomed back to NHSE and he was previously the National Transformation Director, with a real focus on digital convergence and the benefit that digital convergence could bring to everybody. The Chief Digital Transformation Officer for WAHT expressed that it was also important to embrace digital initiatives to support the gap around health inequalities. She added that the paper detailed how to leverage at scale the Digital Data and Technology (DDAT) portfolio across all functions. It also detailed how to work together to build on work that had already been done specifically by the Group Analytics Board (GAB), however recognised the different levels of digital maturity across the Foundation Group. The Chief Digital Transformation Officer for WAHT explained that the Group Informatics Proposal articulated five frames of reference for work through the DDAT portfolio which was Strategic Digital Leadership, Business Intelligence and Informatics, Digital Applications, Implementation and Optimization Infrastructure, and Innovation and Engagement. She continued that recently, there had been the publication of the Digital Maturity Assessment that was a national assessment with over 480 questions relating to digital maturity and digital capabilities. She expressed how the Digital Maturity Assessment would form a baseline to be unable to work and centre investment. The Chief Digital Transformation Officer for WAHT concluded by explaining that there was going to be £3.2 billion available for NHS Technology and we need to work together to understand how we can leverage tech to increase productivity. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive thanked the Chief Digital Information Officer for WAHT for her work on developing a more resilient analytics service across the Foundation Group. He highlighted that the Group Digital Transformation	

MINUTE		ACTION
	Proposal and leadership structure would not take away the need for the individual Trust's accountability and ownership. The Group Chief Executive noted the reference to the NHS Technology funding coming in 2025 and that now was the time to focus on the Group Informatics and Technology Leadership and strategic approach in readiness for the investment. The Managing Director for WVT queried how the workstreams were going to report back to the four Boards and requested that the Chief Digital Transformation Officer for WAHT work through this. The Foundation Group Boards approved and ratified the Group Digital Transformation Proposal recognising that: • the proposed leadership structure would not take away the need for individual Trust's accountability and ownership; • specific analytical elements would be further developed through the established GAB structure and approach; and • the timelines set out in the paper would be revisited. **Resolved – that the** **A) the Chief Digital Transformation Officer for WAHT work through the reporting structure of the workstreams, and** **B) the Group Digital Transformation Proposal be approved and ratified.**	**VL**
24.043	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON THE 16 APRIL 2024** The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting on the 16th April 2024. **Resolved – that Foundation Group Strategy Committee Report from the Meeting held on the 16th April 2024 be received and noted.**	
24.044	**FIT AND PROPER PERSONS TEST ANNUAL DECLARATIONS** The Trust Secretary for SWFT/GEH presented the Fit and Proper Persons Test Annual Declarations to the Foundation Group Boards. She explained that the new Fit and Proper Persons Framework for Board members was published in August 2023. The report demonstrates that all Board Members within the Foundation Group are compliant with the new Framework, and all Board Members (voting and non-voting) have completed their annual declarations. The Trust Secretary for SWFT/GEH and the Trust Secretary for WAHT/WVT have completed Fit and Proper Persons checks. **Resolved – that the Fit and Proper Persons Test Annual Declarations be received and noted.**	

MINUTE		ACTION
24.045	**ANY OTHER BUSINESS** There was no further business discussed. **Resolved – that the position be noted.**	
24.046	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
24.018.01	Question from a SWFT Public Governor (West Stratford and Borders) The following question was submitted by the Public Governor in advance of the meeting: *'There is reference in the Deep Dive on UEC in the SWFT section to a private ambulance. Are SWFT providing this service or using this service and to what end?''* The Chief Operating Officer for SWFT explained that SWFT had been using a private ambulance service for patients that were waiting to be discharged back to their usual place of residence. Usually this would be provided by West Midland Ambulance Service (WMAS), however WMAS they had been incredibly strained with the increase in demand especially over the winter months. The Chief Operating Officer for SWFT added that SWFT therefore employed the support from a private ambulance company which had helped maintain flow and prevented longer lengths of stay for patients. **Resolved – that the position be noted.**	
24.047	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
24.048	**CONFIDENTIAL APOLOGIES FOR ABSENCE**	
24.049	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
24.050	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 7 FEBRUARY 2024**	
24.051	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.052	**FOUNDATION GROUP LITIGATION BENCHMARKING**	
24.053	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 16 JANUARY 2024**	
24.054	**ANY OTHER CONFIDENTIAL BUSINESS**	
24.055	**ELECTRONIC PATIENT RECORDS (EPR) UPDATE AND APPROVAL**	

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Thursday 2 May 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
24.056	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 7 August 2024 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chairman) Date: 7 August 2024
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 2 MAY 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
23.080.01 (01.11.2023), 23.058 (02.08.2023), 24.007.02 (07.02.2024) and 24.035.01 (02.05.2024) Foundation Group Performance Report	The Managing Director of GEH provide an update on why GEH were an outlier for cancer diagnosis from ED attendance at the next Foundation Group Boards meeting.	C Free	
23.060 (02.08.2023), 24.007.03, 24.009 (07.02.2024) and 24.035.02 (02.05.2024) Deep Dive into Additional Performance Measures – Theatre Productivity	The Chief Operating Officers look into recording theatre utilisation data by cost per minute rather than by a percentage. The Chief Operating Officers' look at the variations in the Foundation Group Performance Report, particularly around theatre utilisation, and look at where improvements on productivity could be made across the Group based on best practice.	H Heran / R Snead / A Parker / H Lancaster	Chief Operating Officers are in the process of recalculating theatre productivity to include an indication of the resource cost per unit. Theatre Productivity and Utilisation would be picked up as part of the COO's deep dives schedule in August 2024
24.040 (02.05.2024) Implementation of the Sexual Safety Charter	The Chief People Officer's discuss ways to further support staff and members of the public with national schemes and safe words.	G Nic Philib / Geoffrey Etule / A Keoltgen	
24.042 (02.05.2024) Group Informatics Proposal	The Chief Digital Transformation Officer for WAHT work through the reporting structure of the workstreams.	V Lewis	

REPORTS SCHEDULED FOR FUTURE MEETINGS			

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Update from the Integrated Care Executive (ICE)
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	ICE, Trust Board
Lead Executive Director:	
Author:	Erica Hermon (Company Secretary), on behalf of Frances Martin (NED)
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the WVT Board on the ICE meetings.

