Public Board Meeting

Thu 04 July 2024, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Glen Burley, Russell Hardy, Erica Hermon and Nicola Twigg.

13:01 - 13:01
0 min

2. Declarations of Interest

13:01 - 13:03
2 min

3. Minutes of the Meeting held on the 6 June 2024

Decision *Frances Martin*

2. PUBLIC BOARD MINS - JUNE LF.pdf (16 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

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

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Jane Ives*

4. July 2024 - WVT CEO Report - BOD - DRAFT.pdf (7 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5. WVT IPR Month 2 May 24 - FINAL.pdf (32 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*

13:35 - 13:45
10 min

6. ITEMS FOR APPROVAL

6.1. Digital Strategy

Decision *Katie Osmond*

- 6. Covering Report Template 24-25 v1 Digital Strategy 2024 - 2027_final.pdf (2 pages)
- 6a. Digital Strategy 2024 - 2027 D0.4.pdf (15 pages)

13:45 - 14:25
40 min

7. ITEMS FOR NOTING AND INFORMATION

7.1. ICS and One Herefordshire Update

Discussion *Jane Ives/Jon Barnes*

- ICS and One Herefordshire Update - July 24 Board.pdf (5 pages)

7.2. Agency Reduction

7.2.1. MARP

Discussion *Chizo Agwu*

- 7a. MARP Board Report - M1-M2 April and May 24CA public board.pdf (7 pages)

7.2.2. NARP

Discussion *Lucy Flanagan*

- 7b. WVT IPR - NARP - May Month 2 v2.pdf (9 pages)

7.3. Perinatal Safety Report

Discussion *Amie Symes*

- 8. Perinatal Services Safety Report.pdf (15 pages)

7.4. Guardian Of Safe Working

Discussion *Chizo Agwu*

- 9. Guardian of Safe Working CMO report.pdf (1 pages)

7.5. Freedom To Speak Up Annual Report

Discussion *Jo Sandford*

- 9. FTSU Full Year 2023-24 - July Public Board.pdf (8 pages)

7.6. Committee Summary Reports and Minutes

7.6.1. Audit Committee Report and Minutes 23 April 2024

Discussion *Frances Martin*

- 11.1.a AC Front Sheet.pdf (1 pages)
- 11.1b. Audit Summary April 24 (July submission).pdf (1 pages)

7.6.2. Quality Committee Report and Minutes 25 April 2024

Discussion *Ian James*

- 13.3a QC Summary April 24 Public.pdf (2 pages)
- 11.3b QUALITY COMMITTEE MINUTES APRIL.pdf (18 pages)

14:25 - 14:25
0 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 07.06.24.pdf (3 pages)

14:30 - 14:30
0 min

11. Date of Next Meeting

The next meeting will be held on 5 September 2024 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 6 June 2024 at 1.00 pm
Via MS Teams

Present:

Russell Hardy	RH	Chairman
Chizo Agwu	CA	Chief Medical Officer
Glen Burley	GB	Chief Executive
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FMa	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)
Amie Symes	AS	Associate Director of Midwifery – For Item 7.1

Minute		Action
BOD01/06.24	**Apologies for Absence** There were no apologies received.	
BOD02/06.24	**Quorum** The meeting was quorate.	
BOD03/06.24	**Declarations of Interest** There were no declarations of interest noted.	
BOD04/06.24	**Going The Extra Mile Awards** Team of the Quarter – Quarter 4 – Medical Division Team – The Chairman read out the reasons why the Medical Division Team were nominated for this award. Employee of the Quarter – Quarter 4 – Gajendran Kanagalingam – The Chairman read out the reasons why Gaje had been nominated for this award. The Chairman noted the items discussed at the Board Workshop held that morning.	

BOD05/06.24 **Minutes of the meeting held 4 April 2024**

Resolved – that the minutes of the meeting held on 4 April 2024 be confirmed as an accurate record and signed by the Chairman.

BOD06/06.24 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD07/06.24 **Chief Executive's Report**

The Chief Executive (CEO) presented his Report and the following key points were noted:

(a) Foundation Group Improvement Week 2024 – This was a fantastic event with a huge content from across the Foundation Group. This will be run every year. There were 1868 attendees this year!

(b) Elective Hub Development – It is a huge credit to everyone involved in designing and achieving this. The plan is for this to be opened in the very near future which will play a big part in our plan to reduce our waiting times this year and increase our elective income.

(c) Financial Escalation Meetings – A System Escalation Meeting was held. Our Financial Plan may now be acceptable to NHSE, This includes a large deficit to the System which will be reduced by an allocation from a central contingency pot. This leave us with a big Cost Improvement Plan. Another consequence of having a deficit plan as a System is that we will lose an element of our capital allocation.

(d) Workforce Productivity Diagnostic Tool – We spent time in the Board Workshop this morning looking at our workforce improvements and challenges. It is pleasing to see the improved recruitment and retention of staff. We are now ensuring that this reduces our ongoing high cost temporary labour costs. The Workforce Productivity Tool is in addition to the suite of productivity tools that are coming through this year which shows the amount of activity each Trust is doing and compares that to the growth in workforce. As an NHS, it shows that we are about 11% lower on productivity. Locally it shows an 8.1% overall productivity fall which is made up of workforce growth and an activity increase. We looked at the causes of this earlier this morning, and tackling some of these will be an important part of our plans this year.

(e) Further Capital Incentives for A&E Performance in 2024/25 – There is another capital incentive this year. We also received additional capital this year based on our March performance.

(f) Reducing Premium Temporary Labour Costs – As an NHS, in July our aim is to not use any off framework agencies. The aim is to only work with those agencies that are willing to work within a financial envelope that pays an appropriate premium.

(g) MORE FROM OUT GREAT TEAMS – Update from the Surgery Division – June 2024 – The Division have been hugely involved in the Elective Hub along with 25 productivity aims for this year. There has also been high levels of increased elective activities. When the activity tool is updated, the CEO is expecting this to show a further increase for the Trust.

(h) The Chairman reiterated that we are in a pre-election period and we have to be cognisant at this stage of not signing off any long term strategy plans which might be prejudicial in anyway.

(i) Mrs Twigg (NED) was impressed with the openness and passion of staff to want to do more to personally develop and improve during the Improvement Week. She queried how many people dipped into the "goody bag" and do staff continue on this journey? The CEO advised that the digital "goody bag" contained all the videos and the content of the week. Part of the function of the Improvement Board is to oversee training and capability around improvement and how we use this to tackle our objectives. We will track progress through here and ensure that the Board of Directors are sighted periodically on this. The Managing Director confirmed that we can check who has viewed what. We also started this week our group wide operational development programme for our operational managers which will put these staff in contact with each other so that they can form action sets together.

Resolved – that the Chief Executive's Report be received and noted.

BOD08/06.24 **Integrated Performance Report**

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

a) The highest risk in the organisation is the amount of overcapacity that we are still running at. Today we have around 40 patients either in Accident & Emergency or boarding. This is clearly a risk for patients and staff experience and a financial risk as well. There has been some fantastic work in reducing our vacancies, we are not seeing all the benefits of this yet. The number of delayed discharges has improved significantly, particularly for our Herefordshire patients with the work around this being led by the Chief Transformation and Delivery Officer and the Local Authority to make better use of the Better Care Fund and improving productivity through the discharge pathways means that patients waiting to go home, particularly on our Home First Pathway has dropped from 4 -5 days now to between 1 and 2 days. Despite this, we still have a high number of boarding patients. One of the reasons for this is that we have also seen an increase in demand, figures are included in the Report. Figures show that comparing April and May from this year to last year, we are admitting about 6 patients a day more. We have seen a lot of good improvement work but there is still a lot more to do to manage within the bed base that we have.

b) Given this backdrop, what has been achieved through Urgent Care performance has been remarkable. This has required a lot of people every day doing everything that they can to ensure that they get patients treated as quickly as possible. Also, the Elective work that we are achieving during the difficulties of the numbers of patients is also remarkable. Our target this year was to achieve 117% and in the first month we achieved 125%. As we will have earned more finances for this work, this will help offset some of our financial pressures.

c) We are not where we want to be at Month 1 – we are around £200k over where we expected to be. This mean that there is a lot more work around our CPIP required.

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

BOD09/06.24 **Quality (including Mortality)**

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

(a) The CNO took the Report as read and focused on the review of Paediatric Audiology Services. An independent review was undertaken in 2023 of NHS Lothian in Scotland. This found significant concerns and failings in relation to Paediatric Audiology Services. That subsequently prompted an assessment of services across England. We participated in the West Midlands review process.

(b) A desk top review was undertaken last July in line with NHSE requirements and this identified some shortcomings and areas of improvement. We joined the System Level Bronze Incident Response Cell which worked towards a fuller review. This culminated in a site visit which took place in February 2024. This was led by NHSE's Physiological Lead and a subject matter expert who was a Clinical Audiologist. A Report was issued at the end of February which concluded that our Paediatric Audiology services are safe and could continue to operate with no conditions on our practice. The Report did include some recommendations and the team developed an overarching action plan, the highlights of which are included in the Report. The full Report and action plan were discussed at the Quality Committee in detail.

(c) The review is ongoing and includes a review of clinical cases on both the discharge and non-discharge pathway for children undergoing ABR testing, which is a complex hearing test. The review so far has identified that no patients need to be recalled for retesting, the review is ongoing and there are 31 cases over a 5 year period that are yet to be reviewed.

(d) We have agreed to continue to report into Quality Committee on our progress against the action plan and the conclusion of the ongoing clinical audit progress. We will continue to participate in the Bronze Incident Response Cell. We are also holding a Community Paediatric Workshop on 25 June to look at waiting times and some of the workforce challenges associated with this service.

(e) In addition and separately to NHSE's incident response, the Care Quality Commission wrote to all Trusts in April asking that the Board of Directors are sighted on the quality and safety of Paediatric Audiology Services and to note whether they were making progress towards IQIPS accreditation. IQIPS is a long term aspiration for the Trust, but currently we are focusing on implementing the Quality Management System which is part of the IQIPS programme and have also expressed an interest in the national Audiology Paediatric Improvement collaborative. We will write to the Care Quality Commission by their deadline of 30 June to confirm our aspirations to work towards IQIPS and to update on the safety and quality of our Paediatric Audiology Services.

(f) Mr James (NED) advised that he and the Chief People Officer took part in a visit to Community Audiology last month as part of this review. He wanted to put on record the commitment of staff that he met in maintaining quality services and to address any improvements that needed to be made.

(g) Our 12 month HSMR, which covers the period January 2023 to December 2023, remains at 101.7, which is within the expected range. It is pleasing to see that the 1 previous outlier, Heart Failure, has dropped to the expected range. We will continue to review this.

(h) Fractured neck of femur is an area of concern. A deep dive was undertaken to look into any areas that we can improve upon. There were 2 main areas identified and we will be undertaking improvement work in these areas. One was reducing the number of hours a patient spends in the Emergency Department, We are aiming for less than 4 hours to get them to their definitive bed base. The second is to increase the percentage of patients that get to Theatre in less than 36 hours.

(i) Our extended perinatal mortality is well below the national target. All of our Mortality Leads are being trained on Structured Judgement Reviews and the Learning from Deaths Policy. We had the first Learning from Deaths Committee where the presentation on the deep dive on fractured neck of femur was presented.

(j) The Managing Director advised that although the data has not yet come through, we are aware that we will be below 100 for the first time which is an amazing improvement on where we were a few years ago.

<u>Resolved</u> – that the Quality Report (including Mortality) be received and noted.

BOD10/06.24 **<u>Activity Performance</u>**

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

(a) We delivered our activity plan for April and achieved above the expected figures. We delivered 1300 more appointments and 800+ more elective procedures compared to April 2023. Overall, 300 more elective procedures than in April 2019.

(b) Our Productivity Programme Board continues to see some real improvements on some of the Productivity Schemes, particularly in Surgery. There have been real improvements in terms of the pre-operative assessment productivity gains in terms of reducing the length of time of their clinic slots and seeing more patients which continues into May with really strong plans for June before our Elective Surgical Hub opens. There are also strong improvements on our Theatre scheduling and visibility of our 6-4-2 scheduling process to ensure that we have the right patients in the right slots at the right time.

(c) Diagnostics activity – This remains strong in terms of activity numbers, with our long waiting patients in two particular areas are an area of concern. The CNO has already discussed Audiology and we have some particular concerns with Audiology in terms of both workforce and physical room capacity and the team are looking at different ways of working and how to improve their clinic templates and ways of working. Our greatest area of concern is our Echocardiograms. Patients waiting greater than 13 weeks continues to increase due to workforce challenges (50% vacancies). We are looking to utilising Insourcing companies as well as 2 trainees that joined the team last year who are due to qualify later this year.

(d) Urgent and Emergency Care – The COO wanted to thank the clinical and operational teams for the improvements seen. We have sustained and improved on our Minors and Paediatrics 3 hour emergency access standard. They are both maintained at 94% over the last 3 months. Our triage time also continues to reduce and our time to treatment in the Emergency Department (ED) is the best in the Region.

(e) It has been a challenging few weeks regarding flow which we are focusing on whilst delivering our activity plans. We have a period of industrial action from 27 June to 1 July which is always challenging to our teams to maintain all the operational and clinical pressures as well as prepare for these strikes. We are undertaking a focused MADE virtual event Week Commencing 17 June involving a number of key teams, including Primary Care, ahead of this industrial action.

(f) The CEO noted the increase in length of stay of patients and after the MADE event, it would be useful to understand the makeup of this and whether it is complexity and acuity or around discharge pathways or some missed opportunities to discharge patients earlier who end up staying in hospital longer as a consequence of that. The COO advised that this is the aim of the event. We have good assurance around our pathways 1 – 3 and the long length of stay. The MADE event on 17 June will be mainly focused on Pathway 0 and the long length of stay patients have to make sure plans are in place to ensure that they are on the right pathway and there is nothing further we can do.

(g) Ms Quantock (NED) noted regarding the 28 day Cancer Performance Faster Diagnosis Standard, it talks about the Post-Menopausal Bleeding Pathway, and queried if there is a plan on how this is going to be published and highlighted as there have been cases of patients not having their symptoms picked up as a sign of cancer. The Managing Director advised that the Unspecified Cancer Pathway is being set up with an MDT to review that particular group of patients who have vague symptoms that do not have a specific Pathway to refer them to.

(h) Mr James (NED) noted that ED is still under huge pressures with a lot of work done to improve discharges, but we still have more patients in the hospital that we can cope with and therefore what we can do at the Front Door to ensure that we are only admitting appropriate patients. The COO advised that the focus is on how we stream patients away from ED and navigating at the Front Door to appropriate care pathways. We are working closely with Primary Care around how we screen patients directly with our ED Reception with guaranteed slots, specifically with ED for out of hours and weekends and overnight. We are working close with Taurus around improving these numbers. This is around how we are maximising our Same Day Emergency Care pathways which we have seen a significant increase in over the last few months and expanding our Virtual Wards and capacity.

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

BOD11/06.24 **Workforce**

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

(a) We are seeing good improvements with most of our Workforce KPIs. Our turnover rate is down to 9%. Our HR and Occupational Health teams continue to work actively with Line Managers to reduce sickness absence.

(b) Our Mental Health and Wellbeing Nurse is working closely with our teams. Mental health conditions are still one of the main reasons for sickness. We are doing a lot of work to highlight mental health support awareness. We are also promoting the new Herefordshire and Worcestershire Recovery College with a number of programmes to support mental health within the working environment.

(c) As part of our Equality, Diversity and Inclusion agenda, we supported the NHS wide Diversity and Human Rights Week with a number of senior leads signing the pledge to be an inclusive leader. The Inclusive Pledge is something that we are pushing across the Trust as this fits in well with our Leadership Charter.

(d) Faced with the NHS wide productivity and cost efficiency challenge, we have a Working Group in place, including our Trade Union partners, to look at schemes to support the efficiency and productivity challenge that we face as a Trust.

Resolved – that the Workforce Report be received and noted.

BOD12/06.24 **Finance Performance**

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

(a) Year to Date Performance – This just covers Month 1 – April. Not unique to the Trust, but recognising the impact of the Annual Account workload and the finalising of the plan, we are only reporting the expenditure position for Month 1.

(b) Our pay spend was £0.5m more than we planned to spend in April. This is largely driven by our continued reliance on our temporary workforce and slower than planned cost savings.

(c) Agency spend represented around 5.5% of our total pay bill in April and we are targeting bringing this down to beneath the 3.2% expectation nationally over the course of the year.

(d) We have maintained strong elective income performance this month which will translate in terms of strong elective income performance and will then partly mitigate the higher than expected costs on pay and non-payments into Month 2.

(e) With a deficit plan, cash continues to be a key risk for us. We will require cash support again in 2024/25 linked to our deficit position. The Board of Directors are requested to support our submission for Quarter 2 revenue support request based on cash flow requirements.

(f) Mrs Martin (NED) appreciated the conflicting pressure of more people presenting requiring our case and support and the need to drive down costs and the need to live within our means.

(g) The Chairman noted that we need to drive the new Elective Hub hard and drive elective recovery to get the income in and to minimise the use of expensive temporary labour.

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 APPROVAL

BOD13/06.24 **Quality Committee Workplan and Terms Of Reference**

The CNO presented the Quality Committee Workplan and Terms Of Reference, which were taken as read, and the following key point was noted:

(a) The Workplan and Terms Of Reference are updated to include this year's quality and safety priorities.

Resolved – that the Quality Committee Workplan and Terms Of Reference be received and approved.

BOD14/06.24 **Quality Account 2023/24**

The CNO presented the Quality Account 2023/24 and the following key points were noted:

(a) The Quality Account was presented to the Quality Committee last month and recommended for approval at the Board meeting today.

(b) The Quality Account needs to be approved in advance of the Annual Account and Annual Report due to the publication date of 30 June.

(c) The account is subject to the Statement of Assurance from the ICB, which we received yesterday which did not raise any material or substantial concerns or challenges in terms of content of the Account.

Resolved – that the Quality Account 2023/24 be received and approved.

BOD15/06.24 **Operational Planning: Financial Plan 2024/25**

The CFO presented the Operational Planning: Financial Plan 2024/25, which was taken as read, and the following key points were noted:

(a) The Chairman noted that the numbers are still not all fixed, so we need to agree the Financial Plan recognising this.

(b) Over the course of the planning cycle we have kept the Board of Directors updated on the development of the plan and assumptions.

(c) The paper sets out our final draft Financial Plan and our devolved Divisional Budgets for 2024/25. We knew at the point of writing this that the Plan was not accepted nationally and that further work was ongoing and a further Plan resubmitted, which we have confirmed.

(d) This sets out operational and activity performance assumptions. We are planning to deliver above our 2019/20 elective activity levels. The Activity Plan is based on achievement of high productivity levels through our core capacity. Therefore, we only rely on additional capacity when it delivers additional income funding.

(e) Workforce – This remains largely flat apart from some known growth areas, eg the Elective Surgical Hub and starting our recruitment for the Community Diagnostic Centre. We are also targeting reducing significantly our temporary workforce at premium costs.

(f) The Report sets out a planned deficit of £34.4m. This is what we submitted through the national process on 2 May. It requires delivery of around £20m of efficiency and productivity improvement to achieve this deficit plan. The System continue to engage with the national team in light of the fact that the overall deficit plan at 2 May was not acceptable and based on communication this week and a revised submission next week, we are expecting to reflect 2 further adjustments to our income and expenditure position. One being a further stretch target on the efficiency side and the other being a national technical adjustment around PFI accounting. We are expecting this to result in a deficit Plan of £31.4m.

(g) Capital – Our headline allocation is consistent with last year at £4.5m. This is significantly below the level we have been able to invest over recent years but also significantly below our anticipated requirement based on schemes already planned. We are also expecting reduced access to Capital Funds this year as a result of the size of the overall System deficit. We would therefore expect those figures to change slightly ahead of next week's submission. The CFO already alluded to cash support being required on an ongoing basis both on the revenue side and also on the capital side.

(h) The paper sets out areas of financial risk and potential financial opportunities. There is a significant element of risk in the Financial Plan although we do try to ensure that the assumptions we make in the Plan are credible albeit stretching in terms of delivery. Our significant risk is around the delivery of our Cost Improvement Plan and productivity target which is almost 6% of our cost base.

(i) The CFO is asking the Board meeting to note progress made since the last update, ratify this with the detail around the Financial Plan and Budget, noting that this is subject to the 2 further changes next week as part of the national process.

(j) The Chairman highlighted that we need to approve delegated authority to the CEO, CFO, himself and the Managing Director to finalise any changes.

Resolved – that the Operational Planning: Financial Plan 2024/25 be received and approved with delegated authority to the Chief Executive, Chairman, Managing Director and Chief Finance Officer to approve the final Financial Plan prior to submission.

BOD16/06.24 **Herefordshire and Worcestershire – NHS Five Year Joint Forward Plan Update 2024/25**

The Chief Strategy and Planning Officer presented the Herefordshire and Worcestershire – NHS Five Year Joint Forward Plan Update 2024/25 and the following key points were noted:

(a) A paper is being presented to each Board within the ICB in the System.

(b) This is a high level 4 year plan meeting national and local requirements.

(c) The finance section is still draft. Approval is therefore being asked of the Board meeting today subject to delegated authority to the CEO to approve the finance section.

Resolved – that the Herefordshire and Worcestershire – NHS Five Year Joint Forward Plan Update 2024/25 be approved in principle with delegated authority to the Chief Executive to approve the finance section.

BOD17/06.24 **Update to Standing Orders**

The Associate Director of Corporate Governance (ADCG) presented the Update to Standing Orders and the following key points were noted:

(a) This is part of an ongoing piece of work to align our governance across the Foundation Group.

(b) This has occurred with the Standing Orders given that we should all be following the same code of conduct and governance arrangements.

(c) There are no material changes. These have been adapted for use and reflected Worcester Acute Hospitals NHS Trust and George Eliot Hospital within them.

Resolved – that the Update to Standing Orders be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD18/06.24 **Perinatal Services Safety Report**

The Associate Director of Midwifery (ADM) presented the Perinatal Services Safety Report, which was taken as read, and the following key points were noted:

(a) Due to the improved reporting and the speed at which we can now provide the information, the Report extends beyond the quarterly period, including March and April as well as Quarter 4.

(b) Obstetric Attendance – There was 1 incident where a Consultant was required to attend but was not called. The local learning has been shared. This does not impact on our CNST compliance but we are expected to continue to observe this.

(c) As part of the CNST requirements, the Board of Directors are expected to have oversight of all Maternity Safety Incidents. Due to the Trust only having a small number of births and cases, it is possible for patients to be identified. Therefore, in the Public Board of Directors we will share an overview with a more detailed report being provided to the Private Board meeting.

(d) One case met the threshold for PMRT in March with no cases in April. There were no HSIB (now known as MNSI) cases and no moderate incidents. There were also no concerns raised by external stakeholders during this period.

(e) Cluster Review relating to maternal post-partum haemorrhage – We have had a higher number than usual and do sit outside the national average marginally. This has been improving but further improvement has been identified. We are undertaking a Cluster Review which will look to pull out key themes and will formulate an action plan to address this. This has been reported through Patient Safety Panel where the outcomes and the learning will continue to be shared.

(f) PMRT Compliance – The update is provided within the Report. This is a CNST requirement. We are meeting all of our targets and deadlines that we are expected to meet. The ADM explained that under the grading of care. AA means that there have been no issues identified and no harm caused. Outstanding means that we are yet to grade the case. The cases shared in the Report are joint with Powys, therefore we are reliant on joint processes.

(g) We have undertaken a PMRT Thematic Review – details within the Report.

(h) Patient Experience – We continue to have low numbers of complaints, although we did have 1 concern in March and 1 complaint in April. Overall, our Friends and Family feedback is positive. There is a varied response rate but overall this is around 20% which is slightly higher than the national average.

(i) Care Quality Commission Survey Results – The next Report will include an action plan on how we will manage some of these improvements. The key highlight from the Survey results is that we scored in the Top 5 Trusts Regionally in each of the 8 subcategories.

(j) We are working with the MNVP. The Report includes some of the celebrations and the considerations that have been presented from the 15 Steps visit. We continue to have the presence and the visibility of our Safety Champions who visit our Unit and undertake Safety Walkabouts on a regular basis, also included in the Report.

(k) If everyone approves the new style of the Report, the plan is to continue with the triangulation section which pulls out immediate and short term actions and our longer term actions. This is pulling together all the intelligence that we have to provide a more structured Report.

(l) Workforce – There are no concerns, we continue to be in a stable and improving position. Midwifery has seen a slight increase in turnover but we are recruiting back into these posts.

(m) Obstetric Workforce – The situation is improving and is set to improve further within the Obstetric Consultant Group with recruitment to short and long term Locums along with some substantive recruitments. We are covering 24/7 on the rotas with our own staff.

(n) MDT Ward Rounds – This is an improving picture but there is still further work to do. We are capturing the reasons why staff are not attending. This could be due to them attending Theatre, but they would be brought up to speed after the meeting. We just need to capture more detailed information regarding this.

(o) Neonatal Workforce – There are no escalations and details are included in the Report.

(p) This Report has been presented to the Quality Committee and there were no escalations to be highlighted to the Board of Directors.

(q) The Managing Director noted that regarding the Care Quality Commission Survey Results, the 2 areas that we are in the bottom relate to partners or others to stay. Is this an environmental issue or a cultural issue? The ADM advised that the bottom 5 scores that are reported in the Report are personal to the Trust, they are not necessarily related to the Regional scores. We are below the average for this area. There are some environmental challenges for partners to stay. We do not have individual cubicles, with limited toilet facilities and limited space around the bed. Where there are exceptions or personal requests we do facilitate where we can.

(r) This issue has been raised previously and we have done a piece of work with the MNVP around this. The overall consensus from most women is that they do not want other people's partners encroaching on their privacy and disrupting their evenings.

(s) The Chairman highlighted that the PQSM Dashboard shows that around 50% of patients with us have a Caesarean Section. The ADM confirmed that between 40 and 50% of women are having a Caesarean Section. This is not included as a percentage alone as many years ago there was a drive in reducing the number of Caesarean Section rates which showed that in some cases lower rates did not always correlate with good care. What we do is individual case reviews and look at whether this was appropriate and indicated and then take learning from these cases. The Chairman advised that his focus was on elective Caesarean Sections not emergency sections, with our focus always on safety. It would be useful to see the elective number of Caesarean Sections out of the numbers. In terms of baby health, there is increasing evidence that unless a Caesarean Section is required for safety reasons, this procedure is not without consequences. The ADM clarified around the categories on the Dashboard for the Caesarean Section deliveries (R groups). RG1 – RG5 are the key areas we monitor. Robson Group 5 – the mother has had at least 1 Caesarean Section is highest category and most women who have had 1 section decide to have a further section. There is more informed decision making and counselling that can be provided. We need to ensure that decisions are being well documented. NICE gave out guidance a few years ago that everyone can choose their mode of birth. Our Consultant Midwife vacancy is back out to advert and once recruited, we are hoping that they will make a difference to our numbers.

Resolved – that the Perinatal Services Safety Report be received and noted.

BOD19/06.24 **Patient Experience Quarterly Report**

The CNO presented the Patient Experience Quarterly Report and the following key points were noted:

(a) There continues to be a good response rate for our Friends and Family texts and good overall positive response rate.

(b) There have been no new national surveys published since the last quarter.

(c) We are concerned around the rising number of complaints and concerns, particularly when we benchmark across the Foundation Group, which is an area of focus for us. Positively, less complaints are coming back for a second time. There is still further work to be done around the timeliness of our responses but progress has been made with the backlog of complaints referred to at the last meeting.

(d) We are setting up a Working Group to take forward the Public Health Service Ombudsman Model Service Guidance.

(e) The Patient Experience Committee are now focusing on patient engagement and supporting service users and our volunteers to support us with PLACE Lite and 15 Steps.

(f) The Chairman asked that Healthwatch brief us on their feedback on the whole Health Service system in a future Board Workshop. **LF**

Resolved – that:

(A) The Patient Experience Quarterly Report be received and noted.

(B) To invite Healthwatch to a future Board Workshop to brief us on their feedback on the whole Health Service system. **LF**

BOD20/06.24 **Policy Panel Update**

The ADCG presented the Policy Panel Update, which was taken as read, and the following key points were noted:

(a) There has been a surge in the number of Policies due to expire, but the team are aware and appropriately managing this.