2. Recommendation(s)

The WVT Board is invited to note the continuing development of ICE in providing oversight and assurance in relation to agreed areas of responsibility, including delegated services. There were no issues escalated to the One Herefordshire Partnership (OHP).

3. Executive Director Opinion[1]

ENHANCED CARE IN CARE HOMES

Primary Care Networks (PCN's) are working on the annual stock take of NHS England's Enhanced Health in Care Homes (EHCH) framework which is due to finish end May and will be taken to OHP in June 2024. Additionally, work is ongoing to improve collaborative working and to overcome barriers such as information governance, alongside a full review of the governance of meetings.

PCNs are looking to improve the discharge process with a basic protocol and pathway development, notwithstanding the high turn-over of care home beds and care homes feeling increased pressure. On which point, the first two steering group meetings had taken place and have received positive feedback from care home managers. The main issues discussed were:

- Developing a template to capture and feedback incidents and risks.
- The need to address safeguarding concerns.
- Working with WVT regarding medically fit for discharge as care homes have varying degrees of staff competency which needs to be considered.

DISCHARGE TO ASSESS (D2A)

Critical data, provided through a dashboard, was now in place. Although further refinement was required, it had already improved visibility of the process.

To ensure appropriate support for every patient, irrespective of discharge destination, a new matrix for therapy had been agreed and would allow patients' to be rated according to their re-enablement needs.

ICE acknowledged the improvements that had been seen for pathway 1 patients and the D2A system working required to achieve this. That said, further work was still required to improve the bed days lost, particularly for Powys patients.

Additional staff had been recruited into the Bridging Team (3.42 WTE) and embedded within the Hospital @ Home team so that the capacity could be maximised

[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.

From July 2024, the D2A Board would be relaunched to include more specific attendance and monitoring of individual services.

BETTER CARE FUND

ICE were advised that given there is less money available in 2024/25, funds would need to be managed carefully; all services funded belong to one or other of the partners who understood the budget and its constraints.

The biggest risk was determined to be with discharge services. Notwithstanding the improvements already made in providing an integrated approach and the provision of domiciliary care, in 2024-25 it was essential to design and deliver an affordable D2A solution. Capacity and demand work would commence this month in order to find efficiencies.

ICE acknowledged that the BCF funding streams can be shaped to match the OHP priorities. Accordingly, while the OHP holds overall responsibility for the BCF, ICE will oversee the funds and where necessary and appropriate seek OHP approval to change the distribution of funds.

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☒ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***Sustainability*** ☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*** ☒ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***Research*** ☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Report to:	**Public Board**
Date of Meeting:	**06/06/2023**
Title of Report:	Quality Committee 29 February 2024 Minutes and Escalation Report
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Chair Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and QC Chair
Documents covered by this report:	Quality Committee Minutes February 2024

1. Purpose of the report

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

To consider the summary report and minutes and to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement	***Sustainability***
☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***	☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***
☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***	☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***
☒ ***Work with partners to deliver the improvement plan for Children's services***	☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***
Digital	***Workforce***
☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***	☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***
☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***	☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***
☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***	☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***
Productivity	***Research***
☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***	☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***
☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***	☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***
☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	

[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.

Matters for Noting

1. **Colposcopy Report** – Committee considered the 6 monthly colposcopy report noting recent capacity and waiting-times challenges for screening-programme and GP referrals. Workforce challenges are being addressed and in the meantime clinics have been reconfigured to offer more slots with additional clinics also scheduled at weekends. Quality Committee has focussed in particular on our treatment response where around 75% of patients opt for conservative treatment ie ongoing surveillance. The next report will focus on an audit of patients opting for conservative treatment and their outcomes. Committee noted excellent results from the colposcopy patient survey.

2. **Quality Priority – Timely Critical Medications -** Committee had concerns that progress has been slower than planned with some improvements in Parkinson's patient's delays but no widening of the programme to other conditions and progress still to be made on self-administration. These issues will be reviewed =before the next report.

3. **Quality Priority – Infection Prevention and Control** – The Trust is on track to end the year below our CDif trajectory. Committee noted the improved rigour in cleanliness audit reporting and asked for further information on problem issues.

4. **Quality Priority – Pressure Ulcers** – Committee was concerned to note an increasing trend in pressure ulcers and acquired tissue damage, some associated with an increase in frailty numbers, though there are improvements in Integrated Care Division. Some time is needed to allow the new PSIRF approach to make an impact.

5. **Quality Priority – Improving Patient Experience –** The main area of focus and concern continues to be our response times to concerns and complaints. Our approach is being reviewed following new NHS complaint standards and PHSO guidance.

6. **Maternity PQSM and Quarterly Report –** 2 positive reports: Committee was pleased to note excellent results from the CQC Maternity Survey where the Trust is in the top 5 Trusts regionally for all 5 domains. Staffing cover and sickness continue to improve with no use of agency since November. No issues were raised at the last Safety Champions (out of hours) walkabout.