(b) The Chairman queried if we are learning from the Foundation Group when we are updating Policies. The ADCG confirmed that we are. The Policy Panel is chaired by the Managing Director which the CNO and ADCG regularly attend. We ensure that the Equality Impact Assessment is undertaken and we are sharing best practice.

(c) Mrs Hill (NED) noted that are a number of Policies which are out of date and questioned if there is a plan to remediate this. The ADCG advised that we are looking where possible for an extension when there are no material changes which we will approve through Policy Panel. The Matrix is regularly reviewed and Policy Holders hastened if their Policy is coming up for renewal.

(d) The CEO noted that it might also be worth reviewing the life of the Policy as well to ensure that we are not reviewing them too frequently.

Resolved – that the Policy Panel Update be received and noted.

BOD21/06.24 **Board Assurance Framework and Divisional Very High Risk Report**

The ADCG presented the Board Assurance Framework (BAF) and Divisional Very High Risk Report and the following key points were noted:

(a) This new BAF reflects our 2024/25 objectives.

(b) Where appropriate, we have retained the BAF risks from last year where they can be aligned to our new strategic objectives. Where they are not aligned to our strategic objectives, we have included them within the Risk Register.

(c) There are a number of new BAF risks which the Board of Directors are invited to consider.

(d) The BAF risks that have increased in score are the ones that apply to capital funds and the Digital Strategy.

(e) In future, we will provide a heat map for the BAF which sets out our risks and provide a rolling risk score graph to see the changes within the BAF risks

(f) The Risk Register is more dynamic now. Risks are coming on and off and changing all the time as they are managed through the Executive Risk Management meeting.

(g) Mrs Martin (NED) noted the risk on the Risk Register around the waiting times due to the lack of psychological support and wanted to make sure that this is being picked up across the System and ensuring that our Risk Register is dovetailing with other organisations Risk Registers. The Managing Director advised that the actions around what we are doing are not included in this Report as there is too much detail to include. She advised that the last action was to log this with the Children and Young Peoples Partnership across the ICB and locally.

Resolved – that the Board Assurance Framework and Divisional Very High Risk Report be received and noted.

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD22/06.24 **Foundation Group Board Minutes and Action Log 2 May 2024**

Resolved - that the Foundation Group Board Minutes and Action Log 2 May 2024 be received and noted.

BOD23/06.24 **Integrated Care Executive Report**

Mrs Martin (Chair of the Integrated Care Executive and NED) presented the Integrated Care Executive Report, which was taken as read, and the following key points were noted:

(a) The Chairman questioned if this was moving at the pace wanted. Mrs Martin (Chair of the Integrated Care Executive and NED) advised that there has been significant progress made in the last few months. A lot of work has been occurring around delayed discharges and care at home.

Resolved – that the Integrated Care Executive Report be received and noted.

BOD24/06.24 **Quality Committee Summary Report and Minutes 29 February 2024 and 28 March 2024**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report and minutes 29 February 2024 and 28 March 2024, which were taken as read, and the following key points were noted:

(a) The Chairman asked if there was anything worrying Mr James as Chair of the Quality Committee. Mr James (Chair of the Quality Committee and NED) advised that a major concern relates to the pressure on ED and therefore on the wards. As a Board, our focus is naturally on overall 'flow' and numbers of patients rather than quality and safety of care. The Quality Committee receives a monthly Report which focuses on these issues important issues.

Resolved – that the Quality Committee Summary Report and Minutes 29 February 2024 and 28 March 2024 be received and noted.

BOD25/06.24	**Any Other Business** There was no further business to discuss.
BOD26/06.24	**Questions from Members of the Public** **Q1.** Long stay hospital patients. Nationally it has recently been reported that hospital stays of more than 3 weeks have risen 15% above pre Covid levels. What is the position in Wye Valley Trust hospitals and how does it compare with pre Covid levels? **A1.** The COO advised that comparing numbers to pre Covid, in the Acute Hospital site we have seen a 4% increase in the 21 day stranded patients. This is mainly driven by the 1 – 3 Pathway patient. If we include our Community Hospitals this is a 7.8% increase for our 21 day stranded patients. **Q2.** PALS Visits. Before Covid some PALS volunteers at Wye Valley Trust were used on a regular basis, to interview patients in order to find out what they thought of Wye Valley Trust standards. Obviously this work stopped during Covid. Is it now safe for this activity to restart? If so will the Board initiate a restart programme? **A2.** The CNO advised that it was the PALS Service themselves who undertook the Surveys with patients. There is insufficient capacity to do this, yet we now have several new ways to receive patient feedback which did not exist before. In addition the Patient Experience Committee are now utilising volunteers for the 15 Steps and PLACE Lite visits which includes engaging with patients around their experience of our services. **Resolved – that the Questions from Members of the Public be received and noted.**
BOD27/06.24	**Date of next meeting** The next meeting was due to be held on 4 July 2024 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 4 JULY 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
BOD19/06.24 Patient Experience Quarterly Report 06.06.24	(B) To invite Healthwatch to a future Board Workshop to brief us on their feedback on the whole Health Service system.	LF	On the Board Workshop Agenda for December 2024.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**04/07/2024**
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. Financial Regime Changes

As previously reported to Board, the System plans submitted on 2nd May 2024 forecast an aggregate national deficit of close to £3bn, well above levels at a similar point in previous years. As a consequence, NHS England (NHSE) met face to face with systems and providers to seek further improvements. The discussions centred on each system's ability to meet “revenue financial plan limits”. Subsequently changes have been made to the financial regime to seek to incentivise their delivery. Under the new rules, systems are given revised targets to breakeven or to hit a specified level of deficit. A further 'fair shares' allocation has been identified for each system which allocates a proportion of a national contingency pot. Systems that have a deficit above their fair share of funding will face capital penalties, with bonuses for areas in balance. The new financial framework introduces a helpful element of realism by setting targets that NHSE feel can be hit, whilst also formally acknowledging that some areas will take a while to get back to breakeven.

I have a concern that the focus remains on System level positions. The four Trusts in the Foundation Group are impacted in different ways by these rules, so we are in a relatively unique position to consider their impact. South Warwickshire University NHS Foundation Trust (SWFT) and George Eliot Hospital NHS Trust (GEH) have plans which deliver breakeven in a System which currently plans to be in deficit. This deficit should be above the 'fair shares' position, so we will probably hold on to the system level capital allocation but the two Trusts will not receive an additional capital incentive. Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trusts (WHAT) both have deficit plans and whilst the system plan now delivers the overall level of deficit felt to be 'acceptable' by NHSE, because it exceeds the fair shares allocation we have seen a reduction in our capital allocation overall. Whilst there appears to be no guidance on how this should be handled within systems, I have agreed that the capital allocation to the Health and Care Trust (in breakeven) should not be affected by this penalty. We have therefore agreed a fair way of handling this between WVT and WAHT. But it would have been interesting to see how this would have played out if we hadn't been in a shared leadership model. Elsewhere it is feasible that Trusts in breakeven positions will face capital reductions due to overall system positions. One would question whether this is fair or whether it creates the right incentives for improvement or for effective system working.

Withholding capital from organisations in deficit is always controversial, with critics arguing that allocations should be based on need only and insisting that the restrictions hold back investment that could boost productivity. Many criticised the Payment by Results financial regime but, in my opinion, it helpfully provided an indication of the relative productivity of each provider and provided a clear incentive for improvement. Allocating funding based on activity volumes appears to be fairer than simply allocating funding to deficits. I also feel that systems can play an important role in the overall financial management of the NHS but we should not lose the focus and accountability of the constituent statutory bodies. Incentives generally work in life, so we should seek to maintain some in the NHS. The current regime is due for an overhaul and I continue to seek to influence national thinking on this where I get the opportunity.

2. Urgent and Emergency Care (UEC)

The ever-increasing demand experienced in UEC is also an area which trips into the NHS financial management debate. There was a time where activity volumes were linked to tariff payments and hence Trusts which experienced larger increases in demand had some means of funding capacity to improve flow. In my view this is one of the reasons why performance against the 4-hour standard has dropped. The financial argument is much less important than the quality and safety argument though. We know that, despite the flaws of a single key indicator, good performance against the 4-hour standard aligns to lower levels of mortality and better patient and staff experience. The counter argument to a full tariff-based system is that it potentially encourages the treatment and admissions of patients rather than thinking about demand reduction or delivering more care at home. I have therefore been suggesting a hybrid approach where we would incentivise best practice pathways as we do with other best practice tariffs, such as the very successful model supporting fractured neck or femur.

We are fortunate that most parts of the Group, with the exception of Worcestershire, have integrated hospital and community services. These arrangements facilitate the move to more home first care more easily in that resources can be transferred within the Trusts to build capacity out of hospital. This still excludes other key elements of the health and care service such as primary care, mental health care, ambulance services, social care etc. But it provides a useful reminder that the best solutions to flow problems often sit in partner organisations and as we increasingly take on 'lead provider' responsibilities we will need to find ways to pool resources and move funding within our Places to invest in the best solutions.

3. Pathology Network

Lord Carter set out plans over two decades ago to create Pathology Networks across the NHS. These plans were founded on productivity and service sustainability principles which still hold today. When Lord Carter talked to our Foundation Group Boards Workshop recently, he expressed understandable frustration that the plan set out had still not been fully implemented. Meanwhile, the case to do so has become more compelling and technological advances have made it easier to operate virtual networks.

For a number of years there have been ongoing discussions about the scale of our local Pathology Network. The current consensus is that a suitable scale would embrace Coventry, Warwickshire, Herefordshire, and Worcestershire. The current Coventry and Warwickshire Pathology Network does not extend to WVT and WAHT, so a process is underway to seek to do so.

This is no small undertaking, but I feel that, done in the right way, there should be benefits to patients and savings for the Trusts. We are discussing how the model could work so that we achieve the right balance between local access and flexibility whist benefitting from the sustainability and value associated with the expanded Network scale. This has been added to the Foundation Group Strategy Committee July 2024 agenda for further discussion.

4. MORE FROM OUT GREAT TEAMS – Update from the Clinical Support Division – July 2024

Patient Access

In outpatients there have been a number of developments which support the specialties to deliver improved services. A Virtual Fracture service is commencing which will reduce the need for patient attendance in the busy fracture clinics. This service has also provided career progression within the plaster team to support recruitment and retention. A pre-operative assessment mini screening service has been implemented delivering the right input early on in the pathway to ensure patients are fit and ready for surgery.

A new outpatient scheduling process (6-4-2) started on 17th June 2024, together with a new room allocation template. The aim of the project is to improve availability of rooms and increase room utilisation to above 85%, reduce room DNAs and reduce the instances of clinics being cancelled at less than 2 weeks.

In the first week, room utilisation has increased to 87% compared to 74% in the same week last year. Outpatients Scheduling, Referral Management Centre and nursing teams have worked closely with the specialties to ensure the roll out runs smoothly.

Further specialities are now back to being directly bookable on referral through the national e-Referral Service which gives patients certainty of a date for their first outpatient appointment.

The Referral Management centre has supported the rolling validation programme contacting all patients waiting 12 weeks to ensure they still need their appointment.

Mortuary/Bereavement

HTA/Mortuary

Processes within the service are being modernised with a bespoke Mortuary software EDEN currently being installed. This will remove the risk of errors with paper processes and facilitate audits.

A new Mortuary Manager has been in post for 2 months and is making improvements with SOPs, competencies and audits are underway. The Mortuary management team are working with the site team to review out of hours viewings.

iPassport, a quality management system has been introduced for the oversight of SOP's, training and audits, ensuring these go through correct governance structure.

The bereavement team are working with 2wish charity to refurbish the Mortuary viewing and relatives room. Flowers have been donated to improve the rooms and cards are now available for families to write notes to be left with their loved ones.

Cancer Services

Since February 2024, the Trust has hit the 28 day Faster Diagnosis Target of 75% each month. Despite the national target not being increased to 77% until March 2025, WVT has set a local target to meet 77% from April 2024 and have successfully met this to date. The faster diagnosis target is still being supported with 3 x Cancer Pathway navigators on a fixed term basis. 31 and 62 day performance remains a concern for the Trust however May 62 day data is on track to show a marked improvement. Deep dives are being completed to identify main causes and bottle necks to help feed into the Cancer Actions Plans. Clinical admin delays continue to be closely monitored and the Trust hopes to further improve this area with the development of using text messaging to reassure patients with benign results.

The FIT (Faecal Immunochemical Test) pathway has now gone live having been worked up between Primary and Secondary Care following national guidance which is designed to assist with the management of patients with a low risk of malignancy of Colorectal cancer. Early indications are that this pathway is helping to reduce referrals into the Trust as intended and will be closely monitored over the next few months to assess its success.

The NSS (Non-specific symptoms) pathway went live 3rd May with low referral numbers received to date. The trust is working closely with Primary Care to help promote the pathway and ensure it is used where appropriate and is devising more communications to circulate internally.

The Haematology service has maintained open and safe access with Locum recruitment but unfortunately we were unable to recruit to the substantive Consultant. The Substantive Consultant post has been readvertised and we continue to try and secure an additional locum to support the service in the interim.

Diagnostic Services

The Radiology team have continued to deliver significantly increased capacity across main modalities including; MRI (Magnetic Resonance Imaging), CT (Computed Tomography), USS (Ultrasound Scan) and DEXA (Dual Energy X-ray Absorptiometry/bone density scan) achieving; 180%; 161%; 114% and 107% of 2019 activity in May 2024. Despite ever increasing levels of activity, the waiting list position has deteriorated slightly in spring driven by emergency and inpatient diagnostic demand.

Planning permission was granted in May 2024 for the Wye Valley Diagnostic Centre. Build work continues at pace, with ground works commenced and footings 80% completed, with an opening date scheduled for July 2025. In terms of additional workforce for the new centre, the project is currently 32% recruited to plan. Early work is underway to explore expansion opportunities.

Following a successful NHSE bid, the department have been successful in securing £415,000 toward supply of an additional 3D mammography machine. This will increase scanning capacity for both symptomatic and screening patients, with delivery planned for autumn 2024.

MRI AI Acceleration software is planned for installation on the two MRI scanners on the acute county site in July, which will not only speed up image acquisition improving productivity but also improve image quality. Following testing, this has potential to alter the prostate MRI protocol, reducing the need for consumables (contrast) and reducing appointment scan time offering a further benefit to 28 day faster diagnosis performance.

Digital transformation continues with the Emergency Department having moved fully to electronic order comms in March. Meanwhile GP order comms and clinical decisions support software is progressing to testing stage with rollout late summer/early autumn.

Audiology have had a successful NHSE site visit in February to assess the paediatric service as part of regional and national review, with the service rated as safe. An ongoing action plan has been detailed and relayed both to Quality Committee and Trust board.

Meanwhile, audiology waiting times see an ongoing improvement with the diagnostic 6 week wait `position improving from 51.3% in April to 64.7% in May. A new delivery model for Tier 2 (under 4 year old) patients is being trialled 1st July to attempt increasing clinic throughput from four to eight patients per session due to single testing room limitation.

Pharmacy

Pharmacist recruitment continues to be the department's biggest challenge but through focused work streams have seen Pharmacist vacancy rates fall from 55% in Oct 2023 to 32% currently. We look forward to welcoming three newly qualified Pharmacists in August and another in January. We have pushed 'go' with international recruitment to close the remainder of the vacancy gaps and await applications.

To support our Pharmacist recruitment we increased our cohort of trainee Pharmacists from three to four (and will retain two as newly qualified posts) and we have also increased our trainee Pharmacy Technician roles to 15 who are now qualifying and starting to close the Technician vacancy gaps. Both the Pharmacist and Pharmacy Technician trainees include several cross sector placements with our colleagues in Community (High Street), Mental Health and GP Practice Pharmacy sectors. This collaborate approach is now strengthened with the revival of the One Herefordshire Pharmacy Collaborative. We are making tentative progress to filling all the vacancies within the department but the skill mix and development opportunities within our department are attracting new recruits.

During the peak vacancy rates, work was centralised to the main dispensary, impacting on turnaround times and clinical risk due to lack of oversight at ward level. We are making small steps to re-establishing ward based clinical pharmacy, however mindful of our existing vacancy gaps and changed landscape / acuity post pandemic.

A knock-on-effect of the shortage of Pharmacists has been the impact on the aseptic production service within Pharmacy. This service prepares and clinically checks, amongst other medicines, the chemotherapy for our Oncology and Haematology patients. To safeguard the continuation of this vital service, this area continues to be prioritised with a focus to reducing the risk specifically in this area.

Despite the workforce challenges, a key achievement has been to maintain patient safety with a final checking accuracy rate of over 99.95%.

With the expansion of the Pharmacy service since the opening of the hospital sufficient space to deliver the pharmacy service has exceeded and as a result a short, medium and long term plan to manage this has been developed. The short term plan of moving some Pharmacy staff off site which has now been implemented. The medium to long term plans are now being worked through with an exec led pharmacy estates and planning strategy group.

Pathology

As referenced earlier in this report, the formation of the South Midlands Pathology (SMP) Network has encountered some delays from the initial proposed timelines. However, Heads of Terms have recently been proposed to all Trust Boards involved, and updated timelines are expected soon. In the meantime, regular weekly meetings continue between all Senior Responsible Officers (SROs) for each Trust within the network, with significant progress anticipated once the Heads of Terms are fully approved. In January, our new Clinical Director, joined us and is now the responsible SRO for WVT within the SMP.

There is positive news regarding our Histopathology department since the November update. We have recruited two full-time equivalent Histopathologist's who will start in August.

After their integration into the department, we will collaborate closely with our Consultant team to repatriate some currently outsourced services, aiming to reduce costs and improve turnaround times (TATs).

Since January, the TATs have significantly improved, and we plan to maintain this progress once the new Consultants are in post. We have transferred all outsourcing for Breast histopathology services to Worcester Acute, which already supports our screening services. Longer-term, we aim to bring the Symptomatic Breast Service back in-house once our new Consultants are fully integrated.

The department has not yet fully utilised digital pathology as it is not live at all sites, but we are working closely with our digital providers and the network to fully leverage digital technology.

Following the resignation of our Microbiology Manager in February, our Cellular Pathology Manager, has taken on the role on an interim basis in addition to her Cellular Pathology duties. After significant recruitment challenges over the past 2-3 years, we have now recruited a 12-month fixed-term NHS locum, with the possibility of longer-term recruitment as a CESR candidate. We are developing a longer-term workforce plan for Microbiology to address the significant increase in demand and test complexity. Our Consultant Microbiologists still recommend PCR tests for suspected COVID patients. Additional weekend working was temporarily funded during the pandemic, creating a current cost pressure for PCR testing. Our workforce plans for Microbiology will include options to reduce these cost pressures while meeting service demands.

Our new Head of Blood Science, started in March and has been a welcome addition to the team, bringing fresh ideas and innovations. However, as our only consultant clinical scientist, the Head of Blood Sciences is currently a single point of failure for Duty Biochemist support. We are collaborating with colleagues at Worcester to cover annual leave or unexpected absences in the short term, while we develop more sustainable workforce solutions for the medium to long term.

Our Immunology service remains vulnerable without Consultant Immunologist oversight. We have received recommendations from Bristol Immunology service on making the service more sustainable and meeting UKAS accreditations, which we are working through.

The Managed Laboratory Services (MLS) tender is still ongoing; due to the age of the current equipment, TATs are below recommendations. We expect significant improvements once new equipment is in place from April 2025.

Glen Burley
Chief Executive Officer

Integrated Performance Report

May 2024

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

I have two main and related concerns as we enter the second quarter of the year. The continued pressure on our urgent care pathways and our financial position.

We have continued to board a high number of patients during May and June, driven by increased demand and increased length of stay. The quality impacts of the congested ED and wards and the productivity impact of outlying medical patients in the day case unit and surgical wards is worrying. There is also a direct financial impact of staffing additional beds.

Despite the demand and congestion it is a credit to our staff that we have maintained the improved ED performance that we saw in March—albeit at higher cost than was in our plan. We have improvement plans in place across the whole urgent care pathway in acute and community services and with partners over the course of the summer. This includes admission prevention, in-hospital productivity, early supported discharge, virtual ward expansion and further improvement to discharge pathways.

The elective surgical hub, which is a fantastic state of the art new facility opens on July 8th. It is a three theatre complex designed for high throughput elective lists and is a net 2 theatre increase in our elective capacity (as we will release the current temporary Vanguard theatre). This opens up the opportunity to deliver more than our initial plan for elective work done on site and increase income to improve the financial position.

The opening of the surgical hub has provided the opportunity to reconfigure our bed base again to enable a better match of demand and bed capacity across medical and surgical beds. This will enable less outlying patients, less non clinical patients moves, better continuity and reduced length of stay.

Our financial position is a £1.2m adverse variance to plan at month 2. It is driven by under-delivery of our cost and productivity improvement plans and overspends on temporary staffing and non-pay. We have placed a high degree of scrutiny on our management and clinical teams to develop plans to deliver our financial plan. Our finance and performance meetings last month were focussed on financial delivery and there are numerous opportunities to improve oversight and control of temporary staffing, increase income and identify further cost reductions. My expectation is that by month 4 there will be an improved run rate and a risk assessed plan in place to deliver our CPIP target.

On a more positive note our cancer performance in May has met the end of year national 28 day faster diagnostic and 62 day referral to treatment pathway targets. Also our continued good performance on recruitment and retention has meant that we have been able to plan to revert all of our staff to agenda for change terms and conditions for extra work and overtime. The majority will be enacted in July with a few agreed exceptions by the end of the year.

Lastly I would like to put on record my thanks to Jon Barnes, Jonathan Boulter, the clinical support division and most importantly all our staff who work in pathology services. Following an IT failure of our pathology system which took 4 days to resolve they put in place the business continuity plans, reverted to paper based methodologies and worked tirelessly doubling up staffing to manually manage all pathology tests. All patients were able to access urgent tests and the department had caught up with the backlog of routine tests by the end of the week. An outstanding effort!

Our Quality & Safety – Executive Narrative

Chizo Agwu

Chief Medical Officer

Lucy Flanagan

Chief Nursing Officer

Safety in Sync– Shortlisted for a HSJ Patient Safety Award

Wye Valley NHS Trust, on behalf of One Herefordshire, submitted an application for the 'Developing Patient Safety Culture' award in the HSJ Patient Safety Awards 2024 for the work undertaken at the PLACE Based learning forum; Safety in Sync. The Safety in Sync team includes colleagues from WVT, Herefordshire General Practice and Worcestershire and Herefordshire Health and Care Trust. With attendance from a number of system partners (primary care, secondary care, mental health and community, ambulance and healthwatch) the forum has helped to connect colleagues to work on improvement projects that will directly impact the safety and quality of our services in Herefordshire.

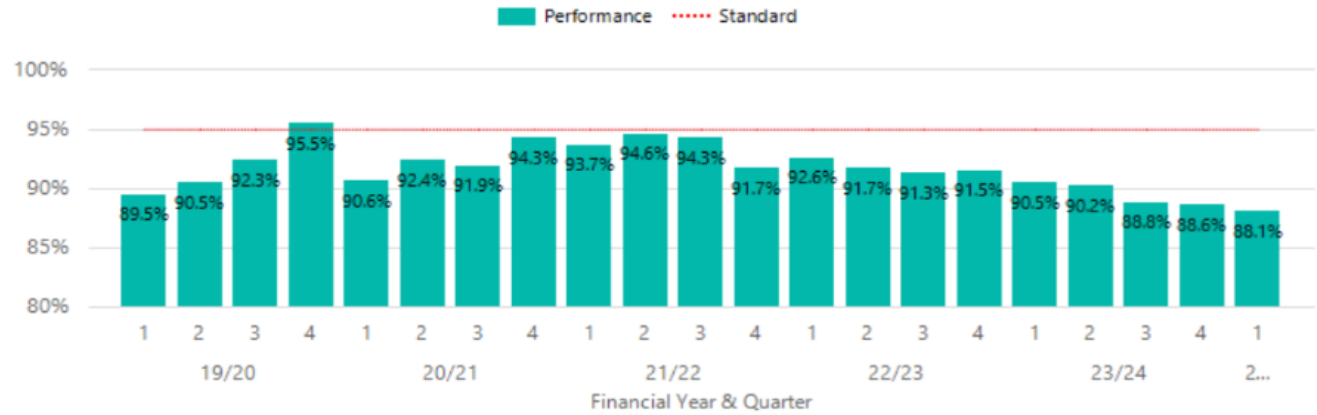
Venous Thromboembolism risk assessment

The national target for risk assessment is 95%. The trust has struggled to achieve the target as can be seen in the chart below. The current performance measure is for the assessment to be achieved within 24 hours of admission, yet as of April 2024 this has changed to within 14 hours and will represent a further challenge.

To tackle the issues the following action has bee taken:

- Committee membership and remit extended and adjusted
- Guidance and support sought from the VTE specialist network
- Risk assessment to be linked to EPMA (expected September 2024)
- Live dashboard developed to monitor compliance at a glance

Further improvement plans include the launch of an awareness campaign, further teaching at induction and extended provision at autumn teaching for all grades of doctors and Advanced Clinical Practitioners. Further development of performance reporting to include timeliness of administration of thromboprophylaxis treatment.



Quality and Safety – Mortality

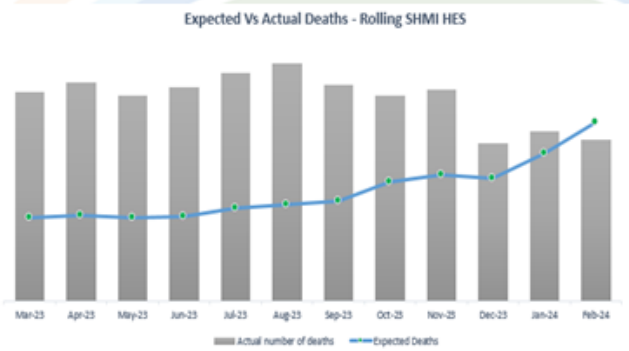
We are driving this measure because:

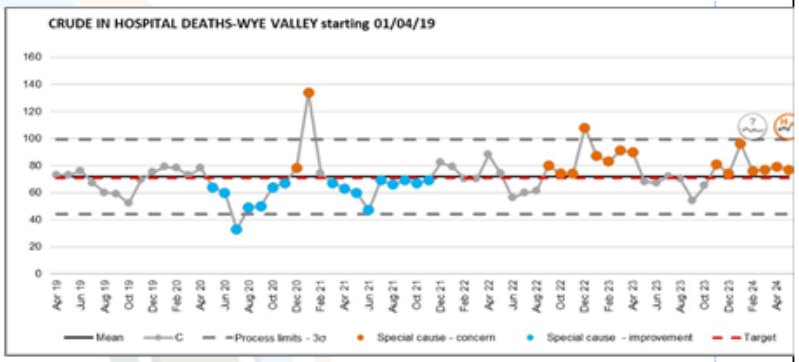
Mortality was previously reporting a 'higher than expected' level of mortality at WVT, based on our SHMI. The past few months have shown significant continued reductions in our SHMI, and has since returned to an 'as expected' level of mortality for our demographic.

Data

Indicator	Description/Notes	Data Period	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	-0.5

Indicator	Description/Notes	Data Period	Month Actual	Change
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Feb-24	99.0	-2.3
SHMI (in hospital)			93.7	-2.7
SHMI (out-of-hospital SHMI)			112.1	-1.41





What the chart tells us:

- Latest **SHMI** (*HES-based*) from March 2023 to February 2023 shows an encouraging reduction to **99.0** for Wye Valley NHS Trust, which now sits under the national average of 100 and continues a positive downward trend. The NHS Digital SHMI has not been updated since last reported (*January 2023 – December 2023*) and remains unchanged at 101.7.
- In regards to our key **mortality outlier groups**, there has been an overall positive month with several significant reductions in the latest data. #NOF and Heart Failure have reported around 5 point reductions, and a return towards the expected levels. Stroke data continues to show a rise in the SHMI and is now reporting above the national average at 106.2. Our two largest cohorts of deaths, Sepsis and Pneumonia, have also reported small reductions in their SHMI to 115 and 100 respectively.
- **Crude mortality** rate for May 2024 was **1.61%** for all admissions, which includes both planned and unplanned admissions to the Trust, equating to 77 deaths. Please note that this does not include any deaths occurring in the Emergency Department deaths.
- During May, 100% of hospital site deaths received a **Medical Examiner** review, with 17 cases escalated for further review.
- **Extended perinatal mortality** and **Stillbirth** mortality rates remain at 'lower than the expected' levels with the latest data (*June 2023 – May 2024*) both reporting rates are at **2.42 deaths** per 1000 live births.