7. **Staffing Report** – Staffing Challenges continue through a combination of patient numbers (particularly boarders), acuity and unfunded areas. Fill rates also reflect/mask anomalies in our "down-time" allowances and Trust Management Board has agreed some adjustments to reflect this more accurately. Committee also noted the additional measures now in place to agree sign-off of additional shifts.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 29 February 2024 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Chizo Agwu	CA	Chief Medical Officer
Ellie Bulmer	EB	Associate Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director

In attendance:		
Sadhia Akhtar	SA	Consultant Obstetrics and Gynaecology – For Item 4.1
Helen Harris	HH	Integrated Care Boards Representative
Rachael Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Leah Hughes	LH	Advanced Practitioner Radiographer – Arrived during Item 3
Val Jones	VJ	Executive Assistant (for the minutes)
Neil Lawson	NL	Chair of the Cleanliness Committee – For Item 6
Sue Moody	SM	General Manager, Acute and Countrywide Services
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Kate O'Shea	KO	General Manager, Womens and Childrens – For Item 4.1
Emma Smith	ES	Associate Chief Nursing Officer – Surgery Division
Emma Wales	EW	Associate Chief Medical Officer, Medical Division – Arrived during Item 3
Laura Weston	LW	Lead Infection Prevention Nurse – For Item 6
Raechel Wordsworth	RW	Medicines Safety Officer – For Item 5

QC001/02.24	**APOLOGIES FOR ABSENCE**	
QC002/02.24	**QUORUM**	
QC003/02.24	**DECLARATIONS OF INTEREST**	
QC004/02.24	**MINUTES OF THE MEETING HELD ON 25 JANUARY 2024**	
QC005/02.24	**ACTION LOG**	
	BUSINESS SECTION	
QC006/02.24	**COLPOSCOPY REPORT**	
QC007/02.24	**QUALITY PRIORITY – ENSURING PATIENTS RECEIVE TIMELY CRITICAL MEDICATIONS**	
QC008/02.24	**QUALITY PRIORITY – IPC (CLEANLINESS/CDIFF) AND INFECTION PREVENTION QUARTERLY REPORT**	

QC009/02.24	**QUALITY PRIORITY – PRESSURE ULCER REPORT**	
QC010/02.24	**QUALITY PRIORITY – IMPROVING PATIENT EXPERIENCE QUARTERLY REPORT**	
QC011/02.24	**CQC REPORT AND UPDATED ACTION PLAN – EMERGENCY DEPARTMENT**	
QC012/02.24	**MORTALITY REPORT**	
QC013/02.24	**DIVISION QUARTERLY REPORT – MEDICAL DIVISION**	
QC014/02.24	**MATERNITY QUARTERLY REPORT AND PQSM**	
QC015/02.24	**STAFFING REPORT**	
QC016/02.24	**BOARDING OPERATIONAL REPORT**	
QC017/02.24	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
QC018/02.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
QC019/02.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	CONFIDENTIAL SECTION	
QC020/02.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
	The Patient Safety Incidents Summary Report was taken as noted but will be added as the first item on the next agenda to ensure appropriate time to discuss the Report.	
QC021/02.24	**ANY OTHER BUSINESS**	
QC022/02.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 28 March 2024 at 1.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**06/06/2023**
Title of Report:	Quality Committee 28 March 2024 Minutes and Escalation Report
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Chair Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and QC Chair
Documents covered by this report:	Quality Committee Minutes February 2024

1. Purpose of the report

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

To consider the summary report and minutes and to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement	***Sustainability***
☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***	☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***
☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***	☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***
☒ ***Work with partners to deliver the improvement plan for Children's services***	☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***
Digital	***Workforce***
☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***	☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***
☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***	☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***
☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***	☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***
Productivity	***Research***
☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***	☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***
☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***	☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***
☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	

[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.

Matters for Noting

1. **Quality Priority - Nutrition** – Committee received an update on the work to improve nutrition and noted the work to ensure safety in placement of naso-gastric feeding tubes with the new local procedure waiting sign-off by the CEAC. The Trust has also developed improved processes to counter nutrition and hydration risks on wards with a new Digital Dashboard enabling oversight of compliance with MUST assessments. Food scores generally are improving and the PLACE audit scores will allow understanding in.
   In view of progress made, Quality Committee agreed to stand-down Nutrition as a Quality Priority.

2. **Quality Priority – Mental Capacity Act and Deprivation of Liberty Safeguards -** Committee had concerns that progress has been slower than planned with success evident on staff training but the planned follow-up audits yet to take place. However, an Internal Audit assessment of staff awareness had raised similar issues to those previously found by CQC, indicating the need for further work.
   Given these concerns, Quality Committee will continue to scrutinise progress via the quarterly safeguarding reports.

3. **Quality Priority – Improving Management of the Deteriorating Patient** – Committee noted good progress in this area with NEWS scores monitoring improved from 26% to 73% and better oversight to ensure these are being carried out in a timely manner. Work is also in train to ensure escalation of care where this is needed and to ensure effective handovers. We are also reviewing enhanced care monitoring models from other Trusts.

4. **Maternity PQSM Report –** Committee noted in particular that there was a Safety Champions walkabout out-of-hours in January which had access to a wide range of staff and a shift handover. There were no concerns raised by staff.
   Separately Committee noted the high turnover of Band 3's which is partly as a result of the positive work done to support career progression of Band 3 Health Care Support Workers meaning loss of some Midwifery Support Workers. This is being addressed through evaluation of the roles and similar opportunities for career progression.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 28 March 2024 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Chizo Agwu	CA	Chief Medical Officer
Ellie Bulmer	EB	Associate Non-Executive Director
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
In attendance:		
Jonathan Boulter	JBo	Associate Chief Operating Officer, Surgical Division
Claire Carlsen	CC	Associate Chief Operating Officer, Medical Division
Jo Clutterbuck	JC	Acting Associate Chief Operating Officer, Medical Division – For Item 11
Helen Harris	HH	Integrated Care Boards Representative
Rachael Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Sue Moody	SM	General Manager, Acute and Countrywide Services
Rachael Skinner	RS	Integrated Care Boards Representative – Left after Item 5.1
Emma Smith	ES	Associate Chief Nursing Officer – Surgery Division – For Item 16

QC001/03.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Lucy Flanagan, Chief Nursing Officer, Leah Hughes, Advanced Practitioner Radiographer, Hamza Katali, Associate Chief Medical Officer, Clinical Support Division, Tony McConkey, Clinical Director, Pharmacy, Tom Morgan-Jones, Deputy Chief Medical Officer, Nicola Twigg, Non-Executive Director and Emma Wales, Associate Chief Medical Officer, Medical Division.	
QC002/03.24	**QUORUM**	
	The meeting was quorate.	
QC003/03.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/03.24	**MINUTES OF THE MEETING HELD ON 25 JANUARY 2024**	
	QC020/01.24 – To change the Associate Chief Operating Officer, Medical Division to Associate Chief Operating Officer, *Clinical Support* Division.	
	Resolved – that with the one agreed amendment, the minutes of the meeting held on 25 January 2024 be received and approved.	

QC004a/03.24	**MINUTES OF THE MEETING HELD ON 29 FEBRUARY 2024**	
	QC013/02.24 – Bullet Point 4 – To add – *Frailty Same Day Emergency Care* – at the start of the paragraph.	
	Resolved – that with the one agreed amendment, the minutes of the meeting held on 29 February 2024 be received and approved.	
QC005/03.24	**ACTION LOG**	
	(a) QC005/01.24 – (B) – Action Log – The specific actions around specialties from Patient Surveys will be included in the next Clinical Support Division Quarterly Report.	**CC**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The specific actions around specialties from Patient Surveys will be included in the next Clinical Support Division Quarterly Report.**	**CC**
	CONFIDENTIAL SECTION	
QC006/03.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC007/03.24	**RISPERIDONE ISSUE**	
	BUSINESS SECTION	
QC008/03.24	**NUTRITION QUALITY PRIORITY UPDATE**	
	The Associate Chief Nursing Officer (ACNO) presented the Nutrition Quality Priority Update and the following comments were noted: • LocSSIPs have been developed to further ensure the safety of NG placement. This is going through the Clinical Effectiveness and Audit Committee in terms of the governance structure for sign off. We will then be able to close the Trust risk associated with this. • Patient Food Surveys – There is a lot of data to be triangulated. The PLACE Audit highlighted concern around food but all the responses from the surveys vary. We are developing a Food and Drink Strategy with colleagues and partners involved in this. A Working Group is pulling all these areas together. • Approval is requested from the Quality Committee to close Nutrition down as a Quality Priority as significant progress has been made and there is an established governance structure in place.	

	• The CMO noted that there was a Round Table recently regarding malnutrition and queried whether we have the right processes in place to mitigate such risks. The ACNO confirmed that we are in a much better position with the importance of nutrition and hydration being highlighted directly into ward areas along with MUST audits being undertaken. The Digital Dashboard enables us to see every ward area and how many MUST Assessments have been completed. We are also moving forward with Ward Accreditation which is an opportunity for wards to show evidence of best practice. • Mrs Rouse (ANED) queried if the HSIB Review findings highlighted anything that is a quality concern for the Trust. The CMO advised that we have received the Report in draft and the Executive Director's Opinion on the Front Sheet answers this question. • Mr James (Chair and NED) asked for an update on the agreed procedure for dealing with NG tube insertion. The ACNO advised that there is a Policy, which includes all elements, which has almost been finalised. This will be presented to CEAC for approval. • Mr James (Chair and NED) queried how we are addressing the issues around quality of food. The ACNO advised that we have had improved food scores with Sodexo and Estates jointly monitoring and reporting on this. We have only just received the PLACE audit and are reviewing this in finer detail. Community Hospitals consistently have good food scores. The Food and Drink Strategy will help support this.	
	<u>Resolved</u> – that the Nutrition Quality Priority Update be received and approval given to stand Nutrition down as a Quality Priority.	
QC009/03.24	**<u>QUALITY PRIOIRTY – MCA & DOLS UPDATE</u>**	
	The ACNO presented the Quality Priority – MCA & DoLS Update and the following key points were noted: • Details of mandatory training are included in the Report with bespoke training being delivered along with open access training and individual training if a member of staff is involved in an incident. • The Staff Questionnaire Audit is included in the Report. It is difficult to translate from all the training delivered to a practical application to measure if we are achieving what is set out in our Quality Priority. This was sent out to all senior clinical staff with only 44 responses received. An Action Plan was developed in terms of improving and offering more bespoke sessions, re-auditing patient records in terms of the quality of the MCA and DoLS work and repeating the questionnaire in December. Due to staff shortages we have not been able to undertake a qualitative audit yet but this is planned in the future.	

	• Mrs Hill (NED) queried how we get assurance that training staff will improve outcomes. The ACNO advised that this is difficult to measure. It is around the practical application of MCA and DoLS and we can only monitor the incidents raised. Mandatory training sessions are centrally prescribed so we are unable to change the content. We can develop more bespoke training sessions if required. • The Integrated Care Boards Representative suggested that staff are asked whether they have the tools required to practically apply the guidance. There also needs to be a support mechanism which is easily accessible The ACNO advised that Clinicians are heavily involved with the Flow Charts for our current MCA/DoLS Policy which has helped them implement this in clinical practice. We have been able to internally transfer an Assistant Practitioner for 6 months to enable more visibility across the wards and to raise the profile of Adult Safeguarding in general and to challenge around MCA and DoLS and best interests. • Mr James (Chair and NED) noted that there is some concern that we have not achieved what we set out in our Quality Priority. The audit found much of what the Care Quality Commission found around the challenges that we still face. We need to ensure that the right plans are in place with the right capacity within the team. He questioned what more Quality Committee can do to ensure we make the progress required for next year. The ACNO advised that the Band 4 support should make an impact on this. Mr James (Chair and NED) advised that the Committee can always ask for a report on a specific area if required as the Quarterly Safeguarding Report is wide ranging and includes a lot of detailed information.	
	<u>Resolved</u> – that the Quality Priority – MCA and DoLS Update be received and agreed that future Reports will be included within the Quarterly Safeguarding Reports.	
QC010/03.24	**<u>QUALITY COMMITTEE TERMS OF REFERENCE</u>**	
	The ADQG presented the Quality Committee Terms Of Reference and the following key points were noted: • There are only minor amendments which are highlighted. • It was agreed for discussions to be held around which Quality Priorities will be included to be undertaken before these are approved.	
	<u>Resolved</u> – that the Quality Committee Terms Of Reference received and approved at the April Quality Committee meeting.	