Key Actions and Updates:

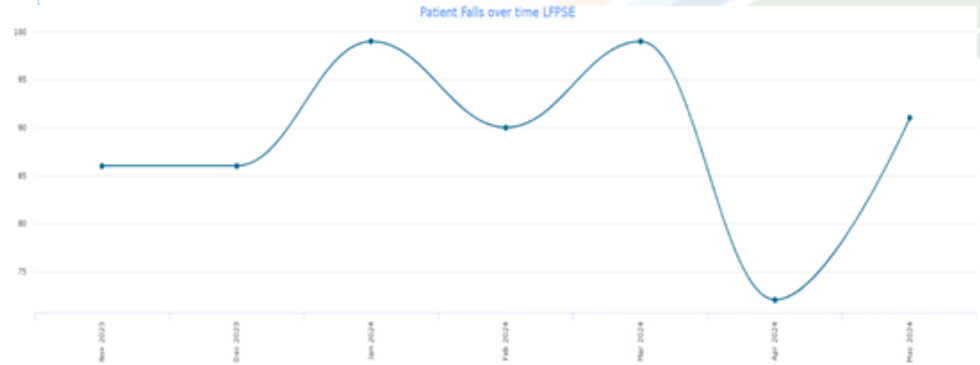
- The first **Learning from Deaths Committee** was held in May at which we had several presentations from various areas, providing updates on their latest data and on-going improvement work. There was an interesting presentation on the current #NOF and Care of the Elderly mortality rates. Actions have been taken to further investigate some of the concerns in the pathway.
- Following a recent Health & Well-being Board workshop, an initial meeting has been set up with Public Health and our local hospital team to better understand some of the various datasets discussed, which flagged some areas as potential national outliers. Further updates will be provided through the committee.
- Our local **Mortality Review Policy** has been updated to reflect the revised governance systems to monitor mortality at WVT. This policy is being discussed at the June Learning from Deaths Committee.

Quality and Safety – Falls

We are driving this measure because:

Falls are one of the highest reported incidents across the Trusts and is a safety priority in the Trust Patient Safety Incident Response Plan.; The safety priority focus is on **Inpatient falls in patients with dementia, delirium or a known high risk of falls.**

Data



	Total Falls	Priority Falls	% of total
Trust	623	65	10.4%
Integrated Care	158	18	11.4%
Medical	378	44	11.6%
Surgical	83	3	3.6%

What the chart tells us:

- The chart on the left shows the total number of reported falls in the trust.
- The table shows the proportion of falls that meet the criteria for the patient safety priority. Whilst Medical division have the highest number they equate to the same proportion as seen in Integrated Care. The clinical areas with the highest number of priority related falls are Dinmore, Garway and Ross CH and improvement plans are focussed in these areas particularly

Key Actions:

- Integrated Care and Medical divisions have comprehensive improvement plans in place to address falls. Demonstrable improvement has been made on the Frailty wards and they have seen an overall reduction in falls with harm in the last 18 months.
- There is a focus on use of bed rails as an emerging theme from incidents linked to the safety priority. This is being addressed through a Trust wide audit and improvement plan. Initial review has seen that falls risk assessments are correctly completed however the correct action is not always taken in respect of using bed rails.

Quality and Safety – Enabling Patient Flow

Enabling patient flow and supporting timely ambulance offloads is a priority to maintain patient safety. This includes the use of Boarding spaces when patients require admission and effective use of the Discharge Lounge to enable patient flow and timely access to bedded capacity..

Data

	Total		Boarders		Escalation	
Date	Average	Range	Average	Range	Average	Range
Nov	30	7-43	18	6-27	12	1-20
Dec	29	7-50	17	5-29	12	2-20
Jan	37	29-47	23	17-29	14	8-18
Feb	39	28-48	24	15-30	15	7-19
Mar	34	17-47	23	15-33	11	2-18
Apr	35	19-47	21	12-32	14	6-20
May	40	25-65	25	16-34	16	9-25

Discharge Lounge			
	Average	Range	Total
Jan	13	1-18	391
Feb	12	4-16	354
Mar	11	3-17	332
Apr	11	2-21	329
May	12	3-21	383
Jun	11	3-22	

	ED attendances per week	Admissions per week
Jan	1296	393
Feb	1393	407
Mar	1699	424
Apr	1755	414
May	1796	413

Performance and actions

The first table shows the number of boarders and the number of escalation beds open each month, the second table shows utilisation of the discharge lounge with daily averages and monthly totals and for context the final table shows the number of ED attendances per week and the number of admissions. What can be seen from this is that the pressure on the ED and admissions has been sustained and increasing without the usual reductions that would usually be expected at this time of year.

The impact that boarding can have on patient and staff experience is far from ideal and we have seen an increasing number of concerns expressed by staff and patients . In order to address this the trust is focussing on:

- Increasing virtual ward capacity
- Improving access to GP out of hours
- Maximising Same Day Emergency Care
- Review and reconfiguration of the bed base given the opening of the Elective surgical hub to provide more bedded capacity for medicine in preparation for Winter 2024
- Cross divisional working to review and optimise the discharge pathways
- Continued focus on service improvements within the Emergency department

Quality and Safety – Staffing

Fill Rate and CHPPD Data

Fill Rate and CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	104%	76%	98%	94%	9.0
Maternity Ward	98%	97%	100%	97%	6.7
Children's Ward	132%	101%	123%	70%	20.1
Lugg Ward	127%	81%	144%	131%	6.5
Wye Ward	123%	81%	120%	93%	7.0
Cardiac Care Unit	100%	95%	100%	100%	11.5
Leominster Community Hospital	156%	106%	100%	169%	7.2
Bromyard Community Hospital	126%	156%	101%	186%	8.0
Ross Community Hospital	102%	118%	101%	138%	6.5
Teme Ward	116%	68%	95%	59%	11.5
Redbrook Ward	100%	97%	100%	98%	5.8
Special Baby Care Unit	87%	-	92%	-	31.1
Intensive Care Unit	123%	-	96%	-	27.0
Gilwern Ward	118%	64%	101%	59%	6.6
Acute Medical Unit	124%	93%	94%	131%	8.2
Ashgrove Ward	112%	87%	103%	123%	7.1
Dinmore Ward	126%	87%	100%	134%	6.5
Garway Ward	121%	90%	99%	111%	6.7
Frome Ward	126%	81%	102%	99%	6.5
Arrow Ward	148%	76%	148%	86%	7.7
Women's Health	116%	92%	100%	-	9.7

Overall Fill rate data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Trust Wide	118%	91%	106%	109%	8.2

There are a several ward areas that are above the 100 % fill rate level:-

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

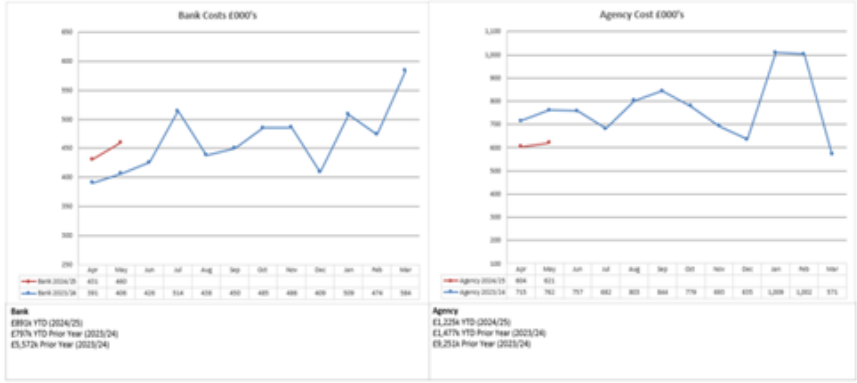
Lugg Ward – Establishment review undertaken, agreement for additional staff, based on acuity and dependency of patients, not yet adjusted within funded establishment.

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

Dinmore, Garway and Ashgrove Wards – 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, but not yet adjusted 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.



Thornbury Usage

March and April saw the lowest temporary staffing usage within Nursing for the past 12 months, this increased slightly in May 2024. This increase has been driven by staffing for additional escalation areas that have been open through out the month., and patients with additional care needs for the acuity and dependency.

Despite the reduction seen in agency spend, further reductions are required in order to meet the 4million CPIP target.

Thornbury Nurse Agency spend decreased slightly from the previous month, now seeing 3 months with very low usage. NHS England have asked for the use of all non-framework agency (this includes Thornbury Nursing Services) to stop by July 2024. The Trust have been implementing a plan and met with NHS England regional team in April 2024, to ensure compliance with this. A break glass process is now in place for any off framework agency.

Our Performance – Executive Narrative

Andy Parker

Chief Operating Officer

During May we continued to see record high attendances through our Emergency Department [ED]. Type 1 ED attendances , described as a Consultant led 24-hour service with full resuscitation facilities, reached almost 6,500 patients, which averaged 214 patients a day, compared with May in 2023, and this is an additional 20 patients per day. The last three months have seen recorded Type 1 ED above 6,300 attendances, a significant increase.

In May we continued to see positive 4 hour Emergency Access Standards for Minor and Paediatric Type 1 attendances, both at 95% for the month, with continued improvements in our Triage times and our Same Day Emergency Care [SDEC] pathways remain strong with increased volumes of patients.

However, the congestion in our ED department and the additional bordering patients in unconventional care beds remains at the same high unacceptable level as the winter.

We continue to see a sustained reduction in patients delayed waiting for discharge Pathway 1 and also the amount of time from Medically Stable for Discharge [MSFD] to actual discharge

Our focus is now on Pathways 2 and 3 bedded pathways, with work being undertaken by operational and commissioning colleagues across our system- this is being monitored through our Discharge to Assess [D2A] Board. In the next few months we are going to launch our D2A Dashboard across the system which will allow System partners to review capacity and delays across the whole system which will allow for easier escalation and working together to resolve issues.

From a quality perspective, our plans around maximising reablement potential is in progress and we are focusing on our reablement education offer. This will be system wide and will be offered to all of our partners and providers, working within our D2A services.

West Midlands Ambulance Service [WMAS] referrals to Urgent Community Response [URC] continue via all agreed routes including Touchpoint calls, clinical conversations and the team reviewing the WMAS Computer Aided Dispatch [CAD] portal. We have seen an increase in both referrals and the number of calls taken of the CAD by UCR in May. Work is ongoing to improve recording of referral location and type. Changes with streaming process at WMAS have seen a rise in inappropriate referrals, which is resulting in capacity issues in our Community Integrated Response Hub [CIRH], due to additional referral management and triage. A deep dive in progress to understand effect.

A phased approach has been developed and commenced, related to our Virtual Ward [VW]

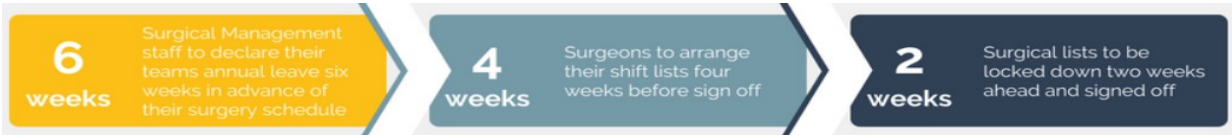
Phase 1 May- July - review of our current 20 bedded ward to reflect on the last 12 months and deliver improvements- our focus being maximising occupancy and improving governance

Phase 2 July- September - the expansion of our VW beds and the transfer of the service to our Integrated Care Division to allow for improved integration with Primary Care and basing the co-ordination function of VW with the community delivery function. Discussions are ongoing with acute services and primary care to identify opportunities for specialties to have beds on the ward.

Our Elective Surgical Hub [ESH] is due to open on the 8th July. Ongoing work and final preparations are happening to get the two new Theatres and Cataracts Suite ready for its first patients.

Morale among our Theatres teams is high in anticipation of this new facility and the Surgical Division and support services are working extremely hard to unsure that testing of technology, patient pathways, changes and revision to Theatre Templates and scheduling of operating lists are as robust as the can be ahead of the “Go Live” date.

Key to the successful running of any Operating Theatres is all in the planning ahead of the day of surgery. The Productivity Operating Theatre concept of the 6-4-2 scheduling supports theatre teams to work more effectively together; to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and overall staff experience.



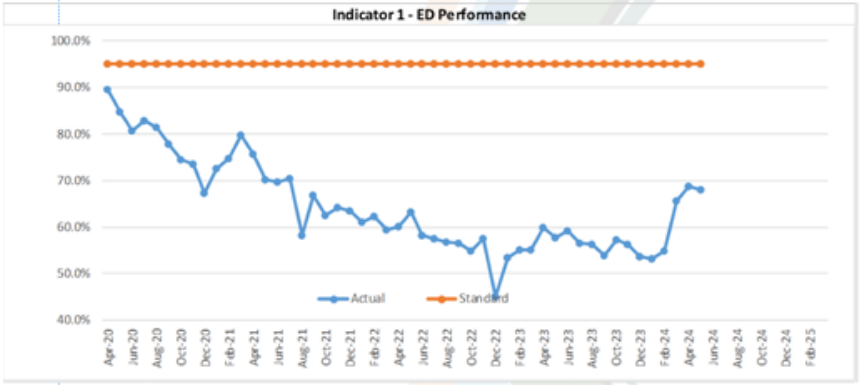
While there has been some positive movement with scheduling, it is acknowledged that we have a huge amount more to do to deliver further improvement but also to transition the Surgical Specialities and Theatre teams into a position where good and effective scheduling becomes business as usual.

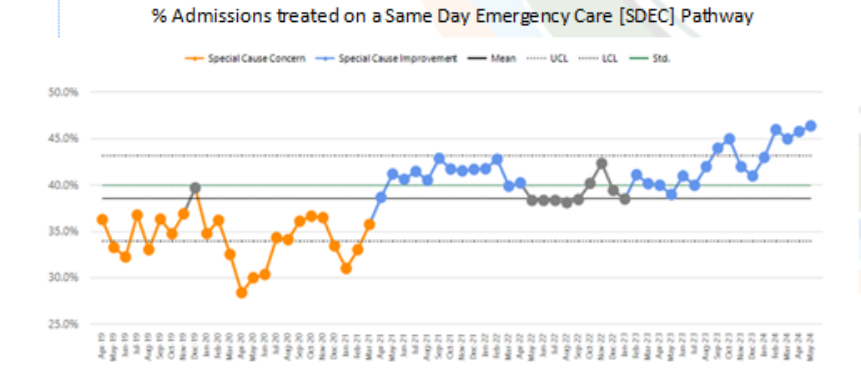
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

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

- 6,700 Type 1 patients attended ED in May. The range of all attendances varied from 193 to 324 with 254 being the average daily attendances. Average daily Type 1 ED attendances in May 2024 was 216 and April 2023 was 188. In May 2023 the average daily Type 1 attendances was 195 per day, an increase of 10%.
- 1, 722 ambulances conveyed to the Trust in month. The range in month was 45 to 77. This includes 10% from Powys [180]
- Ambulance handover delays over 1hr were 10% [167] of all conveyances and 73% [1,157] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,183 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:

- Improvements to ED processes. Work continues to embed some of the successful trials including the navigator role and the minor illness service. We have seen our Minor performance improve to 94% seen and discharged within 4 hours and our non-admitted patients time in the ED reduce, on average, by almost 45 minutes
- Virtual Wards. We have held workshops to look at how we can expand and improve this service and the patient pathways, to increase capacity so that we can provide this service for more patients by later this year. Includes expanding the referral pathways for some of our specialities not included on Virtual Ward and "step up" patients from Primary Care to avoid Secondary Care admissions to physical acute bed.
- Utilisation of current Day Surgery Unit post Elective Surgical Hub "Go Live". Workshop held with Divisions to discuss how we utilise this area for Winter this year to support increased medical beds and reduce medical outliers. Agreed way forward to be presented over the course of the next six weeks

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 68.1%

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

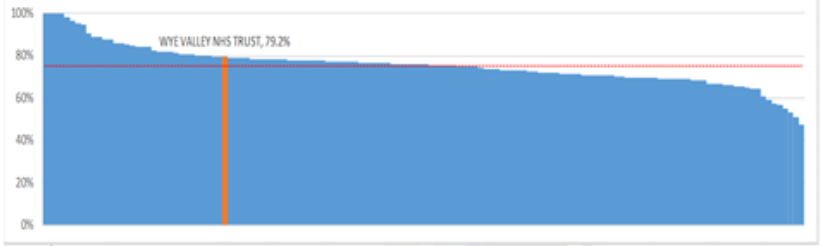
We are driving this measure because:

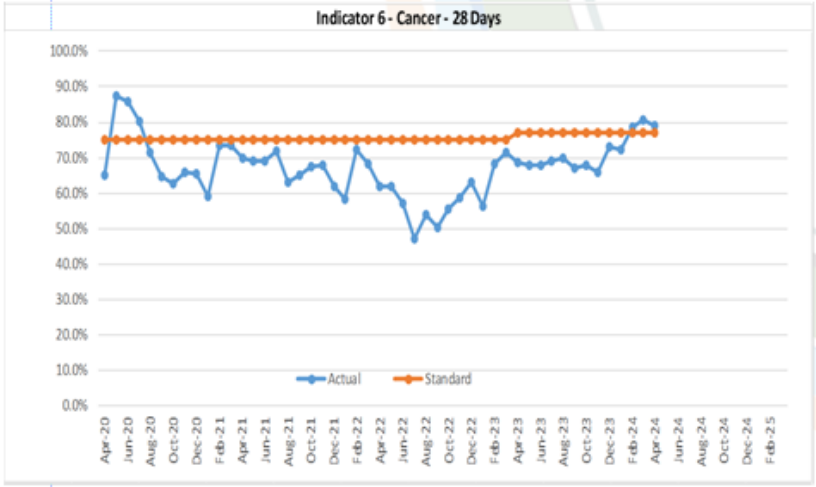
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 75% of patients getting a cancer diagnosis, or 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 34 out of 140 Trusts.





Performance and Actions

Referrals

- Cancer referrals remain high with a 29.1% increase compared with 3 years ago which equates an additional 2707 patients.
- Colorectal referral data shows a significant increase of 38.6% over the past three years, corresponding to 603 additional referrals. Recently, however, there has been a noticeable reduction in the referral rate. This decrease is attributed to the introduction of the Faecal Immunochemical Testing (FIT) pathway, designed to stratify patients by risk and ensure that those at higher risk of colorectal cancer are referred as Urgent Suspected Cancer (USC) cases. The effectiveness of the FIT pathway in reducing unnecessary referrals while maintaining or improving the identification of high-risk patients is under continuous observation. An audit will be conducted to ensure compliance with the FIT pathway guidelines and to assess its impact on referral practices.

Main Issues impacting on 28 day performance and actions:

- Gynaecology services are currently facing challenges due to administrative delays caused by workforce shortages. A working group is actively seeking solutions to mitigate these delays. The situation is expected to improve with the implementation of the Post Menopausal Bleeding (PMB) Pathway, scheduled to go live in Quarter 3. This pathway is anticipated to reduce the number of referrals from primary care to the Trust.
- Computed Tomography (CT), Colonography CT (CTC) and Magnetic resonance imaging (MRI) have increased their access targets to between 10 and 14 days. An increase in demand has driven this position although reporting has improved. Ring fenced capacity has been identified to help manage cancer demand from July.

Improvements

- Administration delays previously noted across some cancer specialties have improved with numerous specialties turning around results within the 5 day local target.
- Head & Neck first seen capacity was previously an area of concern however work has been completed to ensure patients can be seen within 7-10 days of the 62 day pathway.
- Faster Diagnosis Standard (FDS) performance remains above the national target since February 2024. Despite the national target not increasing to 77% until March 2025, a local target has been set at 77% from April 2024 which we have been compliant with to date.

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:

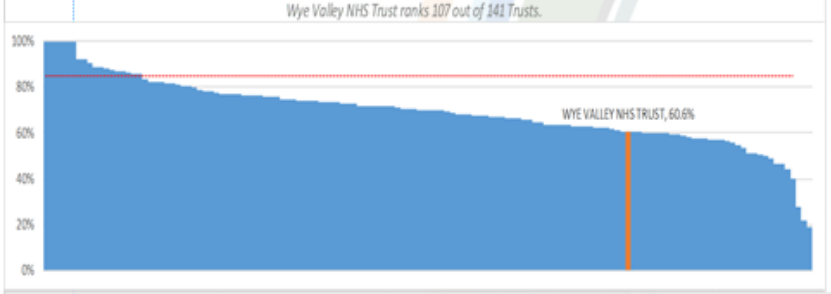
- 28 Day faster diagnosis = Performance against this target was 79% and remained below the target of 75% and below our trajectory for the month.

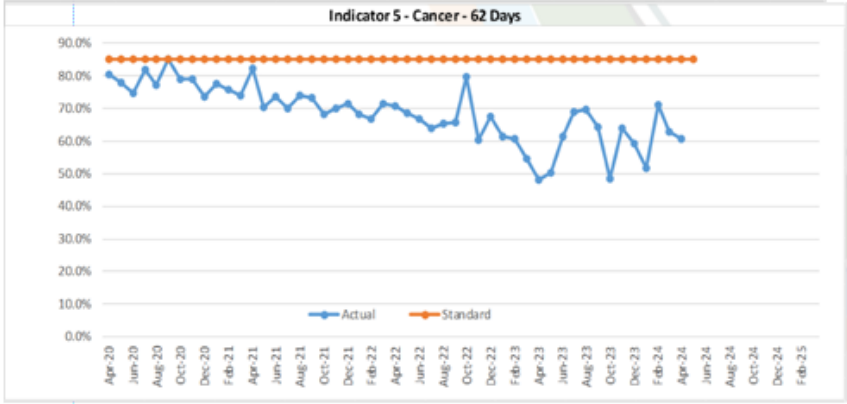
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [April 24]

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 April, the Trust's compliance with the 62-day cancer referral target of 85% was just over 60%, with 30 patient breaches. Breaches are being contributed to by the delays facing the 28 day target and theatre capacity. May performance is expected to show an improvement in this area.
- With regards to the Trusts cancer back log position, in April we maintained a strong position hovering at around 55 patients over 62 day on the cancer Patient Tracking List.
- The trust continues to work towards meeting the national target of 85%, although 70% for 24/25, and continues to complete weekly deep dives to understand the challenges

Key Actions:

- The use of text messaging to reassure patients of benign results is still being worked up with a view of piloting in one specialty first.
- 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.
- The Best Practice Timed Pathway analyser tools have now been developed to provide improved visibility of compliance against each pathway and will be used from July for national submissions to the West Midlands Cancer Alliance.
- Best practice timed pathway dashboards continuing to be developed to show Wye Valley Performance in relation to targets set.

Improvements

- A process to increase the number of patients that can be reassured at the point of endoscopy has been approved and is due to go live in July 2024.

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 60.6% against a target of 85%.
- Number of patients waiting over 63 days reduced to 51 patients at the end of April compared with 118 the end of January.

Operational Performance – Referral to Treatment Performance / Activity / Productivity

We are driving this measure because:

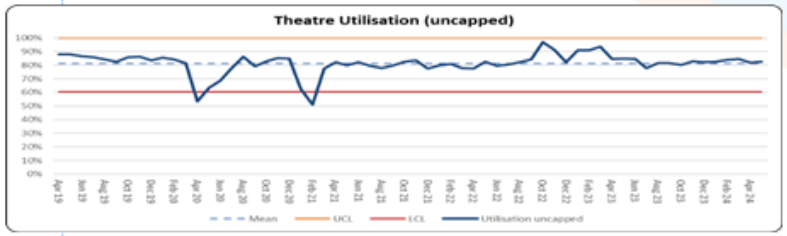
Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments 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

Outpatient Activity		Year To Date
New	2019/20	10309
	Plan This Year	10842
	This Year	11711
	Diff vs 19/20	1402
	Variance	14%
	Diff vs Plan	869
	Variance	8%
Follow Up	2019/20	21293
	Plan This Year	21994
	This Year	25140
	Diff vs 19/20	3847
	Variance	18%
	Diff vs Plan	3146
	Variance	14%

Charts

Admissions		Year To Date
Elective Inpatient	2019/20	548
	Plan This Year	407
	This Year	492
	Diff vs 19/20	-56
	Variance	-10%
	Diff vs Plan	85
	Variance	21%
Elective Daycase	2019/20	3228
	Plan This Year	3115
	This Year	3666
	Diff vs 19/20	438
	Variance	14%
	Diff vs Plan	551
	Variance	18%
Elective Endoscopy	2019/20	1479
	Plan This Year	1534
	This Year	1683
	Diff vs 19/20	204
	Variance	14%
	Diff vs Plan	149
	Variance	10%

Charts



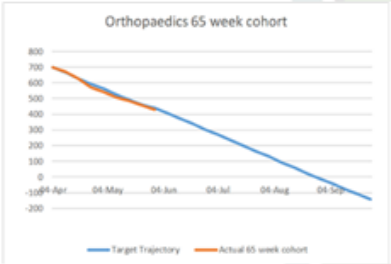
Performance and Actions

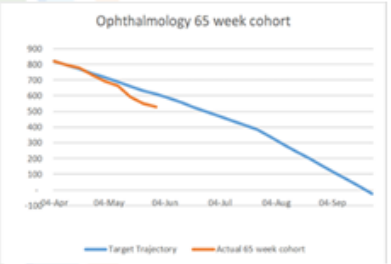
Activity Summary:

- New Outpatients [OP] Year to Date [YTD] activity was 8% above plan / Elective inpatient was 21% above plan YTD / Elective Day Cases was 18% above plan YTD at the end of May 24.

Long Waiting Patients:

- 7 English patients and 6 Welsh patients were waiting greater than 78 weeks at the end of May 24.
- 65 week position at the end of May was 119 English and 35 Welsh patients. The main two specialities driving 80% of our 65 week issues are Orthopaedics and Ophthalmology and weekly monitoring is in place. Both specialities are current at / under trajectory:





- Our 65 weeks end of September risk cohort patients that are undated has reduced from almost 2000 at the end of April to has reduced just over 1100 at the end of May. A reduction in 900 patients.

<u>Theatre Productivity</u>

- Capped Theatre Utilisation was 77.9% for May, an improvement on April performance by 0.7%.
- Increased number of used Theatres sessions in May 2024 at 309 compared with 293 in April. With 737 patients treated in May an increase in the number of cases through Theatres in April.
- Theatres Scheduling remains a key factor in successful Theatre Utilisation and our weekly Scheduling meeting is seeing improvements in the 6-4-2– Scheduling process. We first introduced measures for the 6-4-2 process in late November, at which point that number of lists without a surgeon identified at weeks 5-6 was around 20%. It is now averaging 10%.

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:

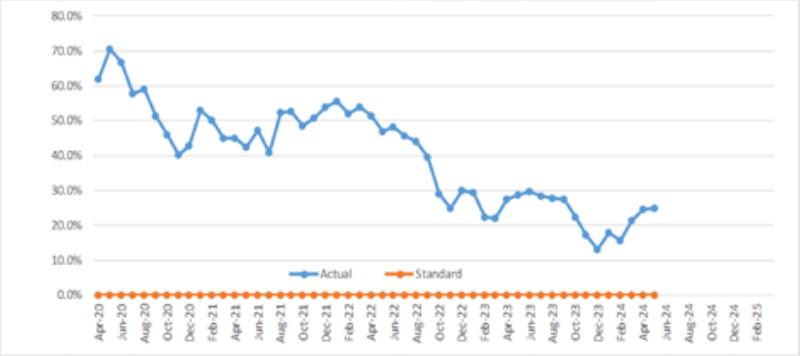
- Performance against English RTT standards in May was 55.5% - 1.1% increase since last month.

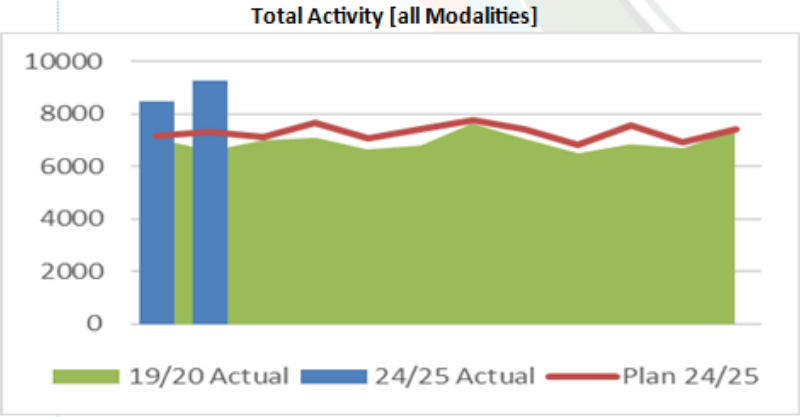
Operational Performance – Diagnostic Performance

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





Performance and Actions

Overall Diagnostics delivered 141% of May`s Activity plan and 127% of the same month 2019/20:

Imaging:

- Magnetic Resonance Imaging [MRI] achieved 180% of 2019/20, 131% of 2024/25 plan activity last month (168% and 120% respectively in April). Despite increased performance, there has been a deteriorated waiting list position due to increased inpatient demand.
- Computerized Tomography [CT] achieved 161% of 2019/20 and 127% of 2024/25 plan activity last month (143% and 112% respectively in April)—again despite improved performance slight deterioration in waiting list position due to increased inpatient and 2ww referral demand.
- Non-Obstetric Ultrasound [NOUS] achieved 114% of 2019/20 and 143% of 2024/25 plan activity last month.
- Overall 6 week wait position at end of last month was 84%. CT and MRI >13 week long waiters will be reduced by August.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] were 14 and 12 days respectively—new average time performance calculations and Power Business Intelligence [BI] dashboards will be available for month 3.
- 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 NHS England key performance indicator.

Audiology:

- Audiology 6 week wait position improved significantly in May to 64.7%, compared to 51.3% in April.
- As anticipated, Audiology 13 week waiters at the end of May demonstrated a slight deterioration from 43 in March to 58 in May due to annual leave effecting capacity. A new operating model for delivering under 4 paediatric assessments is being trialled 1st July - doubling throughput from 4 to 8 per clinic. If successful zero 13 week waits projected September.

Echocardiography [Echos]:

- Workforce challenges continue. 281 patient currently undated over 13 weeks, as of end of June ,with the risk cohort of 943 breaching 13 weeks by the end of August. In order to address an Insourcing plan to clear backlog and delivered by the end of August which commences the end of June whilst core capacity to focus on 6 week trajectory

Risks:

- Increased inpatient / acute floor referring impacting on capacity of service.
- Audiology and Echo capacity and workforce challenges

What the charts tells us:

- End of May 75 % of patients waiting less than 6 weeks for a diagnostic test. Deterioration driven mainly by Audiology and Echo increases in waiting lists. There has also being an impact on imaging due to increases in inpatient and acute floor referrals impacting on capacity.

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

Junior Doctors announced further strike action for 5 days from 27th June until 2nd July. During the forthcoming industrial action the Trust will aim to operate a Christmas ward cover rota as a minimum. Divisional teams have developed comprehensive plans to minimise the impact on our patients.

Specialist and Associate Specialists (SAS) drs have accepted the revised pay offer which will see drs on the 2021 SAS contracts receive a basic pay uplift of between 6.1 and 9.22% of their current pay. This bring to and end their dispute with the government.

We are taking active steps to maintain sickness absence at below 4.5% over the next few months with a focus on employees who have ongoing short term sickness absence and those who have been absent for over 100 days over the past months. Comprehensive plans for each individual are being reviewed by HR and OH to ensure adequate support and appropriate management actions are in place. The main reasons for sickness absence are mental health conditions, gastro conditions and infleunza. The close monitoring and sensitive 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 now stands at 9.2% 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 now stands at to 8.81%. Staff turnover for band 2 hcsw staff now stands at 14.94%. Areas with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments.

Working with ICS wide colleagues, we are supporting the development of the Culture & Inclusion strategy "*Making Inclusion a Reality".* The strategy is based on three key areas which aims to address health inequalities, enhance the staff experience and strengthen the freedom to speak up culture across all ICS organisations.

In our efforts to contribute towards a more inclusive and accepting society, we supported Pride month with our LGBTQ+ colleagues as the annual event serves as a powerful reminder of the importance of acceptance, diversity, and love for everyone.

Our workforce opportunities working group is in place with HR, finance and project leads working on a number of schemes to generate cost savings and enhance productivity through implementing automated processes in back office areas over the coming year.

With effect from 1st July, we are terminating many local pay rates that have been in place over a number of years and reverting back to Agenda for Change pay rates as part of the efficiency savings drive for the Trust.

We have teamed up with Halo Leisure to run our first ever WVT Family Fun Day for Trust staff and their families on the afternoon of Saturday, July 6. A number of local businesses have signed up and the Fire Service will also be supporting the event.

Divisional leaders supported by HR are holding staff engagement/listening events across the trust as part of the InTouch "*Just one thing"* 2024 staff engagement programme on enhancing patient care, health & wellbeing, the working environment and eliminating waste.

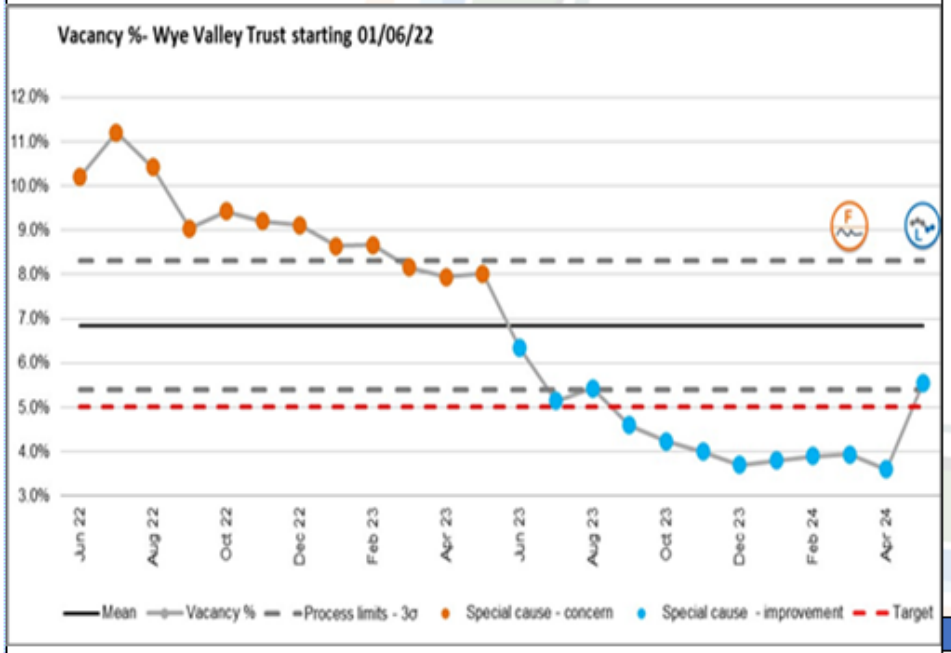
Our Workforce – Vacancy

We are driving this measure because:

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

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
8.0%	6.3%	5.1%	5.4%	4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%

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

We are taking active steps to fill clinical vacancies to meet the additional staffing requirements for planned developments to enhance patient care. A new monthly staff movement/budget report is now in place to track and ensure all staff movements are appropriate and within agreed budgets. HRBPs supported by the central recruitment & medical staffing teams are leading divisional action plans to fill vacancies .

HCSW - the centralised recruitment process for healthcare support workers is now back in place with regular interviews conducted by HR and divisional managers. WVT Ambassadors are supporting career events at schools, colleges and universities, this reflects on our aim to support 'young people' within the county and neighbouring counties to consider employment options at the Trust.

Nurses - we are on target for our international recruitment nurse programme as we will have welcomed 22 nurses into the trust at the end of June. By March 2025, 77 new nurses will have joined the Trust reducing our reliance on agency staff.

Surgical Elective Hub - we continue to work with the surgical division on the workforce required for the elective hub workforce, currently we have recruited and welcomed over 30 theatre nurses/ODPs into theatres. We are now sourcing additional theatre nurses and ODPs for the Hub which is due to open in July.

CDC - the overseas recruitment programme is on track and 29 staff have been recruited to-date for the CDC.

Pharmacy - vacancy rates for pharmacists peaked at 55% during 2023 and are currently at 32%. It is anticipated that the pharmacist vacancy rate will fall to 10% by October 2024 through a combination of incentives and international recruitment.

The Trainee Nursing Associate programme is well underway with another cohort planned for September this year, work is being looked at and scoped to see how many staff would be interested and encouraged to ensure they have the correct criteria to be able to enrol on to the course/programme. To date we have 75 TNAs/RNDAs currently going through the apprenticeship nursing route

The medical recruitment team are focusing on ensuring all gaps for doctors in training are filled prior to the main change over of doctors in August.

Risks: Clinical vacancies .

What the chart tells us:

The rolling 12 month position shows a significant reduction in vacancies over the past year. The increase in May is mainly attributable to an uplift in clinical establishments

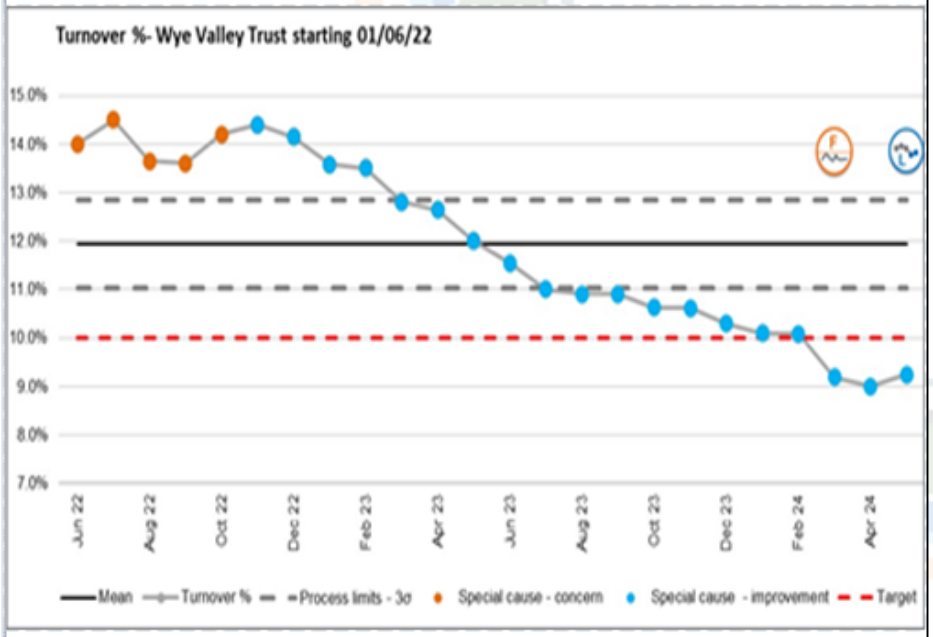
Our Workforce – Turnover

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.

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
12.0%	11.5%	11.0%	10.9%	10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	9.2%	9.0%	9.2%

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 overall rolling 12 month turnover at Trust level is at 9.2% for April 2024.

Staff turnover remains below the NHS wide target of 10% and the WVT recruitment & retention group continues to monitor staff turnover with divisional managers.

Turnover for qualified nurses & midwives now stands at 8.81%. HR teams are putting in more efforts in supporting departments (children's community nursing, wye, mru, frome, a&e, ross) with an increase in staff turnover.

Staff turnover for band 2 hcsw staff now stands at 14.94%. The centralised recruitment project is now back in place with a focus on areas where there has been an increase in turnover (outpatients, frome, ross, women's health, lugg, acute medical unit).

To support our grow our own staff strategy, we will be supporting 20 more healthcare support workers to commence the trainee nursing associate programme at the University of Worcester in September. 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.

We continue to promote apprenticeships to clinical and non clinical staff across all sites. We currently have over 150 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. Volunteers continue to support HR and Occupational Health teams and we are seeking to expand these into other non clinical departments.

What the chart tells us:

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

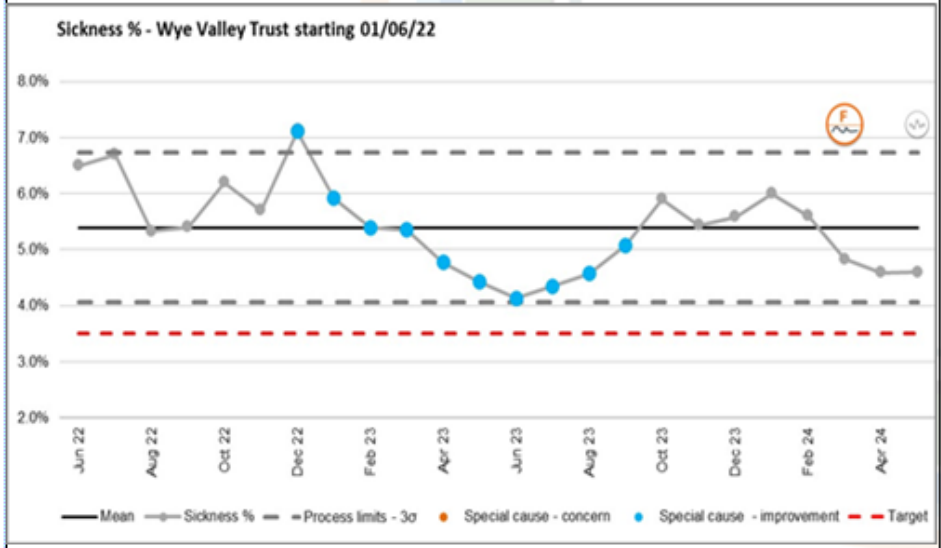
Our Workforce – Sickness

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.

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

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

Sickness absence at Trust level remains at 4.6% and the main reasons for absence colds/flu, gastro and mental health conditions.

To ensure we can maintain sickness absence at below 4.5% over the coming months, we are focusing on employees with ongoing short term absences and those who have been absent for over 100 days to ensure appropriate support and management action plans are in place. Comprehensive divisional reports showing actions being taken to reduce sickness absence will continue to be presented at F&PE meetings. Divisions will also be reporting on deep dives conducted on teams with high absence levels.

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, well-being 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.

Risks:

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

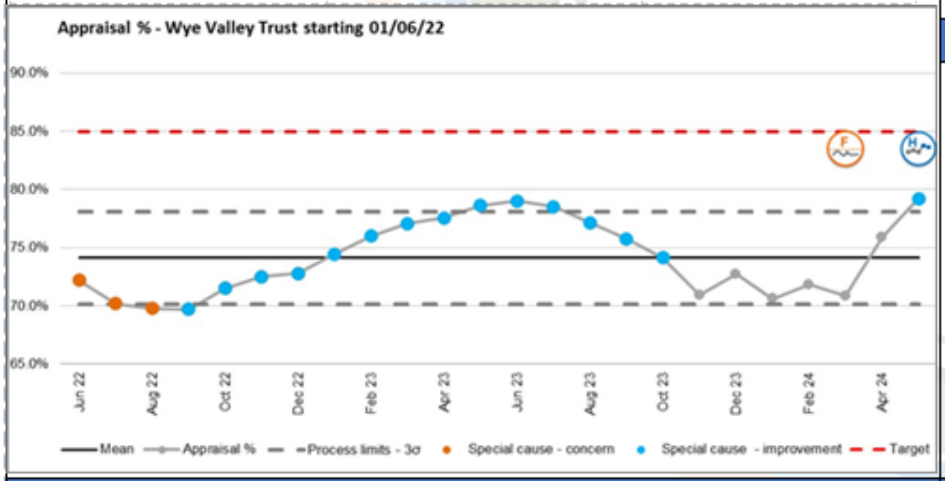
Our Workforce – Appraisal

We are driving this measure because:

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

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
78.6%	79.0%	78.5%	77.1%	75.7%	74.1%	70.9%	72.7%	70.6%	71.8%	70.8%	75.9%	79.2%

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

We have seen an increase in the % of completed performance appraisals from 75.9% to 79.2% and line managers are taking active actions to ensure all outstanding appraisals are completed over the summer months..

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 well-being 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.

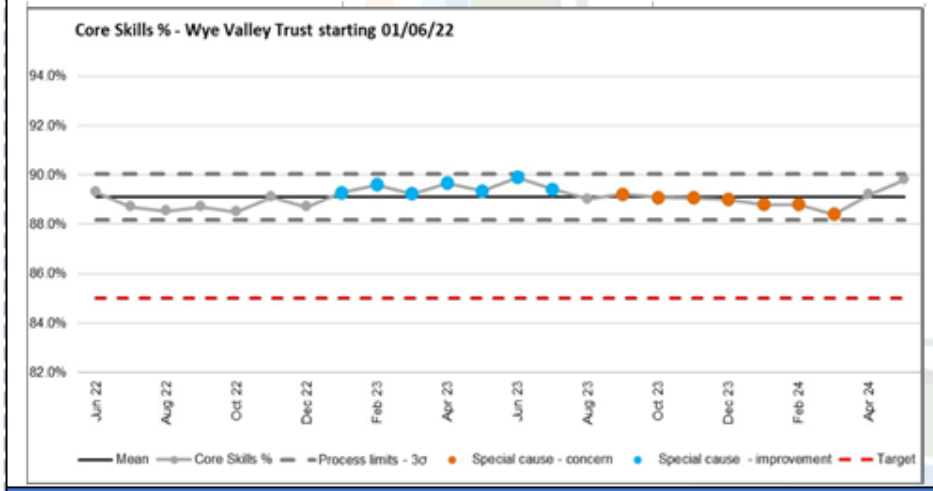
Our Workforce – Core Skills

We are driving this measure because:

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

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
89.3%	89.9%	89.4%	89.0%	89.2%	89.1%	89.1%	89.0%	88.8%	88.8%	88.4%	89.2%	89.8%

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

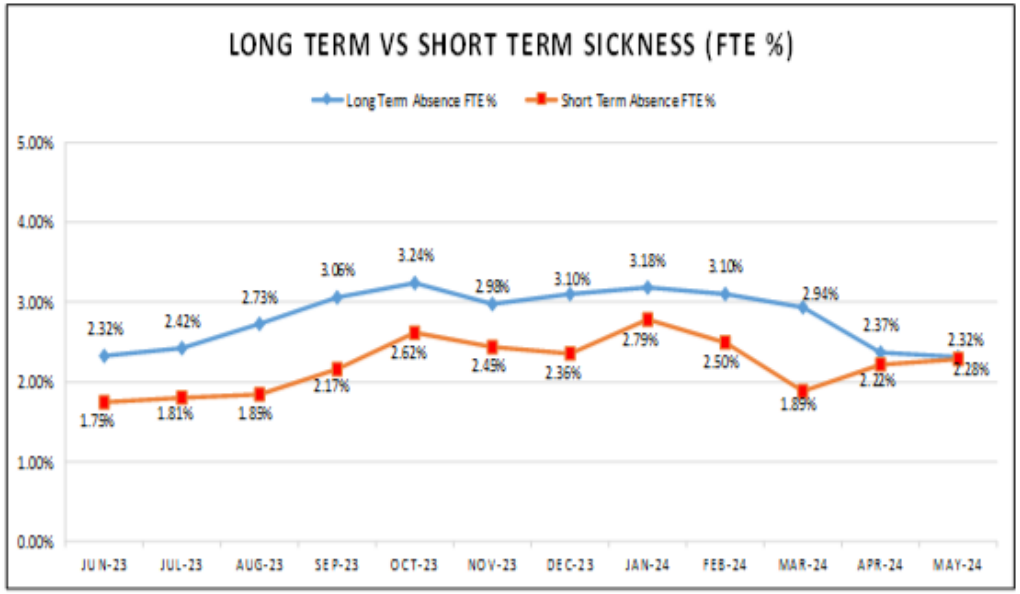
The Trust continues to make good progress in this area. This will continue to be reviewed at F&PE meetings

Risks:

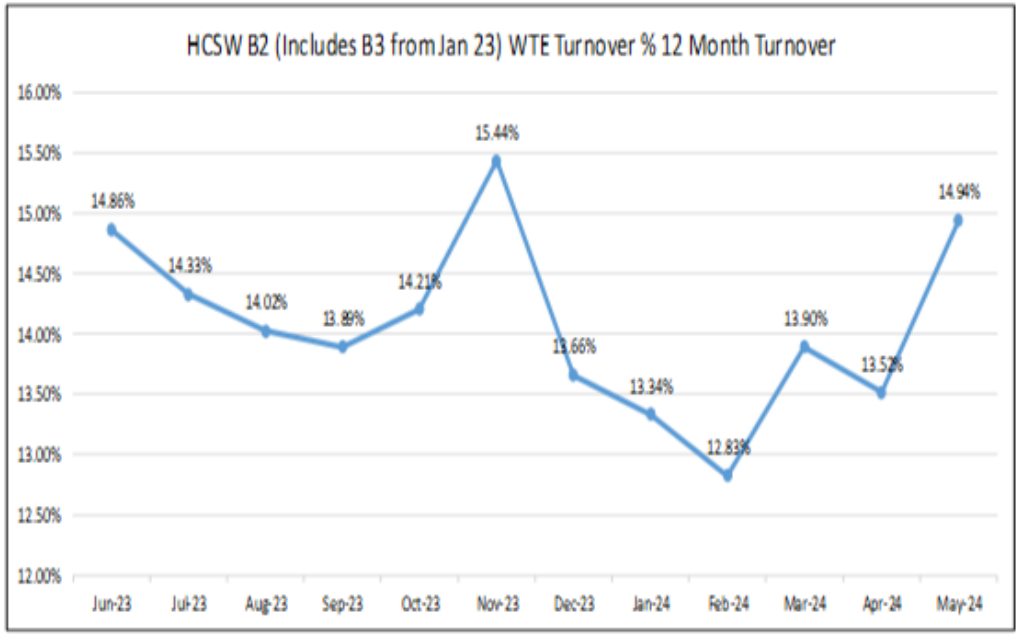
What the chart tells us:

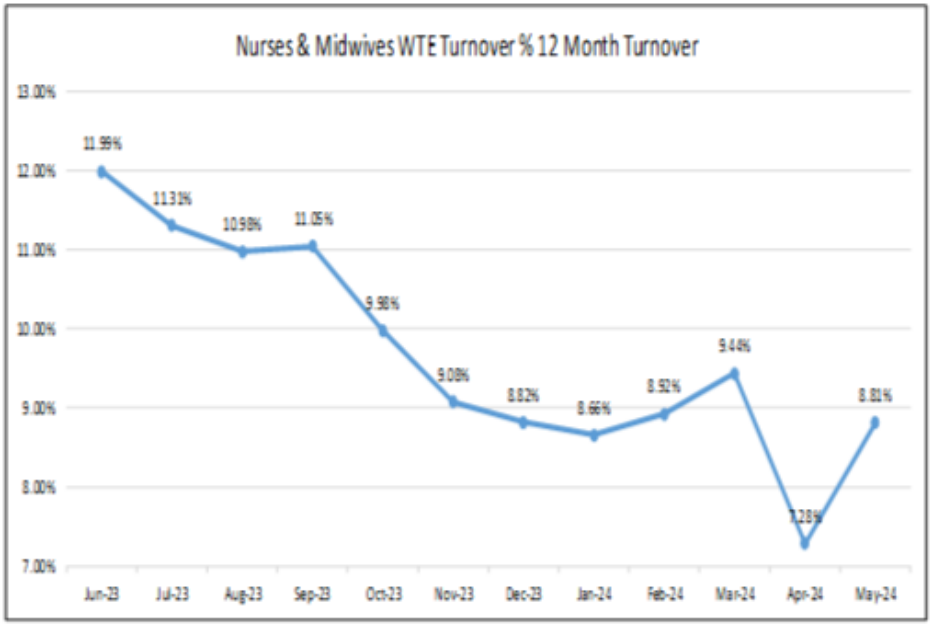
The rolling 12 month position remains fairly consistent above target .

Sickness absence remains at 4.6% and more actions are being taken to reduce absence. Staff turnover for HCSWs has increased in outpatients, frome, ross, women's health, lugg and acute medical unit. Turnover for nurses has increased in children's community nursing, wye, mru, frome, A&E, ross. HRBPs are driving action plans to address recruitment & retention in these areas.



Main reason for absence - Top 5 -May 24	%
S13 Cold, Cough, Flu - Influenza	24.00 %
S25 Gastrointestinal problems	17.99 %
S10 Anxiety/stress/depression/other psychiatric illnesses	12.73 %
S30 Pregnancy related disorders	7.40 %
S16 Headache / migraine	5.87 %





Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

24/25 Financial Plan

The Trust set an income and expenditure deficit plan of £34.4m as part of the overall H&W system plan, which was not accepted nationally. A further submission was made on 12th June 2024 which reflected a **deficit plan of £31.4m**. The changes are additional stretch CPIP target of £1.2m and additional income to reflect the impact of PFI accounting of £1.8m. Reporting will now be against the £31.4m deficit plan.

Month 2 Income and Expenditure position

The month 2 position was a year to date deficit of £7.1m. This was behind the planned deficit of £5.9m, with an **overall adverse variance of £1.2m**. Though the period has been challenging operationally, it is a disappointing financial position at this early stage of the year.

At Month 2 we have seen overspends against planned pay costs of £0.9m, non-pay £1.1m and excluded drugs £0.4m. These were offset by additional income (including ERF) of £1m. A number of factors have adversely impacted the position, including some one off items, though the primary driver of the adverse position relates to CPIP under delivery of £0.9m to date. At month 2 there remains is in the region of £5m still not identified against any opportunity; a cross divisional CPIP workshop was held during May to understand progress, risk and opportunities for further schemes.

Extended Finance and Performance Executive meetings are being held to facilitate deep dives into divisional financial performance to ensure an effective response to mitigating financial risk and delivering the financial plan.

Capital

The capital available to the Trust has reduced by £0.6m as the system's CDEL allocation has been reduced due to the planned deficit. The plan also assumes a saving of £0.9m on ESH can be delivered through the release of contingencies. The restrained capital position continues to require close management and difficult decision making to balance risk with the limited funding available.

Cash

Cash remains a risk which continues to be closely managed. If the adverse variance isn't recovered this will become a real risk to the Trusts ability to pay suppliers on time. NHSE cash support is only available up to the level of the planned deficit.

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.

STATEMENT OF COMPREHENSIVE INCOME - To Month 2 - 31st May 2024 - 2024/25

	2022-23 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Contract Income	290,885	46,633	47,568	934	816
Excluded Drugs	12,801	2,134	2,215	81	(333)
Non Contracted Activity (NCA's)	1,714	286	320	34	32
Other Income for Patient Care	10,068	1,845	1,821	(25)	(12)
Donations For Non Current Assets	4,168	3,444	2,970	(474)	(72)
Other Non Patient Income	7,102	1,200	1,188	(12)	(198)
COVID Funding	332	55	51	(4)	(2)
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**327,071**	**55,596**	**56,132**	**536**	**231**
Pay Expenditure	215,083	35,508	36,364	(856)	(381)
Non Pay Expenditure	90,713	14,335	15,403	(1,069)	(272)
Excluded Drugs	23,933	3,989	4,343	(355)	(258)
Total Operating Expenditure	**329,728**	**53,831**	**56,111**	**(2,279)**	**(910)**
EBITDA	**(2,658)**	**1,765**	**21**	**(1,744)**	**(679)**
Depreciation	14,130	2,413	2,389	24	108
Gain or loss on asset disposal	5,141	0	0	0	0
Interest Receivable	901	318	318	(0)	(0)
Interest Payable on Loans	262	44	31	12	9
Interest Payable on PFI	1,993	332	332	0	0
Dividends on PDC	4,244	612	612	(0)	(0)
Operating Surplus/ (Deficit)	**(27,526)**	**(1,318)**	**(3,026)**	**(1,708)**	**(568)**
Donated Assets Adjustment	3,335	3,305	2,830	(475)	(72)
Net impact of asset impairments	(5,141)	0	0	0	0
IFRS 16 2425 PFI re-measurement adjustment	(2,490)	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	8,204	1,272	1,272	0	0
Adj. financial performance retained Surplus/ (Deficit)	(31,433)	(5,895)	(7,128)	(1,234)	(486)

Performance and Actions

The position at the end of month 2 (May) was a deficit of £7.1m. This was behind the current plan with an overall adverse variance of £1.2m.