QC011/03.24	**QUALITY PRIORITORIES PROPOSAL 2024/25**	
	The ADQG presented the Quality Priorities Proposal 2024/25 and the following key points were noted: • The paper outlines 3 possible additions. • Oversight training for PSIRF – Training has shown that we need to be working in tandem. • Pressure Ulcers – We have made some progress but we need to make further improvements. The highest reported incidents are for Grade 2 pressure ulcers. • VTE – Returning to reporting online in July nationally. We are not yet meeting this target. Engagement in the Thrombosis Committee varies, with the Deputy CMO working on this. • Deteriorating Patient – There is a clear framework of what we want to achieve and the Committee is now in place. • C-Diff Rates and Cleanliness Standards – Our C-Diff numbers are below trajectory and there is strong governance in place regarding our Cleanliness Standards. The Chief Nursing Officer recommends that this is no longer needed as a Quality Priority. • Patient Experience – There has been some improvement but further work is needed. Better responsiveness to concerns and complaints is needed. • Time Critical Medications – We are not seeing the progress with this as planned. • CQUINS are formally suspended for 2024/25. Reviewing whether this will change in the future. Resource linked to this programme is being utilised to support Quality Priorities. • The Managing Director agreed further support is needed for Patient Experience regarding the responsiveness to complaints and learning. • The Managing Director questioned the difference between NatSSIPs 1 and 2. The ADQG advised that there are a lot of different standards around training and education and taking a holistic approach. There is concern that we have not started on this yet. • Mrs Martin (NED) advised that the Trusts Objectives were discussed at the One Herefordshire meeting. Duty Of Candour – We always need to be as open and honest as we can. Having a different way of approaching this is important and is an important priority.	

	• The Integrated Care Boards Representative advised that the system discussion is around pressure ulcers which requires a system approach. She also shared the concerns around work not starting on NatSSIPs yet. • The Integrated Care Boards Representative advised that the Secretary Of State has commissioned a review around Duty Of Candour and suggested that we await this before taking this forward. • Mr James (Chair and NED) noted that there is a large amount of work needed around NatSSIPs and queried whether we have this as a separate Quality Priority to enable focus on this. The CMO advised that we need to consider how we get engagement around this. A paper will be presented to a future meeting around how we plan to improve our approach for NatSSIPs. • Deteriorating Patient – The CMO advised this still requires Quality Committee oversight and further discussion is needed before we make a decision around standing this down. • C-Diff and Cleanliness Standards – It was agreed to stand this down as suggested by the Chief Nursing Officer. • The Managing Director questioned how we report on the Patient Safety Priorities, The ADQG suggested that these are reported to the Quality Committee on a routine basis. • Mr James (Chair and NED) summarised that there are 3 Quality Priorities for consideration – NatSSIPs needs further discussion and an update provided, Duty Of Candour again needs further consideration and Learning From Deaths with the process now re-established. The CMO advised that updates could be provided as part of the Mortality Report. • It was agreed that the Quality Priorities Proposal 2024/25 will be presented to the April Quality Committee meeting including the comments made in the meeting.	**CA** **NO**
	<u>Resolved</u> – that: **(A) The Quality Priorities Proposal 2024/25 be received and noted.** **(B) A paper on the plans to improve our approach to NatSSIPS will be presented to a future Quality Committee meeting.** **(C) The Quality Priorities Proposal 2024/25 will be presented to the April Quality Committee meeting including the comments made in the March meeting.**	**CA** **NO**

QC012/03.24	**MORTALITY REPORT**	
	The CMO presented the Mortality Report and the following key points were noted: • Our SHMI remains stable at 101.4, a reduction from the previous month. • There are key changes that might affect our SMHI in the future – Same Day Emergency Care (SDEC) data is being removed which means that our denominator will reduce. Secondly, Covid deaths will now be included in our SHMI. Depending on how Covid affects various Trusts will depend on how this affects our SHMI. • The SPC chart has been changed to enable clearer identification of trends. Our crude mortality appears to be reducing after the expected peak in December. • Mortality InPhase work has almost finished. This will provide a platform for our Medical Examiners to undertake reviews and pull off reports easily, to see trends and collect Next Of Kin information. • Learning From Deaths Committee – There is a flow chart included in the Report around how this works. • There are 2 new Committees being set up – Mortality Review – This is a standing panel which will undertake in depth reviews on any deaths with issues in care to establish whether they were avoidable or not. The second is the Learning From Deaths Committee – This is for assurance with appointed Mortality Leads, who are receiving their training in April. Mortality Reviews are being undertaken in their specialties but this will enable them to present their work to the Committee along with learning and actions. Key areas will be discussed for wider learning. • The Managing Director queried why we are removing our SDEC coding now rather than the mandated June date. The CMO advised that the SHMI helps us understand our numbers and ensure that we do not lose focus on our outlier groups. Some Trusts have already removed their data so we will not be able to compare accurately against other Trusts for a few months. • Mrs Martin (NED) noted that crude mortality does not include Emergency Department (ED) deaths and we know that patients are spending longer in ED than we would want. We need to ensure that we do not have a problem that we are not sighted on.	
	Resolved – that the Mortality Report be received and noted.	

QC013/03.24	**<u>QUALITY PRIORITY – IMPROVE MANAGEMENT OF THE DETERIORATING PATIENT</u>**	
	The CMO presented the Quality Priority – Improve Management of the Deteriorating Patient and the following key points were noted: • There are 3 areas to improve upon – detection, escalation and timeliness and quality of the response. • Detection – The teams have been asked to work with colleagues to refine the dashboard to ensure that this gives us the information needed to ensure we have situational awareness if observations are not being carried out in a timely manner. • Escalation and Timeliness – The Deputy CMO is leading on this. We need to understand the number of enhanced beds required in the Trust. We are reviewing models from other Trusts to understand how they have set up their enhanced monitored care. • There has been a marked improving in NEWS monitoring from 26% to 73%. • A Business Case for a 24/7 Outreach Service is the first step to formally bringing in Martha's Rule. • We are reviewing the quality of information when deteriorating patients are being handed over. The SBAR Tool is a standardised tool to ensure that the correct information is given. • Education and Training – We are looking at compliance and the culture of escalation of care. Escalation does not always take place to senior doctors as the Policy states. We are working to underpin what is driving this culture. The Committee are focusing on Quality Improvement work but we want this to be business as usual with Divisions providing the assurance.	
	<u>Resolved</u> – that the Quality Priority – Improve Management of the Deteriorating Patient was received and noted.	
QC014/03.24	**<u>BOARDING REPORT</u>**	
	The Acting Associate Chief Operating Officer, Medical Division presented the Boarding Report, which was taken as read, and the following key points were noted: • The level of boarding has increased in February. This is related to the increase in numbers through the Front Door and the issues around transferring patients, especially to surrounding areas. • March numbers have reduced but there is still heavy reliance on boarding. We need to mitigate this as much as possible.	

	• There has been a slight reduction in the number of incidents. We are working with surgical colleagues regarding the new process around who is suitable to be boarded in hours. • Boarding is discussed at every Bed Meeting. • National 4 hour wait reduction in ED – We have significantly improved on this in the Trust despite the number of boarders. • Mr James (Chair and NED) was interested in the Acting Associate Chief Operating Officers, Medical Division view with a "fresh pair of eyes". The Acting Associate Chief Operating Officer, Medical Division advised that this was discussed at the Finance & Performance meeting held the previous day. The number of patients coming through the Front Door are not in our control but there are some processes that we can improve upon. A Working Group has been set up and we are working with the Integrated Care Division. The Acting Associate Chief Operating Officer, Medical Division and the Associate Chief Nurse, Medical Division are meeting to review the process from the Front Door to discharge to review where the bottle necks are or processes that are not working. The findings will be included in a future Boarding Report. • The CMO advised that the Chief Transformation and Delivery Officer led a Workshop on Acute Hospital Capacity with different workstreams looking at the Virtual Ward and reducing length of stay. The Elective Surgical Hub also gives us an opportunity to look at how wards are set up and whether they can be reconfigured. We are also improving discharge pathways. • Mrs Martin (NED) noted that the Discharge Lounge is in the wrong place and design and that there is a long term plan to relocate this, but in the short term we need to improve on this. The additional resource of volunteers supporting in the Discharge Lounge will help with this. We also need to understand by wards are boarding patients differently.	
	<u>Resolved</u> – that the Boarding Report be received and noted.	
QC015/03.24	**<u>EMERGENCY DEPARTMENT CQC ACTION PLAN</u>**	
	The Associate Chief Nurse, Medical Division presented the Emergency Department CQC Action Plan and the following key points were noted: • Of the 88 actions, 59 have been completed. We are meeting fortnightly to ensure these are being addressed. Key are the "Must Dos" that are outstanding. • Documentation and Audits – Band 7 staff are conducting weekly audits and are supported by the Audit Lead. • The Observation Standard Operating Procedure is being reviewed to ensure consistency.	

	• Information board – The ED Dashboard captures all patients NEWS that are above 5. This provides senior staffing oversight. • Clinically Led Navigation – A GP commenced in this role this month with the Navigation Nurse. This has already improved performance, with 28 patients re-signposted yesterday with the majority going home. We are hoping to continue this service into April. • We are reviewing Band 7 posts to ensure that we have 7 day oversight by a Senior Nurse. • Deteriorating Patients and Sepsis – Audits are being conducted by Consultants and snapshots of 10 patients are being undertaken to see if there are any improvements. • There is focus on medical and nurse staffing as it has been deemed not sufficient to run the Department safely. A Business Case for additional Medical Staffing was approved at the Trust Management Board with a Nurse Staffing Business Case being presented next month. • Governance – A new ED Consultant has been appointed who is engaging with governance and is Chairing monthly meetings with ED staff. • Mental Health Concerns – A new room in Majors has been incorporated into our planning. The plan is to include this in the lifecycle plans to minimise disruption. • Mr James (Chair and NED) found the Action Plan difficult to read and asked that the highlights only be included in future reports with bullet points in the Covering Report only needed. • The Managing Director noted the language being used to describe the GP service in ED as a GP Navigator. Primary Care and the concern that this is giving the message that a patient will be seeing a GP in ED. It is important that everyone is aware that they are part of a clinical team and not a GP. • The Associate Chief Nurse, Medical Division confirmed that are caveats for patients that are not streamed through this service.	**SH**
	<u>Resolved</u> – that: **(A) The Emergency Department CQC Action Plan be received and noted.** **(B) The Action Plan in future Emergency Department CQC Reports will include the highlights only with bullet points covering key points in the Covering Report.**	**SH**