- Income shows a favorable variance of £1.0m (exc. grant income). £0.6m is in relation to ERF over performance, £0.1m for excluded drugs/devices, £0.1m contract income gains, and £0.2m other.
- Pay was overspent overall with ongoing high use of temporary staffing and undelivered CPIP, offset by some slippage on recruitment linked to capacity and unfilled vacancies. The backdated consultants pay award went through in M2. This net position includes agency — 6.2% of total pay costs in month which has increased from 5.5% in the previous month. Medical bank use at premium rates further increases this to 10.3% of overall pay. This is driven by volume and price.
- Non Pay overspent overall largely due to undelivered CPIP, MSSE, Clinical Services contracts, Excluded drugs and excluded devices. A review of budgets and run rates is underway to understand the drivers.
- The YTD plan included £2.0m of additional capacity to achieve the operational plan, particularly delivery of elective activity.

If the current expenditure run rate continues this would lead to an £8m overspend by the end of the year. In additional there are significant income risks later in the year, including £6m of Welsh income (requiring NHSE support).

Risks:

Key Financial risks

- Stretch target (£1.2m CPIP not delivered).
- CPIP Cost Efficiency delivery recurrently
- Level of Agency (as % of pay)
- Income includes £333k from the ICB for diagnostics and £167k for Powys delayed discharges which may not be received

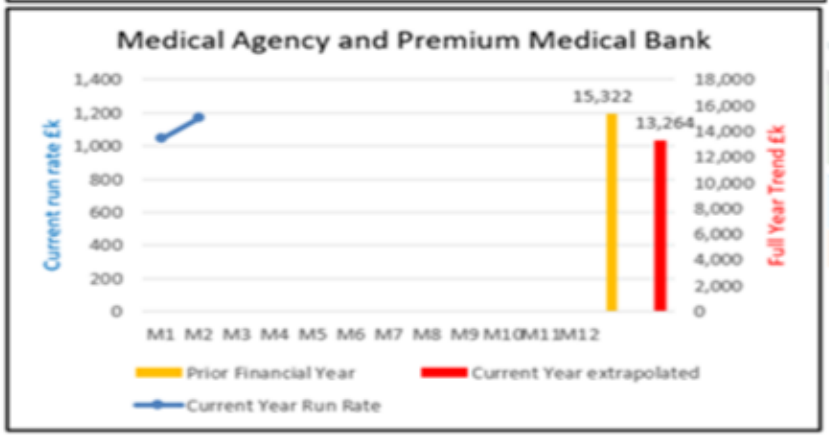
What the chart tells us:

Known financial risks are putting greater pressure on delivery of our planned financial position.

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

Agency represents 5.88% of total pay costs year to date. This benchmarks poorly, and is almost at the NHS Agency Cap Ceiling. There is still a considerable way to get back to an acceptable baseline trend. All agency spend year to date (and excluding premium cost medical bank) has been £2.1m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** Increased control actions through NARP, together with the Master Vend contract rate changes in 2324 showed an improvement since the prior year. The Trust spent £14.0m on nurse agency in 2223 which reduced in 2324 to £9.2m which was more in line with 2122. The current trend for 2425 is £7.6m. We continue to drive reductions in nurse agency spend, including through targeted recruitment and a further rate card review.
- **Off framework Nurse Agency** - there has been a significant reduction in off framework use with only 14 shifts booked in both April and May. A break glass process is in place ahead of the national July deadline for removal of off framework supply.
- **Medical staffing agency and premium cost bank:** Commercial agency and Internal Medical Bank often have a correlation depending upon availability and route into the Trust. Medical bank typically still involves high premium rates, even if marginally lower than agency on average. The Trust spent £14.2m 2223 and £15.3m in 2324. Significant focus remains through the MARP programme, targeting recruitment and enhancing controls over medical bank usage.

Risks:

- Level of Agency (% of pay)
- Increased workforce gaps resulting in greater requirement for temporary workforce.
- Supply and Demand price pressures

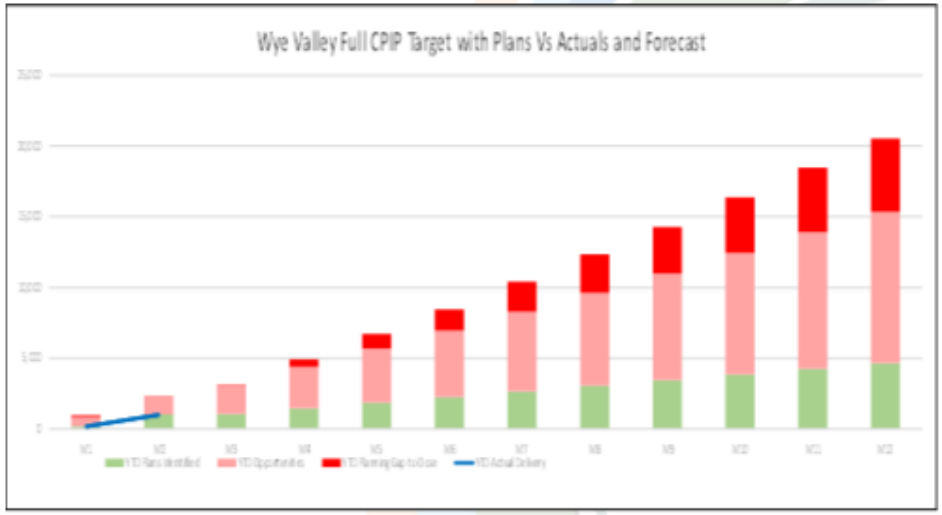
What the chart tells us:

Despite good progress in targeted areas, agency (and premium medical bank) use remains at unsustainable levels and poses a threat 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 £20.6m target breaks down into two areas: £19.4m cost out efficiency (of which £4.4m relates to 2324 items delivered non recurrently, and of which we are targeting a £8.0m bank and agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

Operational challenges over quarter 4 hampered the pace of full identification of recurrent plans to meet the cost out efficiency requirement meaning there is still a large shortfall in identified and fully developed recurrent schemes.

YTD delivery is £0.9m behind plan

At month 2 identified schemes (including MARP & NARP) amount to £14m, although there is currently no YTD delivery against MARP and a very small £0.3m contribution to NARP. Focus with the divisions and corporate teams is on ensuring identified schemes are moved from plans in progress to fully developed schemes at pace, and the ongoing identification of opportunities and development of those into deliverable plans.

Extended Finance and Performance Executive meetings are being held to facilitate deep dives into divisional financial performance to ensure an effective response to mitigating financial risk and delivering the financial plan.

Risks:

- Cost Improvement (CPIP) underachieves or only achieves non recurrent delivery.

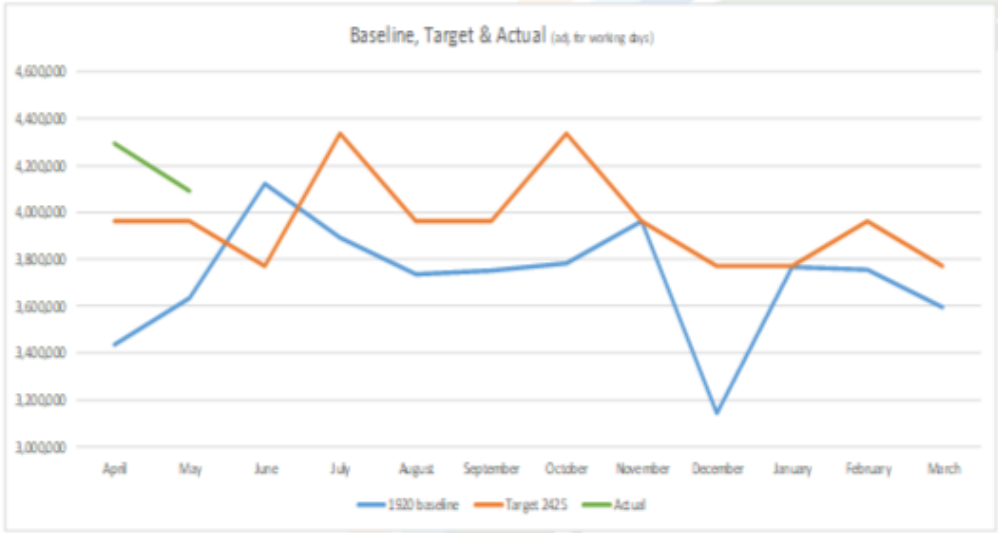
What the chart tells us:

There remains a shortfall in plans to deliver the planned level of CPIP. Focus is on identifying schemes, and converting opportunities into deliverable schemes, in order to deliver a challenging CPIP target in year.

Our Finance – Productivity Improvement

We are driving this measure because:

Delivering productivity improvements is key to successfully mitigating financial risk and delivering the financial plan. Maximising the activity we undertake within the resources available will ensure best use of system resources and support financial sustainability.



Care must be taken when comparing WAU's reported in different places, as data sources must be consistently applied and will vary. The graphs here apply the WAU methodology to the same defined data sources consistently each month so may be compared as a trend (and across the Foundation Group).

Performance and Actions

A significant proportion of our activity is paid for under a fixed contract arrangement. For 24/25 there has been a continuation to the way we are paid for our English Commissioned elective activity.

- Baseline: the elective contract baseline is based on 19/20 activity x price
- Target: uplifted for new 24/25 tariff (Value weighted activity - VWA), increased to 106% of 19/20. We are given a set amount of £7m to achieve the target. The value is based on a 'fair share' of the income given for this purpose to the ICB.
- Actual performance: For H&W ICB our internal estimate at the end of May reflects performance of 118% of 19/20 activity. For Gloucestershire, Shropshire and Specialised commissioning we have continued to use national data. This equates to £0.6m of additional income.

The plan included £9.0m of additional capacity provision to achieve the operational plan, particularly recovering elective activity. Further work is ongoing to provide assurance we are not overspending to achieve the elective activity but are driving productivity.

Cost per Weighted Activity Unit (calculated and reported one month in arrears) remains above the target level though has stabilised. This is a long term trend measure, however as productivity improves we would expect to see a reduction in the cost per WAU.

Risks:

- Deterioration in the operational performance resulting in clawback of system elective activity . Mitigation - Additional capacity funding provided to the Divisions, close monitoring of activity performance and productivity.

What the chart tells us:

Despite the significant operational challenges activity levels are recovering and are above target and planned level.. The increased cost base driven by high agency use, coupled with lower than planned activity levels drive a high cost per WAU. Whilst some productivity initiatives have started to deliver, we are not yet seeing the overall level of productivity required.

Our Finance – Capital

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.

Capital Scheme	Type of Capital	Full Year Plan	Year to Date			Full Year	
			Budget	Actual	Variance	Forecast	Variance
Local Schemes							
ICT - Clinical Systems	Owned	476	61	61	0	476	0
ICT - Hardware	Owned	782	4	4	0	782	0
ICT - Software	Owned	52	0	0	0	52	0
Clinical Equipment	Owned	0	0	0	0	0	0
Estates Works	Owned	807	186	186	0	807	0
ESH 2324 Underspend	Owned	615	0	0	0	615	0
CDC 2324 Underspend	Owned	1,408	0	0	0	1,408	0
Clinical Equipment	Owned	333	59	59	0	333	0
ESH - Local Funding	Owned	2,924	0	0	0	2,924	0
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*(924)*	*0*
System Capital Over-commitment	*Owned*	*(633)*	*(12)*	*(12)*	*0*	*(633)*	*0*
Total - Local CDEL funded		**5,840**	**298**	**298**	**0**	**5,840**	**0**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	1,554	1,554	0	10,972	0
Donated assets	Owned	240	0	0	0	240	0
Clinical Equipment	Owned	33	0	0	0	33	0
Total - Grant funded and Donated		**11,245**	**1,554**	**1,554**	**0**	**11,245**	**0**
National funding							
Clinical Diagnostics Centre	Owned	11,352	65	65	0	11,352	0
ESH - PDC Funding	Owned	2,161	642	642	0	2,161	0
ICT - Clinical Systems	Owned	750	22	22	0	750	0
Total - National PDC schemes		**14,263**	**729**	**729**	**0**	**14,263**	**0**
Leases							
Vehicle	Lease	10	0	0	0	10	0
Clinical Equipment	Lease	400	5	5	0	400	0
Total - IFRS16 Leases		**410**	**5**	**5**	**0**	**410**	**0**
Total Capital Programme		**31,758**	**2,586**	**2,586**	**0**	**31,758**	**0**

Performance and Actions

As part of the finalisation of the revised plan for 24/25, two key changes have been made to the capital plan. Firstly the £2m funding relating to ED performance has now been reflected and secondly, our system allocation has reduced by £633k as a result of the system being in deficit. The ED funds are being utilised to fund the known gap in national funding on the ESH scheme.

The lines in yellow reflect over-commitments currently reflected within the capital position. There is a projected additional £924k of expenditure on ESH based on the current forecast although it is expected that this will reduce as contingencies are reduced as the scheme nears completion.

The £633k reduction is shown as an over-commitment. The capital programme will need to be revised to enable this saving. We continue to bid for national funding opportunities to minimise risk.

Changes on last month

This is the first report for 2024/25. The plan reflects the latest return submitted to NHSE where the phasing was adjusted to match the year to date actual position (hence the reporting of nil variances).

Risks:

The main current risks relate to the over-commitment against capital resources and the need to deliver savings against the ESH plan. Further financing risks detailed below.

Financing Risk

Financing of capital expenditure has not been fully finalised. £3.484m of system capital PDC is required to part-fund local capital schemes and is built in to the financial plan.

£750k FLD - National PDC programme has been included but is not confirmed.

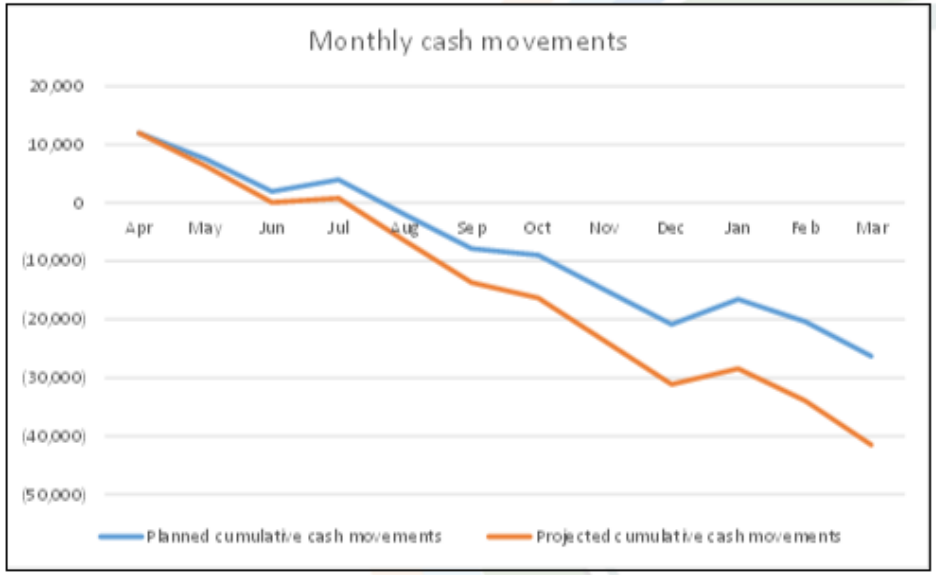
What the chart tells us:

Capital expenditure is broadly in line with forecast, and cash balances whilst sufficient, continue to require careful management.

Our Finance – Cash

We are driving this measure because:

The financial performance of the Trusts, both in I&E and revenue have a direct impact on the Trusts cash position. Sufficient cash balances are required in order for the Trust to undertake its day to day operations.



Cash Balance				
Month	Performance	Target	Direction	Rating
March	26.2	21.7	↑	
April	22.1	34.9		
May	30.2	28.8		

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
March	97.6%	95.0%	↑	
April	98.7%	95.0%		
May	99.0%	95.0%		

In March, the Trust paid 99.0% of invoices within 30 days (99.8% by invoice value). An increase on April and the fourth 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

Funding sources are available to cover the planned deficit of £31.4m and the overall capital plan (see capital section for specific capital funding risks).

If the CPIP delivery does not step up to the levels planned this will lead to a greater monthly cash outflow than the trust has the ability to cover. This is illustrated in the chart.

Risks:

Unavailability of cash (in a timely manner) to meet the needs of the Trust whilst we continue with an adverse variance to plan.

This would impact on the Trusts ability to pay suppliers and staff in a timely manner.

The mitigations are:

- I&E and capital plans to be met
- Continued close management of cash and escalation to system and region if Trust continues to be off-plan.

What the chart tells us:

The chart shows that if I&E adverse performance continues at the levels seen, alternative sources of cash will be required.

As the CPIP plan is more heavily weighted to July onwards, the gap in cash required grows after that point.

Funding sources are in place to cover the planned cumulative cash movements.

Our Finance – Statement of Financial Positon

We are driving this measure because:

Our Statement of Financial Position (Balance Sheet) is a core financial statement and reflects the overall financial position of the Trust in terms of its assets and liabilities. It provides insight across revenue and capital funding streams, and beyond the current financial year.

Statement of Financial Position

March 2024	2023/24	2024/25				2024/25 Full Year		
	Accounts £000s	M2 Plan £000s	M2 YTD £000s	Variance £000s	YTD Change £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:								
Property, Plant and Equipment	151,182	155,130	152,825	2,305	1,643	167,117	167,117	0
Intangible Assets	14,359	13,357	12,925	432	(1,434)	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	14	408	408	0
TOTAL Non Current Assets	**165,949**	**168,895**	**166,172**	**2,723**	**223**	**178,445**	**178,445**	**0**
CURRENT ASSETS:								
Inventories	4,878	4,878	4,891	(13)	13	4,878	4,878	0
Trade and Other Receivables	35,635	28,856	26,775	2,081	(8,860)	28,856	28,856	0
Cash and Cash Equivalents	26,228	28,149	30,216	(2,067)	3,988	27,447	27,447	0
TOTAL Current Assets	**66,741**	**61,883**	**61,882**	**1**	**(4,859)**	**61,181**	**61,181**	**0**
TOTAL ASSETS	**232,690**	**230,778**	**228,054**	**2,724**	**(4,636)**	**239,626**	**239,626**	**0**
CURRENT LIABILITIES								
Trade and other payables	(37,101)	(38,337)	(37,758)	(579)	(657)	(37,275)	(37,275)	0
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(11,386)	(1,307)	1,311	(12,693)	(12,693)	0
Provisions	(192)	(192)	0	(192)	192	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(51,222)**	**(49,144)**	**(2,078)**	**846**	**(50,160)**	**(50,160)**	**0**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**10,661**	**12,738**	**(2,077)**	**(4,013)**	**11,021**	**11,021**	**0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**179,556**	**178,910**	**646**	**(3,790)**	**189,466**	**189,466**	**0**
NON-CURRENT LIABILITIES:								
Borrowings - Loans, PFI and Finance Leases	(53,916)	(50,550)	(52,960)	2,410	956	(42,935)	(42,935)	0
Provisions	(1,619)	(1,619)	(1,811)	192	(192)	(1,619)	(1,619)	0
Total Non-Current Liabilities	**(55,535)**	**(52,169)**	**(54,771)**	**2,602**	**764**	**(44,554)**	**(44,554)**	**0**
ASSETS LESS LIABILITIES	**127,165**	**127,387**	**124,139**	**3,248**	**(3,026)**	**144,912**	**144,912**	**0**
TAXPAYERS EQUITY								
Public dividend capital	306,421	310,185	306,421	3,764	0	351,694	351,694	0
Revaluation reserve	22,047	22,047	22,047	0	0	22,047	22,047	0
Income and expenditure reserve	(201,303)	(204,845)	(204,329)	(516)	(3,026)	(228,829)	(228,829)	0
TOTAL	**127,165**	**127,387**	**124,139**	**3,248**	**(3,026)**	**144,912**	**144,912**	**0**

Performance and Actions

General

The table identifies the statement of financial position as at 31 May against the plan.

Non-Current Assets

Non-Current assets reduced by £2.4m in month due to depreciation and amortisation.

Current Assets

Accounts Receivable have reduced by £13m, compared to month 1 and the start of the year. This was due to the receipt of £13m national deficit support funding via the ICB, invoiced in March. This has positively impacted cash balances - net of increases in current liabilities.

Current Liabilities

Current liabilities have reduced by £4.5m since month 1 as accrued income is released into our income position and as pay our accounts payable.

Non-current liability movements reflect the restatement of PFI liabilities under IFRS 16 and also include lease liabilities.

Taxpayers Equity

The income and expenditure reserve reflects the deficit for the year to date. No PDC has been drawn yet, to support our deficit and capital programme.

Risks:

- The deficit plan presents an ongoing risk to the strength of the SOFP.

What the chart tells us:

Current assets outweigh current liabilities, largely due to the year to date deficit supported by cash PDC.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High	Yes	66.9%	67.9%	65.8%	72.9%	72.4%	78.6%	80.8%	79.0%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause	Yes	78.7%	86.4%	80.4%	88.3%	90.1%	96.9%	95.8%	86.9%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low	Yes	53.8%	71.4%	53.3%	90.5%	95.8%	83.3%	79.3%	47.6%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	87.4%	78.4%	80.0%	73.8%	69.1%	80.8%	89.2%	82.9%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause		10	14	9	8	12	4	12	14	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	64.3%	48.4%	64.0%	59.2%	51.7%	71.1%	63.0%	60.6%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause			50.0%	100.0%	100.0%	60.0%	100.0%		62.5%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		70.8%	55.2%	81.0%	73.9%	48.1%	76.9%	61.8%	76.3%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Concern - Low	Yes	109	113	126	117	142	121	58	51	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		101.8%	115.3%	104.9%	107.1%	121.7%	115.1%	102.8%	112.3%	112.7%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low	Yes	91.0%	90.8%	90.9%	91.1%	90.0%	89.7%	90.3%	85.9%	83.0%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		101.8%	104.6%	104.7%	103.0%	103.4%	109.3%	104.3%	107.7%	107.4%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Concern - Low		76.9%	80.7%	73.0%	73.6%	64.4%	65.8%	71.4%	73.3%	72.7%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		9.9%	6.6%	12.1%	13.2%	20.1%	17.0%	12.2%	10.2%	10.5%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Common Cause	Yes	118.6%	119.0%	112.9%	113.9%	116.8%	123.3%	119.5%	102.2%	97.4%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		44.0%	45.0%	42.0%	41.0%	43.0%	46.0%	45.0%	45.8%	46.4%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	54.0%	57.2%	56.3%	53.6%	53.2%	54.9%	65.5%	68.8%	68.1%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High		15.9%	14.3%	16.0%	17.3%	19.1%	16.9%	12.2%	11.9%	11.7%
	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		1.9%	1.7%	1.9%	1.8%	1.7%	1.7%	1.7%	1.8%	1.8%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		181	213	253	230	305	306	250	292	318
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		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%	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		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		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	1959	1981	1782	1636	1446	1287	1152	1171	

Elective care	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Improvement - Low		34	33	18	16	7	16	9	6	
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<=	0	Fail	Improvement - Low		1	4	4	3	1	1	0	1	
	GP Referrals	Elective care				Improvement - High	Yes	118.3%	110.8%	117.1%	97.7%	104.1%	119.6%	134.4%	110.3%	109.9%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care				Improvement - High		113.3%	111.2%	112.9%	100.6%	111.5%	116.0%	129.1%	113.1%	114.1%
	Outpatient Activity - New attendances (volume v plan)	Elective care				Improvement - High	Yes	81.8%	111.8%	88.4%	121.2%	114.3%	112.6%	83.4%	109.8%	106.4%
	Total Outpatient Activity (% v 2019/20)	Elective care				Improvement - High		109.8%	101.4%	110.2%	101.2%	109.3%	109.2%	123.8%	115.7%	117.5%
	Total Outpatient Activity (volume v plan)	Elective care				Improvement - High	Yes	85.6%	112.9%	93.0%	132.6%	126.2%	120.0%	89.3%	113.0%	111.5%
	Total Elective Activity (% v 2019/20)	Elective care				Improvement - High	Yes	99.9%	95.5%	101.0%	91.5%	98.9%	106.5%	121.0%	112.4%	109.9%
	Total Elective Activity (volume v plan)	Elective care				Improvement - High	Yes	79.9%	104.4%	84.2%	112.2%	103.8%	112.6%	83.9%	119.0%	112.2%
	Elective - Theatre utilisation (%) - Capped	Elective care	>=	85.0%	Fail	Common Cause		75.9%	75.8%	78.6%	77.8%	76.7%	79.0%	79.8%	77.2%	77.9%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care				Common Cause	Yes	30	15	29	31	65	36	31	33	24
	Diagnostic Activity - Computerised Tomography	Elective care				Improvement - High		142.8%	129.7%	129.6%	119.4%	124.9%	111.0%	107.5%	111.8%	126.5%
	Diagnostic Activity - Endoscopy	Elective care				Common Cause	Yes	83.2%	86.3%	131.1%	158.0%	142.8%	150.3%	99.3%	130.4%	98.1%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care				Improvement - High	Yes	185.4%	158.1%	180.9%	148.0%	113.6%	95.3%	148.8%	120.5%	130.6%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care				Improvement - Low		27.6%	22.5%	17.2%	13.2%	17.9%	15.6%	21.5%	24.7%	24.8%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care		90.0%	Variable	Common Cause	Yes	95.4%	96.2%	92.9%	92.2%	91.3%	92.1%	93.8%	94.4%	93.9%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<=	15.0%	Variable	Improvement - Low	Yes	23.9%	23.3%	22.9%	23.8%	24.3%	24.3%	19.5%	19.0%	16.0%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<=	34.0%	Fail	Concern - High		61.7%	63.6%	66.0%	64.9%	63.8%	64.6%	62.9%	60.6%	55.5%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<=	60.0%	Fail	Common Cause	Yes	93.4%	92.5%	92.6%	92.5%	88.4%	88.2%	87.0%	85.5%	87.3%
	Maternity Activity (Deliveries)	Elective care				Common Cause	Yes	98.5%	92.7%	97.0%	95.1%	140.6%	115.0%	99.3%	99.2%	83.9%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<=	40.0%	Pass	Common Cause	Yes	6.4%	6.8%	6.5%	6.9%	6.5%	6.2%	6.0%	6.2%	6.3%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>=	90.0%	Fail	Common Cause		85.1%	81.9%	86.3%	83.6%	83.3%	86.5%	87.0%	86.7%	88.0%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation				Improvement - High		108.2%	97.1%	109.0%	101.5%	108.4%	106.2%	121.5%	117.0%	119.1%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation				Improvement - High	Yes	87.6%	113.5%	95.2%	138.6%	132.2%	123.8%	92.3%	114.6%	114.0%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<=	25.0%	Fail	Improvement - Low		22.0%	21.7%	20.7%	20.4%	21.1%	19.8%	19.2%	20.1%	19.8%

Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term				Common Cause		12.2%	5.7%	6.9%	8.1%	2.8%	13.1%	8.0%	4.8%	6.7%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		99.3%	99.6%	99.6%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%
	Bed occupancy - Community Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		96.1%	96.6%	100.0%	99.2%	89.5%	89.5%	89.5%	89.5%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<=	0	Variable	Improvement - Low		52	81	49	28	24	65	74	54	99
	Patient ward moves emergency admissions (acute)	Safe, high quality care				Common Cause		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		5	6	7	6	7	7	7	7	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<=	3	Variable	Common Cause		2	3	2	2	2	3	3	3	2
	Medically fit for discharge - Acute	Safe, high quality care		5.0%	Pass	Common Cause		24.8%	26.0%	23.3%	21.0%	22.7%	21.4%	18.7%	18.8%	15.3%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Common Cause	Yes	54.3%	43.6%	39.4%	43.6%	50.1%	51.6%	50.1%	46.2%	42.6%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Improvement - High		9.6%	11.3%	11.5%	12.2%	12.0%	12.8%	13.5%		
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Fail	Concern - High		115	111	113	111	112	110			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		103	102	102	102	102				
	Never Events	Safe, high quality care		0	Variable	Concern - Low	Yes	0	0	0	0	0	0	0	1	0
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Common Cause	Yes	0	0	0	0	0	1	0	0	0
	MSSA Bacteraemia	Safe, high quality care				Common Cause	Yes	1	4	4	2	1	2	2	1	0
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care		44	Fail	Common Cause		2	3	3	4	3	3	2	6	6
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause		0	0	5	3	2	2	1	1	4
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<=	0	Variable	Common Cause	Yes	1								
	Serious Incidents	Safe, high quality care				Common Cause	Yes	5								
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		89.1%	88.5%	89.8%	88.0%	87.4%	89.2%	89.3%	89.2%	87.4%
	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		44.7%	62.9%	64.3%	48.1%	53.5%	66.7%	63.0%	64.4%	50.9%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>=	90.0%	Variable	Common Cause	Yes	33.3%	100.0%	100.0%	0.0%	66.7%	60.0%	33.3%	0.0%	66.7%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		70.0%	85.2%	90.9%	90.6%	80.0%	78.0%	83.1%	77.8%	71.1%

Safe, high quality care	Number of complaints	Safe, high quality care			Concern - High	Yes	30	35	34	24	27	29	38	45	32
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Improvement - Low	0	1	0	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Fail	Common Cause	36.8%	32.4%	52.2%	17.6%	34.6%	37.9%	35.3%	44.8%	39.4%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	68.2%	71.8%	73.1%	72.9%	77.0%	75.7%	81.2%	81.0%	81.1%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low	86.8%	85.0%	87.9%	82.0%	85.7%	81.7%	88.6%	86.0%	82.7%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	96.3%	92.9%	89.7%	87.2%	96.7%	92.6%	91.3%	96.9%	85.7%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Improvement - High	19.0%	20.0%	19.0%	19.0%	21.0%	21.0%	20.0%	19.0%	19.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High	16.0%	15.0%	15.0%	15.0%	18.0%	16.0%	17.0%	18.0%	16.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause	26.0%	22.0%	32.8%	31.0%	23.0%	23.0%	16.0%	28.0%	25.0%

People

Sub Domain	KPI	Subject	Target		Target Expectation	Variation	Exception	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>=	6.4%	Variable	Concern - Low	Yes	8.4%	7.0%	7.1%	6.1%	7.9%	8.1%	6.0%	5.5%	6.3%
	Appraisals	Looking after our people	>=	85.0%	Fail	Common Cause	Yes	75.7%	74.1%	70.9%	72.7%	70.6%	71.8%	70.8%	75.9%	79.2%
	Mandatory Training	Looking after our people	>=	85.0%	Pass	Concern - Low		89.2%	89.1%	89.1%	89.0%	88.8%	88.8%	88.4%	89.2%	89.8%
	Overall Sickness	Looking after our people	<=	3.5%	Fail	Common Cause		5.1%	5.9%	5.4%	5.6%	6.0%	5.7%	4.0%	4.7%	4.6%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<=	10.0%	Fail	Improvement - Low		10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	10.4%	9.0%	9.2%
	Vacancy Rate	Looking after our people	<=	5.0%	Fail	Improvement - Low		4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target		Target Expectation	Variation	Exception	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	(£3173k)	(£1198k)	£425k	(£2906k)	(£2430k)	£9902k	(£9316k)	(£355k)
	I&E - Margin (%)	Finance				Concern - High	Yes	(£0k)	(£0k)	£0k	(£0k)	(£0k)	£0k	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance				Concern - High	Yes	(£1229k)	£221k	£1720k	(£208k)	(£3427k)	(£3019k)	(£13529k)	£783k
	I&E - Variance from Plan (%)	Finance				Common Cause		(£0k)	£0k	£0k	(£0k)	(£0k)	(£0k)	(£0k)	£0k
	CPIP - Variance from plan (£k)	Finance				Common Cause	Yes	(£878k)	(£1056k)	(£862k)	(£841k)	(£708k)	(£830k)	£906k	£0k
	Agency - expenditure (£k)	Finance				Improvement - Low	Yes	£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
	Capital - Variance to plan (£k)	Finance				Common Cause	Yes	(£111k)	(£409k)	(£366k)	£520k	(£2959k)	(£689k)	(£1572k)	£0k
	Cash - Balance at end of month (£m)	Finance				Common Cause		£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
	BPPC - Invoices paid <30 days (% volume)	Finance				Common Cause	Yes	£1k	£1k	£1k	£0k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**04/07/2024**
Title of Report:	Digital Strategy 2024 - 2027
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:	David Warden, Associate Director of IM&T
Documents covered by this report:	Digital Strategy 2024 - 2027

1. Purpose of the report

The paper below sets out the Trust's high-level digital strategy from 2024 – 2027. The Trust reviews its digital strategy every three years. This edition builds upon rather than supersedes the 2020 strategy.

The content has been developed in consultation with the Lead Nurse Digital, Chief Clinical Information Officer and operational leads as well as the Trust's internal subject matter experts and key suppliers, including Hoople Ltd., a shared services company hosted by Herefordshire Council and part owned by the Trust.

Workshops were held with the Digital Programme Board in August 2023 and the Board of Directors in October 2023.

The strategy was drafted in December 2023 by the Associate Director of Information Management and Technology and agreed by the Digital Programme Board in February 2024 following minor amendments.

It was endorsed by TMB on 19th April 2024 with the chair advocating an ambitious approach to its implementation, subject to available funding.

The updated strategy is built around the four tenets agreed at last year's Board workshop:

- Clinical Systems
- Back Office and Infrastructure
- Citizen Access
- Benefits Realisation

It is presented today for Board approval and formal adoption by the Trust.

2. Recommendation(s)

To adopt the 2024 -2027 Digital strategy.

3. Executive Director Opinion[1]

I am pleased to recommend this Digital Strategy to the Board. We are grateful to all colleagues who have engaged with its development.

[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***

Wye Valley NHS Trust

Digital Strategy
2024 - 2027

Date Approved	
Date Issued	
Review Date	
Author	
Distribution	

Purpose

The Trust's Digital Strategy is intended to help the organisation select, deploy and run technology to achieve its objectives. It focuses on using digital tools to enhance operations, increase efficiency and improve the patient experience. It is a roadmap for the effective use of digital assets.

The approved strategy is underpinned by a governance framework reporting regularly to Trust Management Board via the Digital Programme Board. These committees have a role to ensure that the plans that are developed to deliver the strategy are realistic, affordable and achievable.

The delivery of the digital strategy remains an iterative process of aligning digital capability with business needs. Success comes after multiple 'do and learn' cycles.

Background

In December 2020 the Board of Directors approved a three year strategy to

- Complete and optimise our clinical programme
- Maintain and improve essential infrastructure
- Explore the potential of new technology

In the three years since this strategy was adopted the Trust has

- Completed its original EPR programme
- Implemented a centralised clinical systems function
- Replaced end of life data centre hardware and software and created a fully DR-capable/resilient secondary data centre fit for purpose to support the Trust's increased reliance on clinical IT
- Invested in business continuity and implemented a test regime
- Explored RPA and AI in specific applications such as Stroke diagnosis

In December 2022 the Maxims EPR went into "business as usual". At this point the Trust's IT programme can be regarded as having delivered "the basics". This updated strategy has been developed following a Digital Programme Board workshop in August 2023 and a Board of Directors workshop in October 2023. It sets out to build upon those basics through a broader digital strategy with an additional focus on digital inclusion and benefits realisation.

National Context

National digital strategy is for Trusts to increase their clinical digital maturity. This is now measured using the NHS bespoke What Good Looks Like (WGLL) Digital Maturity Assessment (DMA). This comprises a core set of fifty questions and a further set of approximately one-hundred "contextual" questions.

NHS England also sets out a minimum level of digital capabilities for secondary care provider organisations in the Digital Capabilities Framework (DCF), formerly the Minimum Digital Foundations. This will iterate as national expectations develop. Currently, the DCF is split into three capability levels:

- Core capabilities: These capabilities set the bar for a minimum level of digital maturity for the levelling up agenda. These capabilities have a well-established market offering.
- Transformational capabilities: There is an emerging and scalable market offering for these capabilities with example implementations present in selected organisations, although not widespread across the regions.
- Innovation capabilities: These capabilities have yet to be proven at scale but hold promise. Such areas should be included in future development plans of digitally mature organisations, with support from the market to develop such solutions, including developments to support future national requirements.

In addition, NHSE have set out seven short-term objectives ahead of the 2024 general election. These are capabilities which are expected to be deployed quickly and for which funding opportunities are expected to be available.

- Smart System Control - ICS level dashboards
- Electronic Bed and Capacity Management
- Digitised Records and Workflow (EPR)
- Optimising Waiting Lists
- Dynamic Discharge
- AI diagnostic support
- Patient Portals App Programme

Local Context

The Trust is part of the Herefordshire and Worcestershire ICB and also a Foundation Group incorporating Wye Valley NHS Trust, Worcestershire Acute Hospitals Trust, George Eliot NHS Trust in Nuneaton and South Warwickshire NHS Foundation Trust. The Foundation Group spans two adjacent ICBs.

A longer term objective of the Foundation Group is to achieve economies of scale across back office functions. As has been seen with the establishment of the Procurement shared service this is most easily achieved where all parties use the same ICT system. Conversely, lessons abound of corporate mergers and acquisitions which have failed or experienced integration difficulties due to incompatible technology and inadequate digital planning. For example, the problems faced in 2022 by Banco Sabadell in integrating TSB into its banking operations following its acquisition from Lloyds.

The key message is that the sheer volume of digital interactions today create a lot more vulnerabilities when it comes to service integration.

Herefordshire and Worcestershire ICB are seeking to ameliorate these risks through a focus on digital channels and platforms, such as the patient portal. Also through joint working on data analytics and population health management. The emerging ICB strategy is to ensure integration and consistency across digital touchpoints whilst retaining the adaptability and flexibility needed to support individual, independent and different organisations.

The Foundation Group Strategy Board, which is comprised of Executive and Non-executive Directors from across the 4 Trusts within the Group have recently received a proposal in respect of the Digital Data and Technology (DDaT) Portfolio.

The Outline Case for Change articulates the benefit of leveraging the DDaT Portfolio whilst acknowledging the different levels of digital maturity and operating landscape across the Group.

The Foundation Group level approach recognises key domains related to:

- Strategic DDaT Leadership
- Business Intelligence & Informatics
- Digital Applications *deployment, implementation & optimization*
- Infrastructure *resilient, secure by design*
- Innovation and engagement

A concentrated focus on these key domains will help to drive up the digital maturity of the individual organisations across the group. Develop and build on the continuous improvement ethos already embedded within the Foundation Group culture and create the right environment for a digital revolution to support the delivery of high-quality patient care.

Trust Context

Since establishing its EPR programme in 2015 Wye Valley NHS Trust has made considerable progress on its Digital journey. Having started near the bottom of contemporary digital maturity league tables the Trust now has an established EPR in both Acute and Community settings used in over 60% of patient contacts.

The Trust also now engages more effectively with regional initiatives being the first site to go live with Digital Pathology in early 2022 and the first spoke site to go live with RapidAI in stroke diagnosis in November 2023.

However, these advances come at a cost. The clinical importance of maintaining a reliable modern infrastructure is greater than ever and the increased number of client devices, servers and network ports means the cost of technology refresh across the IT estate (in order just to stand still) now runs at £800k - £1,000k per year before further development and enhancements are taken into account. This figure is derived from the cost of replacing 1/5 of the client hardware estate each year (to keep the age of client IT within five years) and recent notifications from Hoople about the end of life of key data centre hardware.

Clinical Systems Timeline 2015 - 2022

EPR Programme initiated 2015

Initial Contract with IMS Maxims August 2015

NPfIT PAS replacement July 2017

GDE/FF Funding Agreement October 2018

EPMA procurement completed Summer 2019

Community paperless record March 2020

Enterprise Nurse Clinical Noting & Whiteboards April 2020 onwards

EPMA pilot areas October 2020

EPMA go-live from March 2021

Inpatient Clinical Noting from May 2022

Shared Health and Care Record from July 2022

Renewal of Maxims Contract August 2022

Nurse Clinical Noting Stage 1 Optimisation August 2022

Outpatient Clinical Noting from November 2022

Wales and Powys

Previously, although some advancements have been made with digital information exchange with Wales on an opportunistic/tactical basis (mostly utilising the Welsh Clinical Communications Gateway) there has not been a plan to include Powys in the Trust's digital strategy. The Welsh Government has now endorsed a three year plan from 2022 – 2025 to invest in digital communications across the border. Powys Teaching Health Board and Wye Valley NHS Trust welcome this opportunity to

reduce the reliance on paper information exchange and relevant work is being commissioned from Hoople to facilitate further integration.

Development of the Strategy

The intention is for the 2024 strategy to be an organic development from the 2020 strategy and not a step change.

Workshops were held with the Digital Programme Board in August 2023 and the Board of Directors in October 2023.

The Board felt it important to take time to reflect on the developments to date and to ensure that they are working optimally and delivering the anticipated benefits. Anecdotally, there is room for ergonomic improvements to the user interface. Staff are complaining about “too many mouse clicks”. There was an appetite to continue to build on the recent improvements to nurse noting (achieved by moving from the enterprise EPR platform to mHealth apps) and to keep the user interface as simple as possible.

Although in general the Maxims development methodology has been effective, there is a feeling in some instances that paper processes have been digitised too literally and consequently the technology is not being used to its best advantage. This is reflected in the continuing need to enter the same information more than once across multiple forms. It was felt that better business/problem analysis would lead to better solutions to the problems we are trying to solve.

Delays and gaps in support for equipment on the wards are starting to show and need to be addressed, picking up the point already made about the cost of maintaining a larger IT estate. It was felt that both the process and the funding needed to improve.

The Board felt a new priority should be citizen access and digital inclusion, supporting the patient portal and use of the NHS App as a front-end. Done right, this will help the public to take more responsibility for “self-management” of chronic conditions and engage with initiatives such as PIFU.

The Trust makes good use of the Shared Care Record, but there are further developments, such as the online RESPECT form, which would return even greater value and benefits for patients.

The Trust’s responsibility for maintaining part of the critical national infrastructure was acknowledged along with the need for continual improvement in service, maintenance and cyber-security.

It was agreed to build the new strategy around four tenets

Clinical Systems

Back Office and Infrastructure

Citizen Access

Benefits Realisation

Technology

The focus of the Trust's strategy is people rather than technology. Developments are prioritised in terms of their potential benefits, ultimately to our patients and the residents to whom the Trust provides services. For this reason, the original strategic aim to deploy new technology has been removed. It is now implied across the digital strategy that technology that is the best fit for the purpose or problem being solved will be used.

The Trust is aware of ongoing developments in Robotic Process Automation, Artificial Intelligence Virtual and Augmented Reality, Chat Bots and the Internet of Things. All potentially have a part to play alongside more traditional Information technology in helping the NHS to face the challenges and opportunities of the 21st Century.

For example, the use of robotics in Pharmacy has been identified during capital planning as an opportunity to work around limitations of the physical building whilst also delivering greater efficiencies dispensing drugs.

Clinical Systems

Developing Clinical Systems Group

Digital Maturity

Frontline Digitisation

Professional Standards

Electronic workflow

Automation

The Trust completed phase 2 of its EPR programme in December 2022 with the establishment of the Clinical Systems Group, merging PAS, EPR, EMIS and EPMA

support staff into a single, centralised support function. This has been generally successful. A “one year on” review by the Associate Director of IM&T has highlighted longstanding vacancies and both technical and non-technical training needs. An affordable plan to address these gaps will be put in place over the next 18 months.

Phase 2 of the EPR programme narrowly missed taking the Trust to HIMSS level 5. This was due to changes in the HIMSS requirements during the lifetime of the programme which had to be extended due to the Covid-19 pandemic. The Trust submitted a number of blueprints for national adoption which were developed during its time on the Global Digital Exemplar programme as a Fast Follower. The Trust was also recently included in the EPR Optimisation Playbook published in December 2023 by NHS England.

The NHS now uses its own Digital Capabilities Framework (DCF) to measure clinical digital maturity via an annual self-assessment developed by McKinsey and Company, Inc. The national ambition is for all Trusts to meet the core capabilities by March 2025.

Funding is available through the Frontline Digitisation Programme to address gaps in digital capabilities. The Trust has applied for funding to support its business cases for:

- Single Sign On
- Emergency Department EPR
- EPR Phase 3 (optimisation and expansion)

Despite having been awarded an on-boarding payment in February 2023 further funding has so far been delayed due to third-party contractual queries raised by NHS England.

The ability for the EPR to support emerging professional documentation standards and the development of real-time dashboards is an opportunity for the Trust to improve patient safety and the consistency of outcomes. This work is being led by the Lead Nurse Digital reporting to the Director of Nursing.

Electronic workflow, including Powys through the welsh programme referred to above, is also being refined and updated as the potential for electronic solutions becomes embedded in the organisation.

New technology is now being successfully integrated with the Trust embracing opportunities around AI (stroke diagnosis), RPA (gastroenterology two-week wait referrals) and Robotics (Surgery and potentially Pharmacy).

This on-going development and optimisation of the Trust’s clinical systems will be supported by a renewed rigour around benefits management led by the recently appointed Benefits Manager.

Back Office & Infrastructure

Telecoms

Microsoft

National versus Local Identity

Business Intelligence

Hoople's Role

By contrast to the on-going development and optimisation of the Trust's clinical systems, during the lifetime of this strategy there are a number of step-changes required in back-office technology and infrastructure.

BT Openreach has announced that in December 2025, they will permanently switch off the UK's old analogue telephone network (ISDN and PSTN). This action will completely shift communications technology into the digital space and every phone line in the UK will become digital, with calls routed over internet-based technology known as Voice over IP or VOIP.

The Trust is currently highly dependent on legacy analogue telephony and is preparing for this change by leading the ICB procurement for a new VOIP contract. Robust plans are being developed to implement the new solution across Trust sites in time for the switch-off. As well as securing the future of traditional site-based telephone and switchboard operations the new technology will better support home and hybrid working, which has become the norm for some staff groups since the Covid-19 pandemic, by integrating with MS Teams and Mobile devices.

Microsoft will end support for many of the products which the Trust currently relies upon on 14th October 2025. This includes Windows 10, Office 2016 and the on-premise Exchange (e-mail) server via which the Trust currently receives the wvt.nhs.uk mail service from Herefordshire Council.

Hoople are working to present the Trust (via the Digital Programme Board) with costed options and some provision has been made in financial planning for the anticipated extra cost of subscription-based licensing and the capital cost of change.

The Trust has around 600 client devices that are not able to run Windows 11 and which will need to be replaced before October 2025.

As part of these changes, the Trust may need to consider whether changing from its local wvt.nhs.uk identity to the national nhs.net would be worthwhile financially. Hoople have been asked to present costs on a year-by-year basis. It is anticipated that although this change could save money in the long-term it may actually be more expensive (and disruptive) in earlier years working counter to the short-term imperative to control costs.

ICB and Group collaboration on Business Intelligence and Reporting continues with a recognition that the Trust will need to modernise its technology in line with the Group direction during the coming years.

Hoople's role was discussed at the Board workshop where the value of the asset the Trust had in its part-ownership of Hoople was acknowledged and the desire to continue current ICT contracting arrangements reaffirmed. Hoople ICT have been a valuable partner to the Trust through the EPR programme. Latterly, Hoople have acquired more Health customers and have increased their involvement in the local health system through Hoople Care, which has grown steadily since 2018 when it started working in partnership with Herefordshire Council as part of Home First. Hoople are also a likely partner in the plans being developed by the Trust for a new Education Centre.

Citizen Access

Patient Portal

Trust Website

Digital Inclusion

Access to Support

Prior to 2022 the Trust's ability to engage digitally with the public was limited due to its internal reliance on paper and limited electronic workflow. The EPR programme has changed this and the pandemic saw early opportunities for virtual and remote consultations, patient initiated follow-up and remote monitoring. Unfortunately, some of the solutions procured during the pandemic were unsustainable and growth in these areas has since waned.

The Trust's lowest scores for citizen empowerment in the 2022 digital maturity assessment related to online access to their record and self-triage capability. The ICB patient portal and its integration with the NHS App and IMS Maxims will go a long way towards addressing the gaps in access to records. The Board recognises that providing more content to encourage independent use of services is a priority. Through the Patient Portal project the Trust is taking the opportunity to overhaul its patient advice leaflets and update them into digital formats.

The Trust website is a key communication channel between the Trust and the public which receives over a million views per year from patients, visitors, potential recruits and interested citizens. In August 2023 the Trust was informed by the Government Digital Service, which is part of the Cabinet Office, that its website did not comply with accessibility standards. An options appraisal has been developed by the Trust's

Communications Manager in collaboration with Hoople to address these shortcomings.

Research has shown that a lack of digital skills and access can have a negative impact on a person's life, leading to poorer health outcomes and a lower life expectancy, increased loneliness and social isolation, with less access to jobs and education. It can mean paying more for essentials, financial exclusion, and an increased risk of experiencing poverty.

In June 2023 HM Government's Communications and Digital Committee published a report on Digital exclusion. The Committee highlighted concerning figures around the level of digital skills and access in the UK:

- 2.4m people are still unable to complete a single basic digital task to get online.
- 5m workers will be acutely under skilled in basic digital skills by 2030.
- 1.7m households have no broadband or mobile internet access.
- £63bn is lost each year to the UK economy each year due to overall digital skills shortages.
- 1m people have cut back or cancelled their internet packages in the last year due to affordability issues.

These factors are exacerbated in Herefordshire by limited access to fast broadband, poor 4G/5G coverage and the lack of affordable, local ICT support.

These are not problems that the Trust alone can solve, but they must be borne in mind when providing digital access to services, particularly if these services are not equally available by other means. It is recognised by the Board that commitment, involvement and a meaningful contribution to multi-agency initiatives to tackle digital exclusion will return health and financial benefits to our patients, staff and visitors.

Benefits Realisation

Benefits Management

Review of EMIS, EPR and EPMA Benefits

Paper Reduction

Access to Training

In its digital journey since 2015 the Trust has spent in excess of £20m public money. The Board recognises not just the need to demonstrate a return on this investment but also the role Digital has to play in making the patient journey quicker, safer, more consistent, more accessible and more accountable. In order to help achieve this a key role included as part of the establishment of CSG was the Benefits Manager.

The Trust is pleased to have recruited to this role an experienced clinical benefits lead with experience of working on national programmes.

As well as formalising the structure for benefits management across new clinical projects and business cases the benefits manager is reviewing key completed projects to enable the Trust both to track and promote expected benefits. An overview of this on-going work can be seen in Figure 1 CSG Benefits on a Page.

Reducing the use of printing, paper and paper notes is key aim of the Trust during the lifetime of this strategy. This will be achieved through a focus on benefits, usability and training. A recent case-study looking at the deployment of EMIS in the community highlighted that this had save one-million sheets of paper during 2022-23 with an ecological benefit of saving 15,700Kg of carbon dioxide emissions.

Workforce benefits will be achieved through training and up-skilling whilst freeing up staff from the need to do tedious, repetitive manual tasks. Alongside the benefits work, CSG plans to make the clinical systems training function more proactive and visible to clinicians in the Trust ensuring more consistent use of systems across departments and improving data quality.

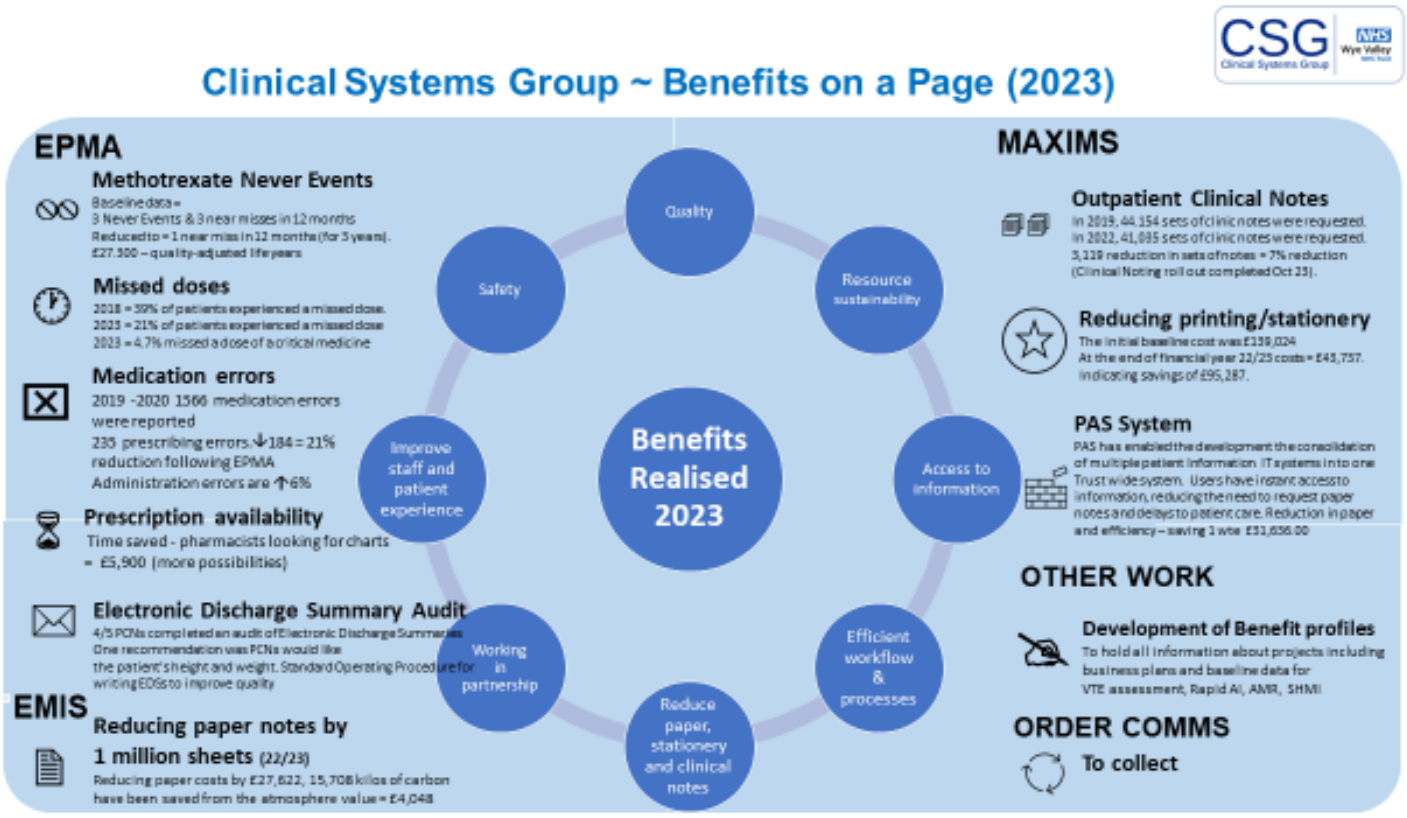


Figure 1 CSG Benefits on a Page

Funding & Delivery

A draft five year capital plan was produced for the ICB in December 2023. This includes known high-level projects required to deliver this strategy. References to

specific current projects are to accommodate where these may be expected to run/overrun into future financial years.

The recommended level of capital investment remains at approximately £4m per year noting that the plan is front-loaded due to projects that have not proceeded as planned in 2023-24 following delays with the anticipated Frontline Digitisation funding. These delays arose because the Trust's existing contract with IMS Maxims pre-dates the Frontline Digitisation programme and therefore does not comply with its latest procurement guidance. This issue has been escalated to the national Director of Frontline Digitisation for a decision.

The Trust currently spends approximately £6m revenue annually on operating its digital and ICT estate. This includes the annual support and maintenance of key clinical systems such as Maxims, the £1.4m cost of the Hoople contract and staffing the in-house Clinical Systems Group. A £4m capital investment on top of this would represent a total annual spend of 3.4% of the Trust's nominal annual turnover of £295m. This is below the 4% - 5% target previously proposed by NHSE in 2019 and slightly higher than the historical 3.2% of turnover the Trust averaged in the years preceding the pandemic.