QC016/03.24	**MATERNITY PQSM REPORT**	
	The Associate Director Of Midwifery (ADM) presented the Maternity PQSM Report, which was taken as read, and the following key points were noted: • The minimum data set is a national requirement. This is suitable for this forum but is presented currently to the Private Board of Directors due to the sensitive nature of the Report. • There were no perinatal losses, no HSIB cases, no concerns raised by HSIB and no Coroner regulations. • There was one PSII reported during January. The ADM provided the background to the case. • Our sickness rate is amber, but this is lower than it has been for some time. This fluctuates through different areas. • MSW Position – There is a high turnover rate. Since the Band 3 uplift of some Health Care Support Workers, some staff have left to obtain roles that are less demanding for the same grade in the Trust. A piece of work is being undertaken around re-evaluating the previous Band 3s as there is some disparity around this. • There are improved positions across much of the medical workforce. • We have received 1 complaint during January. The ADM provided the background. We have learnt from a neighbouring Trust where they store all Penicillin containing medications in a separate place to increase knowledge around these medications. • Complaints – So far we have received 8 complaints this year, we received 9 last year. • The Safety Champions undertook a walkabout in January out of hours. This provides access to a wider range of staff and crossover of shift. There were no concerns raised by staff. • There was 1 post-partum haemorrhage with an MDT Rapid Review taking place and downgrading the incident as care provided was appropriate. • Training Data – There have been improvements as well as a discrepancy in data which means that our position is more positive than thought. • Mr James (Chair and NED) queried if there was a progression pathway for the Band 3 staff. The ADM advised that there is little opportunity to progress further. Apprenticeships recently put in place offer a clear pathway for progression. If this goes well, more apprenticeships will be offered in future years.	

	<u>Resolved</u> – that the Maternity PQSM Report be received and noted.	
QC017/03.24	**<u>DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE DIVISION</u>**	
	The General Manager, Acute and Countywide Services presented the Divisional Quarterly Report – Integrated Care Division and the following key points were noted: • Falls rates have increased in Community Hospitals along with an increase in incident reporting. We achieved a very low level last year so are now back to expected levels along with having more beds open. • There were 4 complaints received during the period, details within the Report. • There has been an issue with overdue incidents on InPhase for a variety of reasons. This number has now reduced. • Tissue Viability incidents are included in the Report for District Nurses and Community Hospitals. This peaked in January but reduced in February. • There were 5 Infection Prevention outbreaks across 3 Community sites during this period. • We have achieved a Band A in our SSNAP audit data for the first time in the Trust. • Stroke Community Project – Early results from this project show improvements. Details within the Report. • There was a new leadership team in December in Leominster which is already showing improvements. • District Nursing Bags – Due to charitable funds, the Team have a bag each to store their equipment and dressings securely. • NEDs have been visiting Community Hospitals which the teams have found very useful. • Recruitment is an ongoing issue and it is not always possible to book agency staff. There are also District Nurses capacity issues and we have lost 2 managers. • The Managing Director queried regarding stroke, how we compared for timeliness for discharge to the Early Supportive Discharge Team and if more investment would enable better results. The General Manager, Acute and Countywide Services advised that the Trust have good results in this area. Hillside was closed as a Stroke Rehabilitation Unit and staff were redeployed to the Community There is good discharge planning on Wye Ward and it is rare that stroke patients are admitted onto another ward which is positive.	

	<u>Resolved</u> – that the Divisional Quarterly Report – Integrated Care Division was received and noted.	
QC018/03.24	**<u>DIVISIONAL QUARTERLY REPORT – CLINICAL SUPPORT DIVISION</u>**	
	The Associate Chief Operating Officer, Clinical Support6 Division presented the Divisional Quarterly Report – Clinical Support Division and the following key points were noted: • There are 2 areas of concern – lower reporting of incidents and overdue incidents. Work is occurring in the monthly Governance Meetings around areas that should be reporting incidents. Due to changes in staff, overdue incidents have not been reallocated to new staff to pick up the actions – this has now been addressed. • There are no concerns regarding NICE and CAS Alerts. We have implemented I-Passports, background provided. • Radiology – The Associate Director Diagnostic Programmes have been attracting capital with new MRI AI software being installed in our scanners in May which should increase our capacity. We have also recruited 10 international Radiographers. • Urgent Care 76% Challenge in March – One of the Radiologists and ED Consultants are working together regarding this. • There has been a successful bid for another Mammography machine which will be in place in October. • We have successfully recruited a Lung Screening Manager. • There is a trial in ED of an Imaging Portal to help improve requests to scan times. We are delivering over 95% in all mortalities apart from Dexa. Key achievements are now achieving scan to reporting time for faster diagnosis patients between 1 – 3 days which is a significant improvement. • There are concerns over the suspension of Dexa scanning, with scanning recommended on 12 March. The Advanced Practitioner Radiographer is reviewing plans on dealing with the backlog and managing this risk. • Pathology – A new General Manager and Clinical Director commenced in post in January. Last week, the Head of Blood Sciences was appointed. • As part of the SMP Networking, we are developing the Managed Laboratory Services tender. A 12 month contract has been agreed with Roche whilst this is being developed. • There is a long standing issue with recruiting Histopathology Consultants. Positively there are 2 applicants for the interviews in April.	

	• Microbiology staffing continues to be of concern. There is Locum and Associate Specialist cover currently. We are working with the Network for a medium and long term solution. • The Data Manager is looking at an almost live dashboard to be launched in the next few weeks to manage cancer site turnaround times. • Histopathology are increasing their dissection capability which will improve turnaround times. • Mortuary – The Eden tracking system has been approved and will implemented over the next couple of months. • A Mortuary Manager has been appointed. They will provide links with the Foundation Group to support and help with trainee APTs. • Pharmacy – Senior Pharmacy recruitment is improving with 3 appointments since November and 2 members of staff returning to work. There is also an international recruitment scheme starting for Band 6 staff. The first Hospital Pharmacy Assistant in the Midlands has been trained to become an accredited Checking Dispenser. • The Associate Chief Operating Officer, Medical Division is very proud of the Pharmacy Team for sustaining the service during a period of reduced staffing and their ability to continue our dispensing accuracy reliability rate of 99.95%. There is still concern around the ongoing national shortage of Pharmacists. • Patient Access – Several specialties have now agreed to move forward with e-RS, with the roll out over the next 4 months. • Virtual Fracture through Outpatients is in place from April. • Patient Access have achieved 4.5 out of 5 stars for Friends and Family scores on Outpatients. • There has been difficulty recruiting Band 2 staff in the Referral Management Centre (RMC). The team are working with Recruitment and local colleges to advertise this role. There are now apprentices in post. • The issue around the proposed new phone system for the RMC has been resolved. • A permanent Cancer Transformation Manager and Data Validation Co-Ordinator are in post. A Non-Specific CNS has been appointed for 2 years for cancer. • An agreed career progression pathway for SACT Chemotherapy Nurses has been agreed. • 28 day performance was at 79% but is 80% for March which is very positive.	