Capital Scheme Name	2024/25	2025/26	2026/27	2027/28	2028/29	Total
EPR - Phase 3 (incl. Surgical Pathway & DNN)	400	400	400	400	400	2,000
Smaller IM&T Schemes	150	150	150	150	150	750
ED System Replacement	750	250	0	0	0	1,000
EPMA Integration & Optimisation (e.g. Pharm Stock Control)	100	100	100	100	100	500
Outpatient Prescribing (EPS)	350	50	0	0	0	400
EMIS / Community Optimisation	75	75	75	75	75	375
Robotics	0	0	0	1,000	0	1,000
Ophthalmology EPR	0	0	0	0	1,000	1,000
Apex Hardware Replacement						0
GP Order Comms						0
Order Communications Optimisation	75	75	0	0	0	150
Oncology Database Modernisation (OAST)		130	20			150
Pathology LIMS			200	200	200	600
ITU EPR system replacement				500	500	1,000
ICB Project Trust Resources (e.g. Patient Portal)	200	200	200	200	200	1,000
Managed Print Implementation	0	0	200	0	0	200
ICB WAN Implementation	200					200
Data Warehouse & BI		500	500			1,000
Hoople Core Infrastructure Replacement - Rolling Programme	500	500	500	500	500	2,500
Client Device Replacement	500	500	500	500	500	2,500
E-Rostering Medical						0
Single Sign On	375	375	0	0	0	750
T-Pro Implementation (speech rec)	200	50	0	0	0	250
MS Windows 11 Implementation	200	200				400
MS Strategy Implementation (incl. NHS Mail Migration)	400	400	200			1,000
Video Conferencing			300			300
Telecom Upgrade Programme	300	300	0	0	0	600
	4,775	**4,255**	**3,345**	**3,625**	**3,625**	**19,625**

Figure 2 Draft Five Year IM&T Capital Plan December 2023

Conclusion and Next Steps

Digital transformation is vital for the Trust and this includes a robust ICT operation that ensures process continuity. Whilst managing the legacy, the Trust also needs to focus on the smarter use of its data.

In the three years since the December 2020 strategy was published the Trust has continued to make significant progress advancing its digital maturity. It is almost inevitable that this progress will now need to slow down. The Trust and the local health system are financially challenged and the sums needed both to maintain what

has already been deployed and continue to deploy new digital technology at pace are unaffordable.

It is therefore appropriate that the next three year period is characterised by taking stock of what has already been delivered and optimising it, broadening its internal appeal and public reach whilst maximising its operational and financial benefits. This is exemplified by the ongoing push to reduce the use of paper. This said, the Trust cannot afford to stand still and on-going modernisation at a sustainable pace (supported, where appropriate, by national funding) remains an important part of our strategy.

Report to:	**Public Board**
Date of Meeting:	**06/06/2024**
Title of Report:	Integrated Care Board One Herefordshire Update Briefing
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Managing Director**
Author:	Jane Ives and Jon Barnes
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To ensure the Board remain informed and up to date with consequential issues that are being managed or discussed at the integrated care board, integrated care partnership assembly or one Herefordshire partnership

2. Recommendation(s)

For Information.

3. Executive Director Opinion[1]

This report outlines the funding available in the BCF for this year, the progress made already on improving the productivity within the discharge to assess pathways and sets out the challenge to further improvements in the current year.

In addition to the agreed improvements for discharge to assess there will be a review of the other BCF funding and further opportunities for improvement in the other funding streams

4. Please tick box for the Trust'2022/23 Objectives the report relates to:

Quality Improvement

☐ Improve the experience of patients receiving care by improving our clinical communication

☒ Improve patient safety through implementing change as we learn from incidents and complaints across our system

☐ Reduce waiting times for diagnostics, elective and cancer care

☒ Develop a new integrated model for urgent care in Herefordshire improving access times and reducing demand for hospital care

Integration

☒ Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meets demand on the day

☒ Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level

☒ Improve quality and value for money of services by making a step change increase in the range of contracts that are devolved to the One Herefordshire Partnership

☐ Join up care for our population through shared electronic records and develop a patient portal to transform patient experience

Sustainability

☐ Create sufficient Covid-safe operating capacity by delivering plans for an ambulatory elective surgical hub

☐ Stop adding paper to medical records in all care settings

☐ Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain

☐ Increase elective productivity by making every referral count, empowering patients and reducing waste

Workforce and Leadership

☒ Improve recruitment, retention and employment opportunities by taking an integrated approach to support worker development across health and care

☒ Develop our managers' skills and system leadership capability

☐ Continue to improve our support for staff health and wellbeing and respond to the staff survey

☒ Further develop place based leadership and governance through the one Herefordshire Partnership and Integrated Care Executive

[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.

1.0 Integrated Care System Update

Nothing of note to report

2.0 One Herefordshire Partnership Update

The Better Care Fund

The Better Care Fund is a partnership programme between the Department for Levelling Up, Housing and Communities, NHS England, the LGA and DHSC. It is government's 'flagship' fund for integration of health and social care

The two purposes of the funding are:

- Spending on social care services to benefit health and to improve overall health and social care outcomes
- Facilitate the smooth transition of people out of hospital, reduce the chances of re-admission, and support people to avoid long term residential care.

Every Health and Wellbeing Board is required to submit a BCF plan with the aim of working towards improved performance against the two programme objectives:

- To enable people to stay well, safe and independent at home for longer
- To provide people with the right care in the right place at the right time
- The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support, and public health.

The Memorandum of Understanding

The Memorandum of Understanding (MOU) between the Herefordshire and Worcestershire Integrated Care Board (ICB) and the One Herefordshire Partnership (One HP) sets out a series of delegated responsibilities including a responsibility for the Better Care Fund (BCF). Specifically, One HP is responsible for the following.

- Building consensus between partners and setting objectives beyond the nationally determined outcomes as part of the annual planning of the Better Care Fund, including the BCF Plan.

- Development and implementation of new and/or revised services or care pathways.

- Monitoring, delivery and reporting of performance and outcomes.

- Budget management and ensuring spending lives within the resources allocated, identifying remedial actions where spending is off trajectory.

BCF planning for 2024/25

Funding for the BCF has increased by £2.6m for 2024/25. However, funding of £2.3m utilised in 2023/24 is not available in 2024/25: the BCF underspend reserve was fully depleted by planned spending in 2023/24,

The net effect of the changes is an increase of £0.3m in funding. This increase in funding is not sufficient to meet inflationary increases in recurrent commitments, so reductions in expenditure are necessary to deliver a balanced plan.

2024/25 BCF FINANCIAL PLAN- SUMMARY					
Funding Stream	**2023/24 Plan Value**	**Change in Funding**	**2024/25 Total Funding**	**2024/25 Plan Value**	**Balance of Funding Over / (Under) committed**
MANDATORY TRANSFER TO ADULT SOCIAL CARE	£6,874,214	£389,082	£7,263,296	£7,263,296	£0
NHS COMMISSIONED OUT OF HOSPITAL SERVICES	£9,114,213	£515,862	£9,630,075	£9,630,076	£0
DISABLED FACILITIES GRANT	£2,466,616	£7,919	£2,474,535	£2,474,535	£0
IMPROVED BETTER CARE FUND	£6,782,841	£0	£6,782,841	£6,782,841	£0
ADULT SOCIAL CARE DISCHARGE FUND	£1,998,716	£1,681,734	£3,806,849	£3,806,849	£0
BCF UNDERSPEND RESERVE	£1,879,060	-£1,879,060	£0	£0	£0
LOCAL AUTHORITY URGENT & EMERGENCY CARE FUND	£413,761	-£413,761	£0	£0	£0
TOTAL	**£29,529,421**	**£301,776**	**£29,957,596**	**£29,957,596**	**£0**

The main area of financial pressure on the BCF for 2024/25 is within Discharge to Assess funding, continuing to procure the same volume and type of supported discharge services that was procured 2023/23 would have seen a significant cost pressure on the BCF.

The capacity and demand planning undertaken for the 2024/25 plan identified a number of opportunities to create a Discharge to Assess spending plan that would remain within the budget available.

The following 3 tables summarise the capacity and demand plan for this year. The plan requires a number of improvements to be delivered in year.

- Improvement in occupancy levels and average length of stay for all reablement providers.
    - Pathway 1 – HomeFirst
    - Pathway 2 – Hillside
    - Pathway 3 – Ledbury Intermediate Care Unit
- A more responsive Pathway 1 service seeing patients going home within 24 hours on average compared to the 108 hour average we saw last year.

D2A HOME FIRST DEMAND & CAPACITY SUMMARY		
2023/24 Home First Demand	73,400	hours
Reduce demand by reducing average length of stay in home care	-2,467	hours
Demand moved to Home First by reducing discharge delays	7,426	hours
2024/25 Revised demand	**78,359**	**hours**
Home First 2023/24 capacity	34,397	hours
Increase capacity by reducing staffing vacancies	9,304	hours
Increase capacity by reducing average length of stay	3129	hours
Home First 2024/25 capacity	**46,830**	**hours**
Bridging Service 2023/24 capacity	**7,654**	**hours**
Spot purchase capacity required	**23,874**	**hours**

D2A Home First Costs	**2024/25 Budget**	**2023/24 Outturn**
Budgeted costs of Home First	£2,842,156.28	*£2,922,747.00*
Additional costs of reduction in Home First vacancies	£0.00	*£0.00*
Budgeted costs of Bridging Service	£160,042.77	*£156,751.00*
Estimated costs of spot purchase hours	£542,712.36	*£320,840.91*
Total cost of Home First	**£3,544,911.41**	***£3,400,338.91***
Planned Increase in Costs	***£144,572.50***	

D2A RESIDENTIAL CARE DEMAND & CAPACITY SUMMARY		
2023/24 Residential Care Demand	10,883	OBDs
Move demand to Home First by reducing discharge delays	-2,543	OBDs
2024/25 Revised demand	**8,340**	**OBDs**
Hillside 2023/24 capacity	6,310	OBDs
Increase capacity by increasing occupancy levels	240	OBDs
Increase capacity by reducing average length of stay	614	OBDs
Hillside 2024/25 capacity	**7,164**	**OBDs**
Optimum block contracted capacity	**462**	**OBDs**
Spot purchase capacity required	**715**	**OBDs**

D2A Residential Care Costs	**2024/25 Budget**	**2023/24 Outturn**
Budgeted costs of Hillside	£1,311,317.00	*£1,384,620.00*
Additional costs of increased occupancy at Hillside	£0.00	*£0.00*
Estimated costs of contracted beds	£54,699.30	*£117,958.00*
Estimated costs of spot purchase beds	£127,884.66	*£526,123.00*
Total cost of residential care	**£1,493,900.96**	***£2,028,701.00***
Planned Reduction in Costs	**-£534,800.04**	

D2A NURSING CARE DEMAND & CAPACITY SUMMARY		
2023/24 Nursing Care Demand	8,032	OBDs
LICU 2023/24 capacity	3,026	OBDs
Increase capacity by increasing occupancy levels	300	OBDs
Increase capacity by reducing average length of stay	153	OBDs
LICU 2024/25 capacity	**3,479**	**OBDs**
Optimum block contracted capacity	**462**	**OBDs**
Spot purchase capacity required	**4,091**	**OBDs**

D2A Nursing Care Costs	**2024/25 Budget**	**2023/24 Outturn**
Budgeted costs of LICU	£1,320,817.58	*£1,255,649.37*
Additional costs of increased occupancy at LICU	£0.00	*£0.00*
Estimated costs of contracted beds	£69,600.06	*£223,966.00*
Estimated costs of spot purchase beds	£673,673.98	*£688,027.00*
Total cost of nursing care	**£2,064,091.61**	***£2,167,642.37***
Planned Reduction in Costs	***-£103,550.76***	

Progress to date

Commissioning work undertaken in 2023 by council commissioning colleagues to improve the capacity and responsiveness of the domiciliary care market has been very successful. 12 months ago there were circa 150 individuals across their own homes, in Pathway 1 or 2 provision or in a Hospital bed, all assessed as needing domiciliary care but unable to receive that care. This is consistently now down to under 20 and is often in single figures.

The MOU came in to place at the end of 2023 since that time One H has been able to make a number of improvements to Discharge to Assess performance.

- Working with Home First to reduce the wait time for medically safe for discharge from 4.5 days to within 1 to 2 days.
- Utilise BCF funding to recruit an Analyst to design a D2A dashboard to allow the monitoring of performance and quality metrics.
- Created a D2A Board to oversee plans and provide assurance to the wider system
- Deliver a One HP approved BCF plan supported by the ICB

Medical Agency Reduction Programme (MARP) – Executive Narrative

Chizo Agwu

Chief Medical Officer

The Medical Agency Reduction Programme (MARP) is established as one element of the Trust's overall drive to maximise Best Use of Resources, Productivity and Efficiency and will specifically target the reduction on the reliance and use of medical temporary staffing, to include medical agency, external bank locums and internal overtime for cover need.

Success in this area should further enhance the quality of care offered to our patients, releasing resource for other patient care activities, and release management time to concentrate on other priorities such as recruitment and waiting list target performance.

There is evidence we are employing more Whole Time Equivalent (WTE) medical staff than we are losing to unbudgeted maternity leave, sickness leave and vacancies. This is therefore not the main driver for MARP.

Key areas of focus in this respect are:

◊ Controls and governance

◊ Medical staffing HR related complexities

Recruitment however, as likely to be expected, remains pivotal. MARP has identified an opportunity to improve upon timely recruitment, not exclusively, but mainly at junior and middle grade level and also recognises that additional attention and support is needed for recruitment into fragile services and Consultant posts that are hard to recruit into.

The main key performance indicators used by MARP are:

◊ Medical temporary staffing cost and volume for both medical agency and medical bank

◊ Direct comparison of the use of WTE in medical temporary staffing terms against the WTE gap at specialty and grade level

◊ The medical WTE vacancy position

◊ WTE recruitment against plan

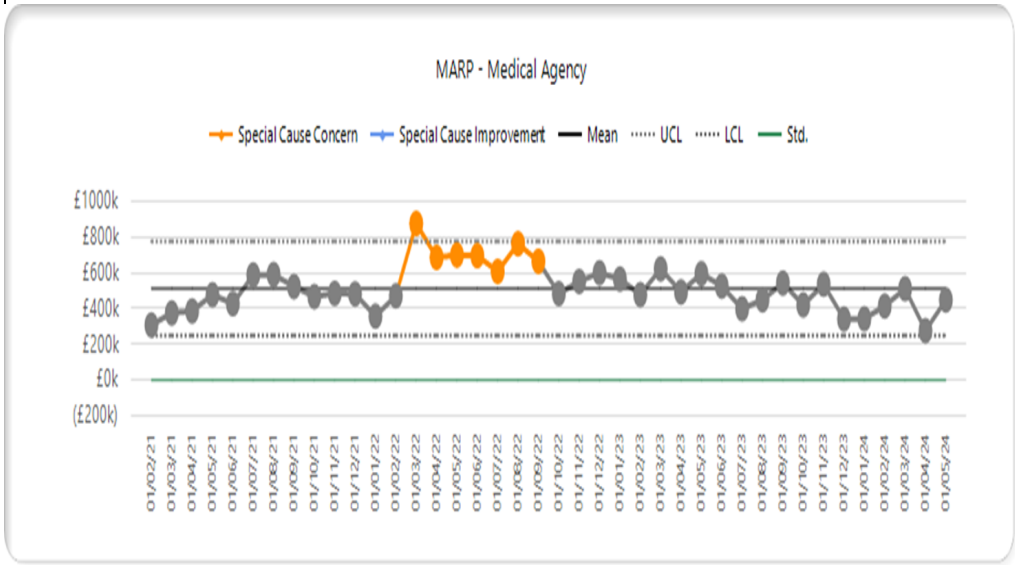
◊ High cost locums and average rates paid to medical bank

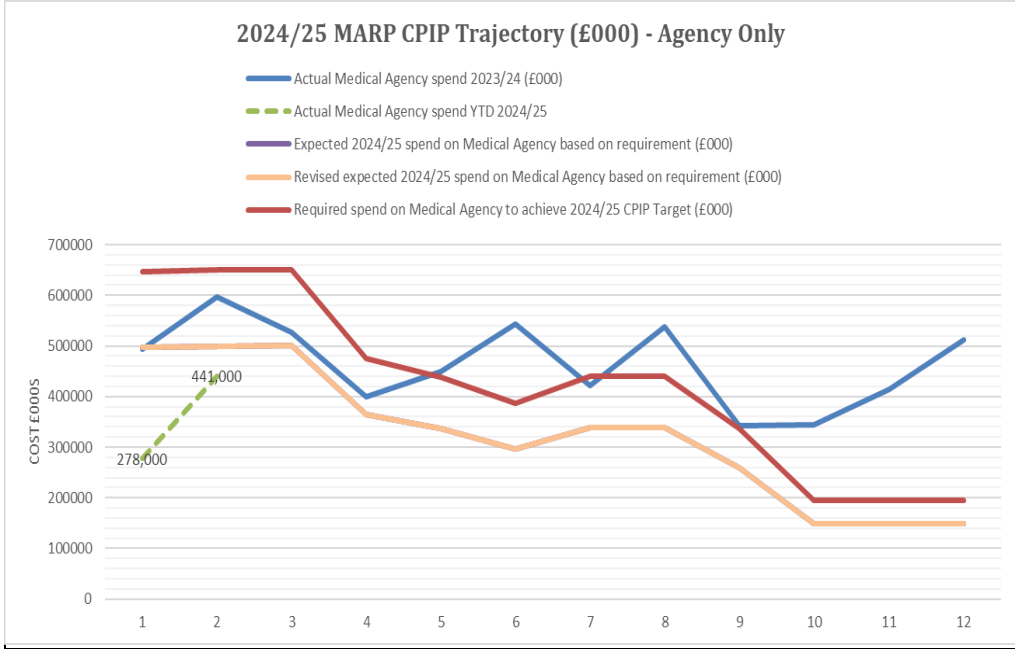
This report provides a view through a number of drivers and performance measures. The slides provide insight into MARP performance and the direction of travel MARP is headed in as we enter into 2024-2025.

Medical Temporary Staffing Cost Trends - Agency

We are driving this measure because:

We monitor monthly agency costs closely as it is an indicator of volume change and informs us of the direction of trend.





Performance and Actions

The 24/25 YTD M2 medical agency position is 34% less than the same period in 23/24.

The SPC chart is showing a steady decline, which is reflective of the improvements and consistent approach against the agency spend. This is despite continuing higher levels of Consultant vacancy. The YTD M2 position is well within the 24/25 CPIP target trajectory, by 45%

24/25 actions include:

- Recruitment into new posts to replace the medical temporary staffing (MTS) with a substantive workforce
- Increased controls and governance in line with revised establishment and in particular additional controls for medical bank
- Provision of written rota and annual leave rules
- Review of HR complexities to eliminate or reduce other gaps on rotas relating to HR issues.
- MARP focus on timely recruitment, particularly at middle and junior grade, supported by the Medical Workforce Team
- MARP focus on hard to recruit to areas, supported by the Medical Workforce Team
- Rate reduction programme through the H.T.E framework
- Additional focus on other measures against medical temporary staffing use, such as gaps created on rotas due to rota changes and medical staff removed from rotas

Risks:

- Recruitment into hard to recruit areas and further medical staff retiring/resigning
- Utilising agency for additional activity i.e. RTT and recovery

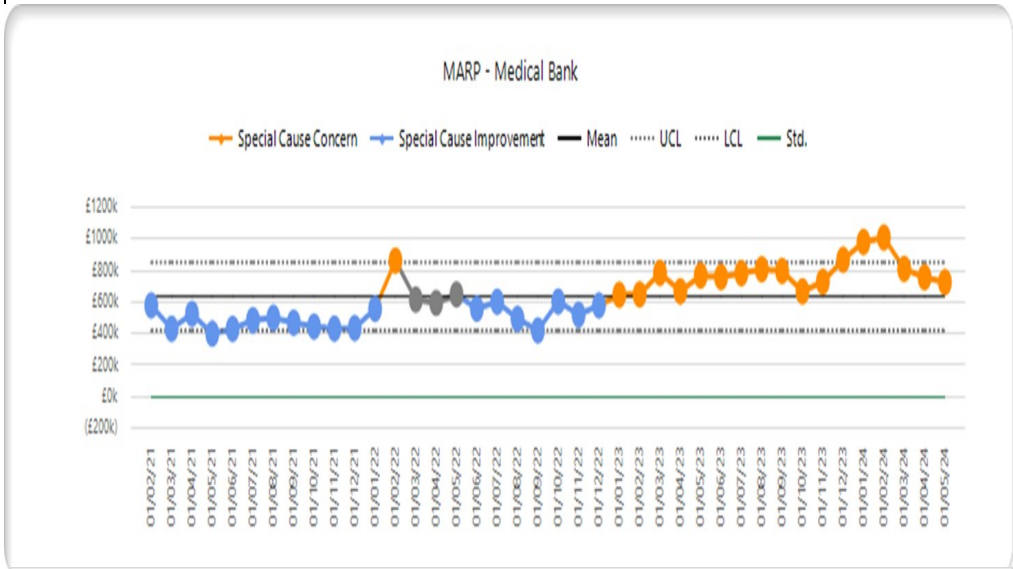
What the charts tells us:

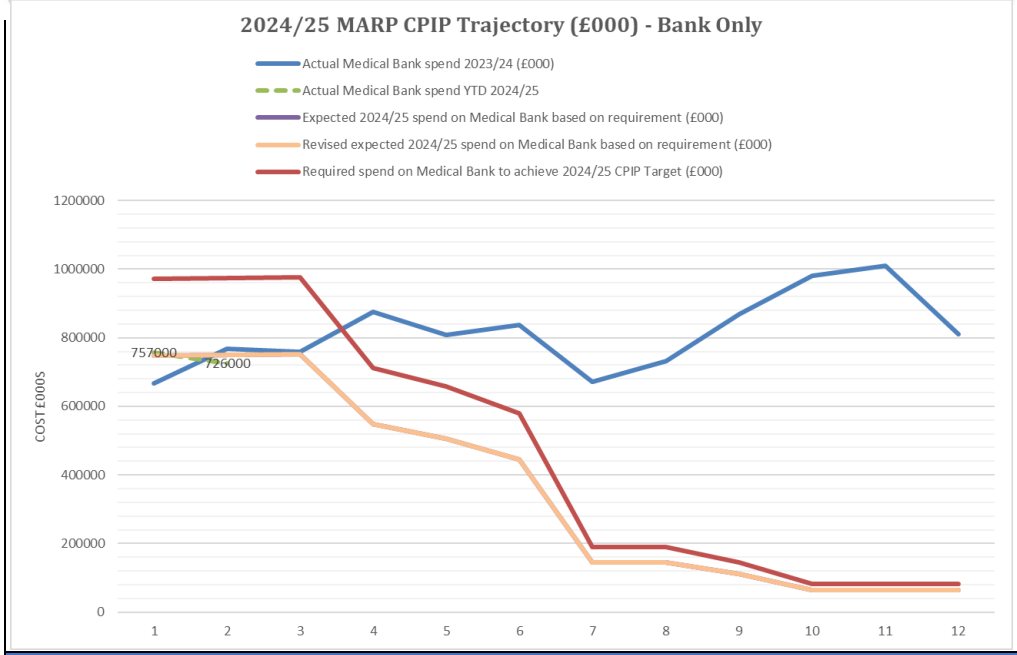
There is a 34% improvement against the 23/24 agency spend YTD but the direction of trend has not changed sufficiently. There is a still a huge opportunity for improvement against the medical agency spend.

Medical Temporary Staffing Cost Trends - Medical Bank

We are driving this measure because:

We monitor monthly medical bank costs closely as it is an indicator of volume change and informs us of the direction of trend. Medical bank costs often opposes agency cost





Performance and Actions

The 24/25 YTD M2 medical bank cost position is more or less in line with the same period in 23/24. There has been month on month reduction arresting the steep rise

The SPC chart is showing a cause for concern against the medical bank spend. The main reasons for this unfavourable position is identified to be due to utilising medical temporary staffing to provide cover outside of the funded establishment. This matter is being resolved through an urgent establishment review and recruitment into newly approved vacancies.

We should begin to see the positive impact of this from August.

Despite these concerns, the YTD M2 position is well within the 24/25 CPIP target trajectory, by 24%

Ongoing actions include: As per slide 2.

Risks:

-
- Recruitment into hard to recruit areas and further medical staff retiring/resigning
- Utilising medical bank to replace agency, instead of preventing the requirement
- Industrial action

What the charts tells us:

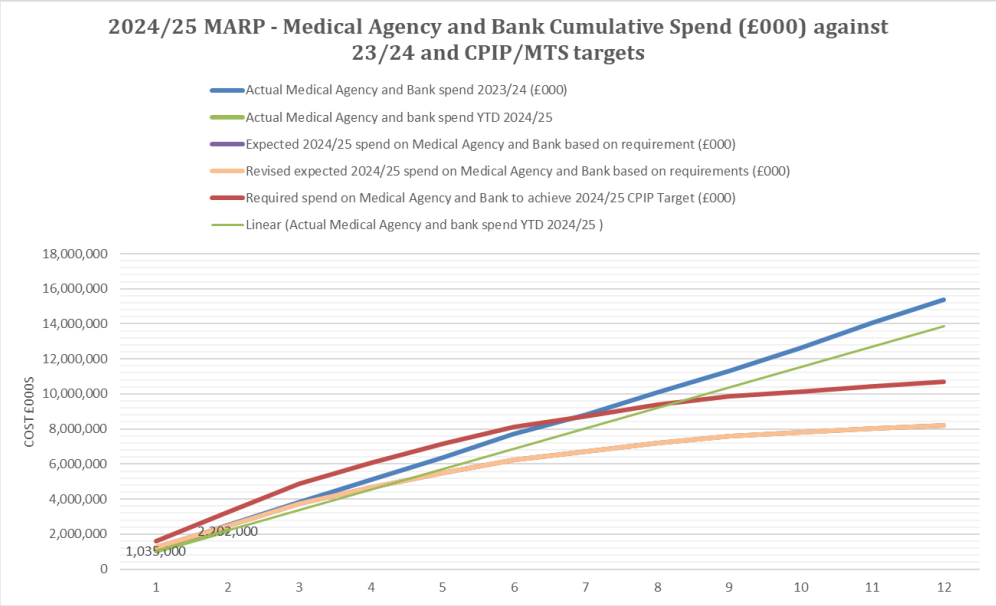
The overall volume and direction of trend against the medical bank spend remains a serious cause for concern.

Medical Temporary Staffing Cost Trends - Combined Position (Agency and Bank)

We are driving this measure because:

We monitor monthly medical bank and agency costs combined closely as it provides an overview is an indicator of volume change and informs us of the direction of trend.

			CPIP Target Performance	
Month	Required Spend to Achieve CPIP (£000)	Actual Total MTS Spend YTD (£000)	Difference in Cost (£000)	Percentage Difference
April	1,617,954.0	1,035,000.0	582,954	39%
May	1,624,610.0	1,167,000.0	457,610	28%
YTD	3,242,564.0	2,202,000.0	1,040,564	32%



Performance and Actions

The M2 YTD combined (agency and bank) position is within the CPIP target trajectory by £1 million (32%).

Despite a positive start to the year, the trend line is however still showing a high predicted yearend spend. It is therefore essential that the cost and volume continue to reduce in line with, or below the planned CPIP trajectories shown on slides 2 and 3.

Ongoing actions include: As per slide 2.