	• Haematology – A new medical model has been approved with trainee ACPs to help this service whilst they have challenges with their clinical recruitment. • There is no agreement if we lose any of our Locums but there are ongoing conversations around this with the ICB. • The CMO queried why only the Clinical Support Division was introducing the I-Passport and whether this was due to licensing issues. The Associate Chief Operating Officer, Medical Division confirmed that there was an issue with licenses but will review whether we are able to progress this to the wider Trust. • The Managing Director congratulated the Division for achieving the virtual Fracture Clinic which has been some years in achieving. • The Integrated Care Boards Representative questioned whether there is any harm to patients regarding the delays in Dexa scanning and if the team are working with the GPs regarding the backlog of reports. Will the Closure Report come back to the Quality Committee? The Integrated Care Boards Representative advised that the Advanced Practitioner Radiographer is leading on this from a Radiology perspective and producing a paper on this. The Chief Transformation and Delivery Officer is also providing a weekly update at the Executive Directors meeting. The Chief Transformation and Delivery Officer and the Associate Director Diagnostic Programmes also attending the GP Leadership Forum to provide updates. Mr James (Chair and NED) suggested that the update is provided as part of the quarterly reporting.	**CC** **CC**
	<u>Resolved</u> – that: **(A) The Divisional Quarterly Report – Clinical Support Division be received and noted.** **(B) The Associate Chief Operating Officer, Medical Division will review whether we are able to progress introducing the I-Passport to the wider Trust.** **(C) The Closure Report on the delays in Dexa scanning and any patient harm caused will be presented in the next Clinical Support Division Quarterly Report.**	**CC** **CC**
QC019/03.24	**<u>STAFFING REPORT</u>**	
	The ACNO, Surgical Division presented the Staffing Report and the following key points were noted: • It was another busy month in ED and the Trust. Escalation Areas were open along with additional beds in Community Hospital and Endoscopy. • There were high levels of boarders during the day and night.	

	• SDEC is fully functional with agreement for these areas to be funded, not in establishment, until April. • The fill rates reflect this data with many areas above 100%. This does not take into account the additional beds and high patient acuity. • Training is underway for the Safer Nursing Care Tool. The next data collection is from Monday until the end of April. • We have seen a decrease in agency spend in month, just over 16WTE. Bank spend has also decreased. • We have 188WTE above establishment which is a decrease from the previous month. The highest use is in Frailty, Community Hospitals and ED. • Last month's analysis included the utilisation of additional staffing. Funded establishment in Surgery was 124WTE with an extra 63WTE utilised. Of this, 3.5% was for sickness. There is a 2% budget for study leave but for nurse training and TNAs required an additional 7.39%, and other leave (compassionate leave) was 6WTE and supernumerary at 3WTE. Escalation areas not funded was 20.8WTE in month to cover these areas. • Additional staff required for 1-2-1 care is broken down for each Directorate. This was less than requested. • We have also seen a significant reduction in Thornbury usage. • Mrs Martin (NED) asked what is driving the CAMHS support in ED. The Associate Chief Nursing Officer, Surgical Division advised that discussion has been held previously about taking this out of ED figures as the cost needs to move to Medicine. This has not occurred due to the additional resources required by the Finance Team time to move them. • Mrs Martin (NED) queried when will the Trust stop using Thornbury altogether. The Associate Chief Nursing Officer, Surgical Division advised that we struggling with cover SCBU and Paediatrics in the Trust as we do not have these specialised nurses available from ID Medical. We have stopped Thornbury usage in all general wards over the last few weeks. We are working to the July national date of not using off framework agencies. • Mr James (Chair and NED) queried why there are a relatively high number of staffing incidents in the Delivery Suite. The Associate Chief Nursing Officer, Surgical Division advised that this area always has the highest number of incidents and they are very good at reporting. They always report if they have to bring additional staff in. There are no concerns around this area.	
	<u>Resolved</u> – that the Staffing Report be received and noted.	

QC020/03.24	**CLINICAL EFFECTIVENESS AND AUDIT COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Clinical Effectiveness and Audit Committee (CEAC) Summary Report, which was taken as read, and the following key points were noted: • There are a number of ongoing actions from CEAC. Noting that this is a bimonthly meeting but these need to be closed. • Mrs Martin (NED) queried if clinical engagement has now improved. The ADQG advised that NatSSIPS have been an issue for some time with engagement variable. It was agreed at CEAC to pause on NatSSIPS and focus on NatSSIPS 2. • There has been 1 escalation item escalating the options appraisal for future management of procedural documents highlighted resource impacts and weaknesses in governance arrangements. There is a Policy for Procedural Documents but this is not easy to follow and there have been various attempts to improve this. The process is burdensome for staff. There is focus to make this document more manageable.	
	Resolved – that the Clinical Effectiveness and Audit Committee Summary Report be received and noted.	
QC021/03.24	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC022/03.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 25 April 2024 at 1.00 pm via MS Teams.	

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
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
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
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
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
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
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MASD	Moisture Associated Skin Damage
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
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
PROMs	Patient Reported Outcome Measures
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
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