-

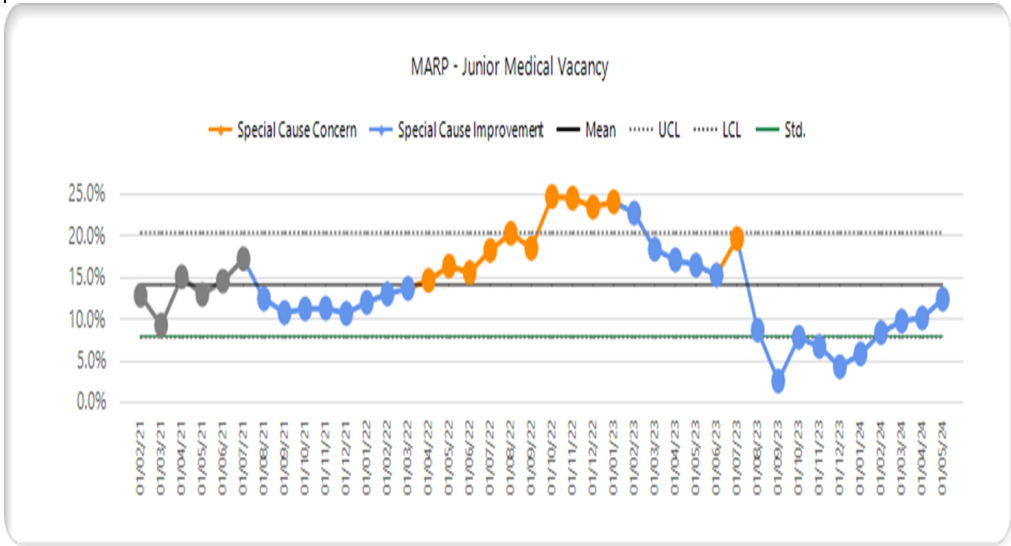
What the charts tells us:

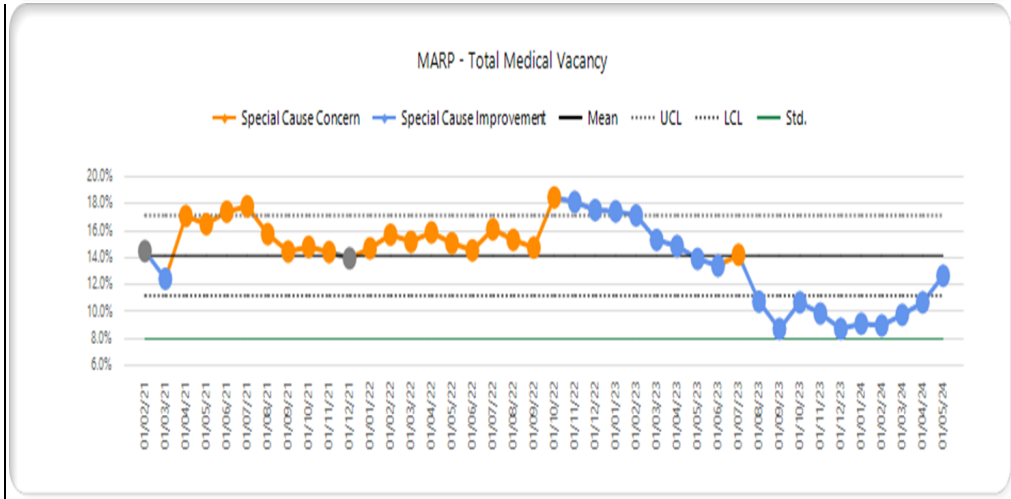
Although improved, the overall volume and direction of trend against the combined medical bank and agency spend remains a serious cause for concern.

Medical Staffing Vacancy Position — Junior and Trust Total

We are driving this measure because:

Vacancies directly lead to an increased use of temporary staffing and can also be used as a performance indicator against the volume of medical temporary staffing being used.





Performance and Actions

In 23/24 MARP Focused on junior recruitment, as performance in this area was poor. This is reflected in the SPC chart.

The Trust is expecting a disturbance in performance due to a recent increase in the junior workforce establishment which will require recruiting into and impending deanery gaps from August (the latter is proactively being mitigated with recruitment plans)

24/25 medical recruitment actions include:

- Ongoing fortnightly divisional recruitment meetings with the Medical Workforce Manager to review recruitment progress and plans.
- MARP focus on plans for hard to recruit to areas and longstanding Consultant vacancies.
- MARP focus on timely, proactive recruitment, particularly at Middle Grade and Junior level.
- Ongoing review of deanery gaps and delays with a view to mitigate this risk.
- Further consideration of alternative plans for hard to recruit to areas e.g. replace Consultant workforce with middle grade or AHP support.
- Confirmation of recruitment plan for hard to recruit to areas to include -
  - Incentives package
  - Personal development plan/wraparound support for new starters (international)

The Trust total vacancy position is consistently good despite the difficulties we continue to face at Consultant grade.

Risks:

As per slide 5

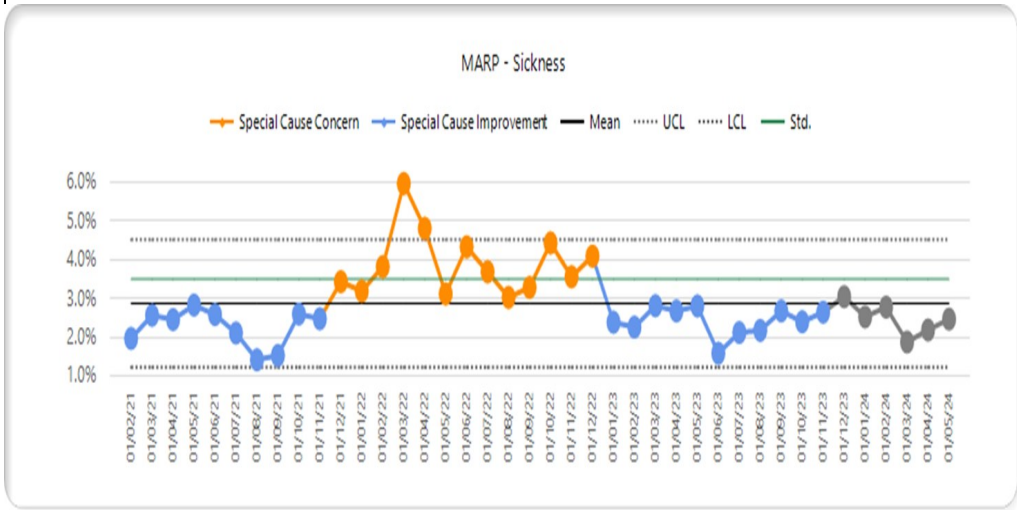
What the charts tells us:

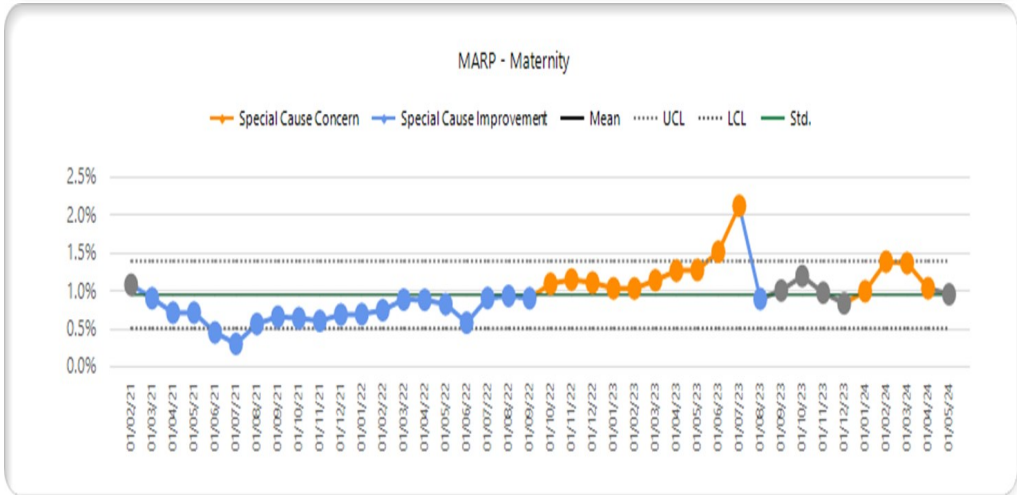
Both the junior and Trust total vacancy positon are consistently good.

Overall workforce performance for Medical Staffing

We are driving this measure because:

We provide and monitor this wider performance across medical staffing as this provides essential context. This section provides the context of sickness and maternity leave





Performance and Actions

Sickness levels are below the national threshold of 3%. It is not anticipated that sickness levels have impacting significantly on the overall medical agency and bank spend.

The maternity vacancy has recently reduced to below the national average of 1%. Again it is not anticipated that maternity leave is impacting significantly on the overall medical agency and bank spend.

Ongoing actions:

- Review and triangulation of sickness during MARP divisional review meetings with specialty teams and triangulation against sickness recorded on ESR.
- Sickness absence management policy application monitored via Divisional HR Teams and training provided where required.

Risks:

- Ongoing high levels of maternity leave and sickness
- Sickness information not recorded on ESR and/or not aligning with divisional assessment

What the chart tells us:

Sickness has stabilised since a sharp increase in 2022 and is below the national average. Maternity leave is in line with the national average.

Top Earning and Longest Serving Locums

We are driving this measure because:

Top earning and longest serving locums are a key performance indicator. We are attempting to reduce rates paid and end the long term use of individual locums.

Performance and Actions

Our performance against long serving and high cost locums remains unsatisfactory.

We have commenced a review and are developing plans to end contracts for long serving and high cost locums wherever possible. Exceptions include fragile services and exceptionally hard to recruit to areas such as Haematology and Stroke

24/25 Actions:

- Approval of ED business case, subject to finance
- Completion of recruitment plans into hard to recruit to areas as outlined on slide 6
- Escalate high rates to Exec colleagues for approval
- Attend regional Agency rate reduction collaboration in July 24

Risks:

- Reliance on individual locums, particularly for fragile services
- Recruitment into hard to recruit to areas, particularly in specialist areas
- Locum availability

What the chart tells us:

Nurse Agency Reduction Programme (NARP) – Executive Narrative

Lucy Flanagan
Chief Nursing Officer

The NARP programme has been established as one element of the Trust's overall drive to maximise Best Use of Resources, Productivity and Efficiency. In this respect, specifically to target the reduction on the reliance and use of high cost commercial agency. This should further enhance the quality of care offered to our patients, releasing resource for other patient care activities, as well as placing most value and effort into recruiting and retaining our substantive nursing workforce.

This financial year we will target the reduction in nurse agency expenditure, through a mix of price improvement and volume reduction and against the current 23/24 outturn baseline of £9.3m.

The NARP efficiency plan is incorporated into the wider Trust Plan for 2024-25 and is valued at £4.0m, this equates to not spending more than £5.3m on Nurse Agency. This is a highly challenging target but would return us below the level of expenditure of 2021-22 (which was £8.5m).

This report provides a view through a number of drivers of the position and performance measures*. It also shares how we manage and monitor the master vendor agency supplier and introduces the Efficiency plan and target which we have set through NARP for 2024/25. Progress is monitored and captured through this report.

*There are some final budget adjustments based on investments and uplift which will be fully reflected in month 3.

The acid test must always be to be able to demonstrate we are using no more Whole Time Equivalent (WTE) in agency terms than we are losing to unbudgeted maternity leave, sickness leave and vacancies. In this respect, for the period of May the WTE count for agency HCA's employed of 40.72 WTE, compared to the 71.20 WTE lost to these factors above normal factored-in downtime/timeout.

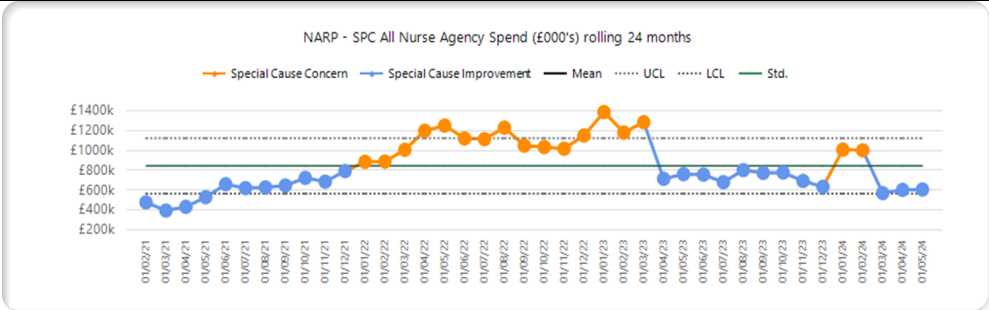
For RN's the comparison is 69.69 WTE agency employed to 63.19 WTE lost (which is the most balanced this has been in some time)

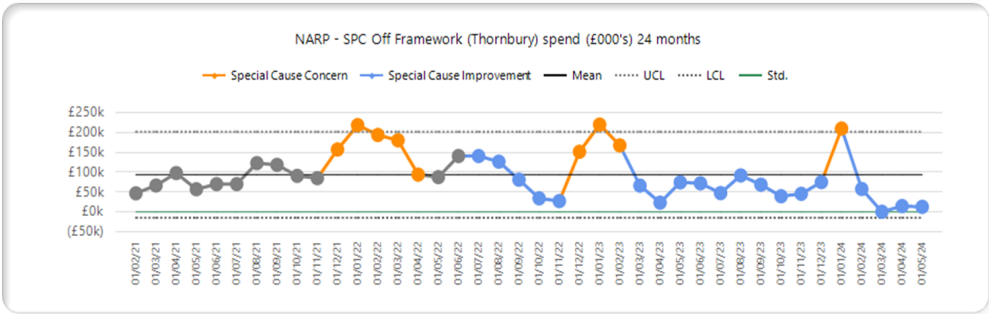
Despite many workforce metrics moving in the right direction we have seen a deteriorating vacancy position and sickness for health care support workers (10% and 8% respectively). This alongside boarding patients, escalation areas and additional beds is driving a high level of temporary workforce demand. We have reintroduced the central recruitment process for HCA's to close the vacancy gap as soon as practical with the aim to cease health care support worker agency use.

Overall Nurse Agency Cost Trends

We are driving this measure because:

We monitor monthly run rate closely as it is an indicator of either volume or price change (or both) and provides insight into direction of trend.





Performance and Actions

The first chart shows overall expenditure on commercial nurse agency over the period of the last 3 years. Also, the fact that in SPC terms the position moved for the first time into Special Cause Concern in January 22 and remained in that category through to March 23. Whilst not being of Special Cause Concern most of the 2324 financial year, it had reached Special Cause Concern in January 24 reducing back down from March 24.

The second chart shows over the same period the cost of off-framework (Thornbury) agency nursing. Again the SPC trend differentiates between statistical improvement and concern, although clearly the standard must be set and considered to be zero use, as all use of Off framework, represents variation from plan and extremely poor value for money. Additional controls and scrutiny of off framework agency is in place with significant reductions seen in the last 3 months.

We are working hard to achieve the elimination of Thornbury by the end of June in line with NHSE expectations, yet have some concern over staffing specialist areas such as SCBU and paediatrics. Alternative options/suppliers are being explored through HTE

Best Use of Resources:

The table below shows the range of rates for agency nursing. The true cost of substantive being the benchmark in the centre (uplifted for holiday pay and current actual sickness rates) against Thornbury off framework to the left and Master Vend rates to the right. All agency represents poor value for money as evidenced in the table.

New Rate Card £	Band 2				Band 5 (General)				Band 5 (Critical)			
	NHSI	Tier 1	Tier 2	Tier 3	NHSI	Tier 1	Tier 2	Tier 3	NHSI	Tier 1	Tier 2	Tier 3
Standard Day	£18.32	£19.43	£22.50		£24.06	£35.00	£37.50	£40.00	£29.78	£35.00	£40.00	£43.15
Night/Sat	£21.75	£21.75	£21.88		£31.29	£35.00	£38.50	£40.49	£38.71	£40.00	£42.00	£43.78
Sun/BH	£28.18	£28.18	£28.18		£38.51	£38.51	£42.50	£44.92	£47.65	£47.65	£47.65	£47.65

Revised KPI %	Band 2					Band 5 (General)					Band 5 (Critical)				
	NHSI	Tier 1	Tier 2	Tier 3	Total	NHSI	Tier 1	Tier 2	Tier 3	Total	NHSI	Tier 1	Tier 2	Tier 3	Total
KPI %	35%	60%	5%		100%	40%	30%	25%	5%	100%	20%	55%	20%	5%	100%

Weighted Av for Benchmarking

	HCA	B5	Crit
Standard Day	£19.20	£31.50	£35.36
Night/Sat	£21.76	£34.67	£40.33
Sun/BH	£28.18	£39.83	£47.65

The Benchmark - Substantive

	HCA	B5	Crit
Standard Day	£9.95	£12.64	£15.36
Night/Sat	£15.10	£18.75	£22.64
Sun/BH	£20.36	£24.33	£29.44

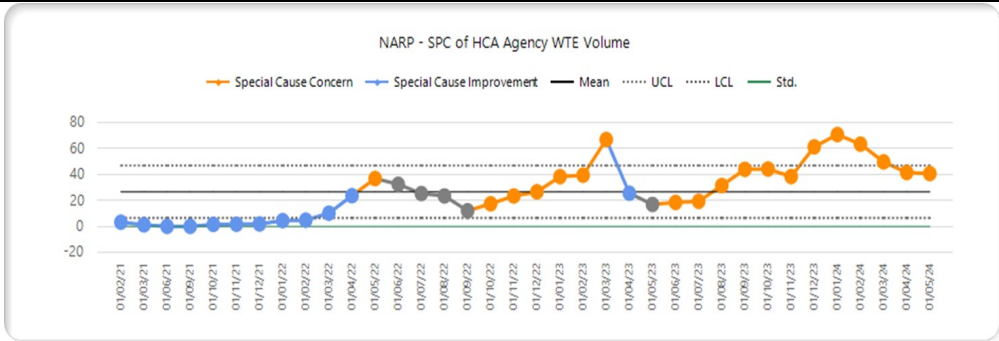
Benchmark compared to weighted Av

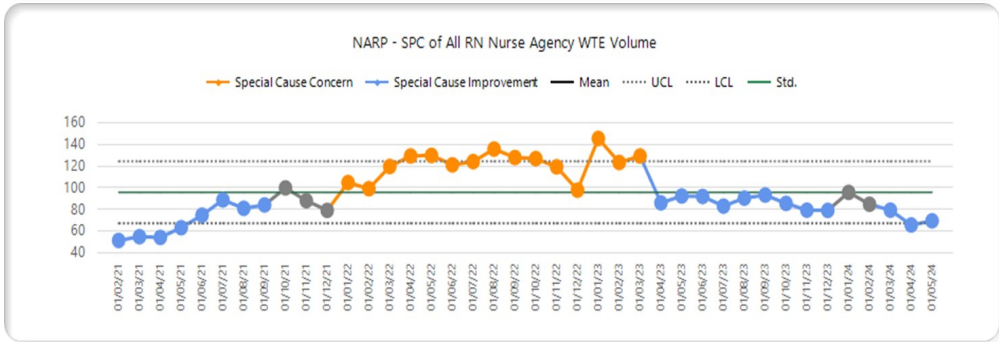
	HCA	B5	Crit
Standard Day	193%	249%	230%
Night/Sat	144%	185%	178%
Sun/BH	138%	164%	162%

Volume Run Rate Usage

We are driving this measure because:

We monitor WTE usage and supply weekly to ensure we are monitoring significant variation and targeting a reducing trend on agency reliance





Performance and Actions

The first chart monitors our use and requirement of HCA agency nursing which until March 2022 had never been a feature in agency demand. As a Trust we should really not be viewing commercial agency as a solution for HCA staffing. Divisions have been asked to eliminate where possible/or limit agency use to within vacancy thresholds. The current vacancy position for health care assistants stands at 60 WTE and is a deteriorating position.

The graph shows how volume demand has grown over the last year. The rising demand has been due to a deteriorating vacancy position, boarding patients, additional beds open and a recent deteriorating sickness position. In addition, service developments have been funded yet not achieved full recruitment.

The second chart shows our use of professional level commercial agency nurses which were at the highest level in the January 2023 and have subsequently reduced over the last 12 months.

Risks:

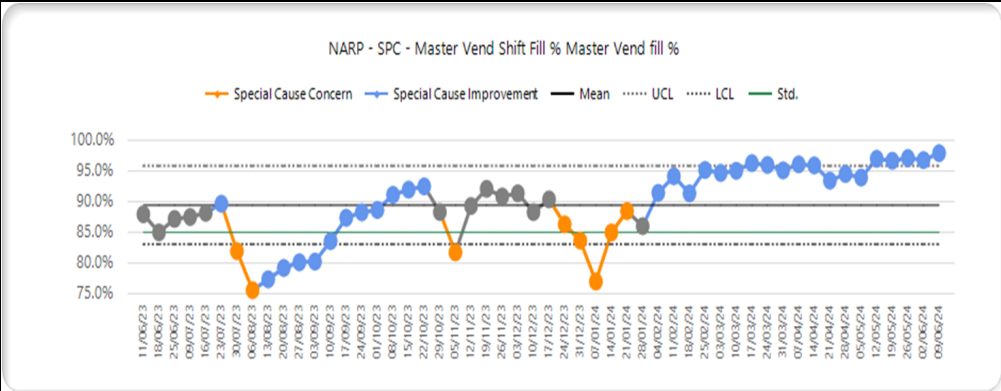
What the chart tells us:

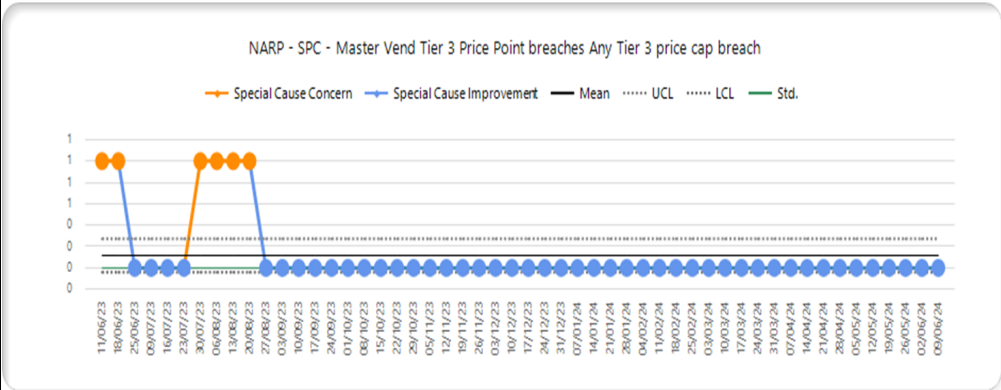
The chart evidences the WTE volume use of HCA and nurse agency.

Master Vend Trend Performance on Price and Fill

We are driving this measure because:

The supply contract is monitored on a weekly basis as part of close performance management of the Master Vend contract approved by the Board in October 2022. The contract runs for a 24 month term from 1st September 2022. Performance expectation are firstly to achieve minimum fill volume against any demand. Secondly, this fill to match or exceed a specified minimum and maximum distribution across price tiers.





Performance and Actions

Fill compliance—The chart plots fill % against the contractual requirement of a minimum overall fill of 85% against whatever our demand is each week. Within this the contract expects a reduced fill performance of at least 70% for those shifts released with less than a weeks notice.

As the trust demand has dropped over recent months the master vends ability to fill and meet contractual requirements has been consistent since February 2024

The second chart focuses in on any breach of price cap at the higher cost tier 3 level. This is contractually capped at 5% maximum. This is a binary measure in the chart, on this one specific performance measure whereby the chart shows whether a breach has occurred or not. Where tier 3 has been breached it has been pre-authorised by the Trust for patient safety reasons.

For an overview of wider contract performance of the Master Vend please refer to appendix A.

The Master vend contract is due for renewal later this year. The finance team are working with nursing colleagues to review the arrangements in advance of contract expiry. Options were considered and discussed with HTE colleagues and the plan is to present a high level options appraisal to TMB in early July with a fully costed options appraisal for consideration and approval at TMB in September.

Risks:

Contract performance is clearly very sensitive to wider market forces in the commercial agency market. Equally it retains a close link to the Trust demand levels and how much notice we can provide to achieve the lowest price on the contracted Tier rates.

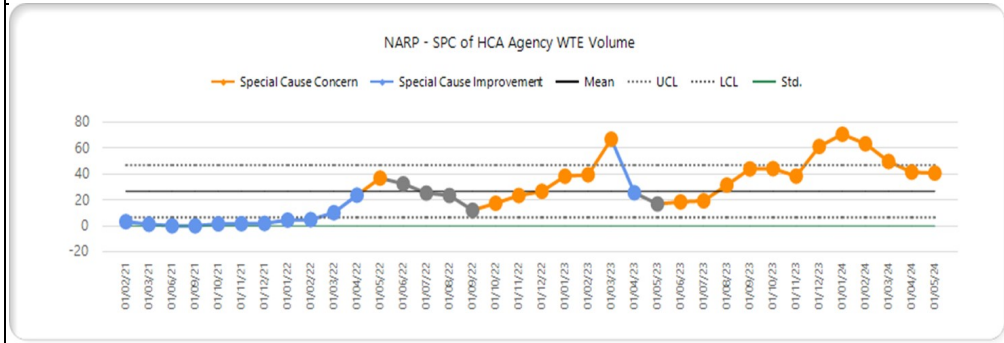
What the chart tells us:

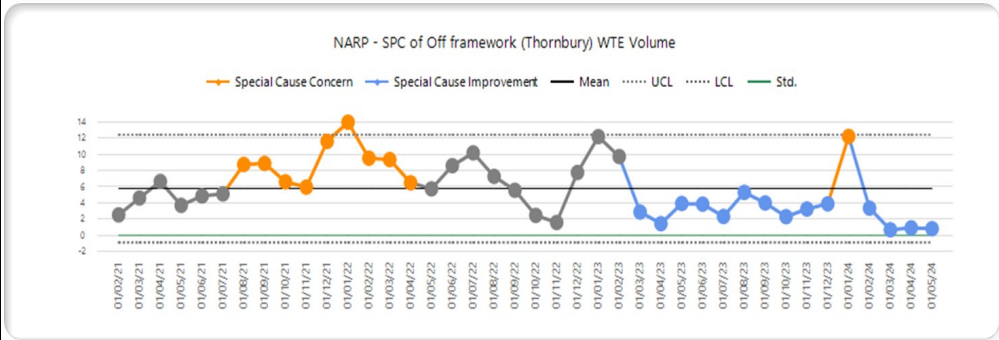
The charts should be read along with the wider performance summary in Appendix A. They should provide assurance in terms of close monitoring of both contract and contractor performance and indicate improvement opportunities on both sides of the Master Vend partnership.

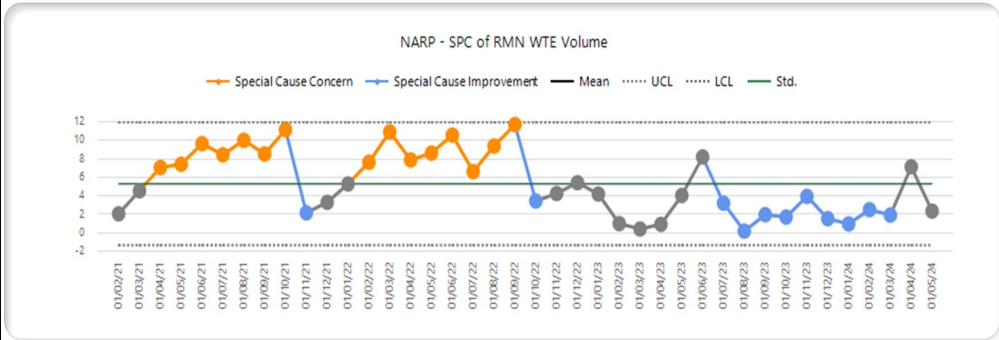
Progress against three specific targets for reduction—use of Thornbury, Agency HCA's, Agency RMN's

We are driving this measure because:

This is monitored on a monthly basis as we believe opportunities exists for improving best use of resources and targeting specific reductions across these three themes.







Performance and Actions

Reduction in reliance on HCA Commercial Agency

Reliance on agency for HCA's is moving in the wrong direction and has been a special cause concern since October 2022. The position is largely being driven by increasing sickness, deteriorating vacancy position, boarding patients, escalation areas and additional beds being open.

The central recruitment process has been reintroduced and is showing early signs of success yet is having to play catch up given the deteriorating vacancy position and recent investments in certain areas.

Reduction in reliance upon off-framework Commercial Agency Companies (Thornbury) with excessive rates.

Enhanced controls have been introduced and despite the variation seen in January the numbers of Thornbury shifts are reducing and small in number. We are working hard to eliminate Thornbury completely by the end of June yet do have some areas of concern as previously highlighted.

Reduction in the volume and practice of RMN Commercial Agency Use.

The scrutiny on RMN use continues and is an area that requires further scrutiny and focus.

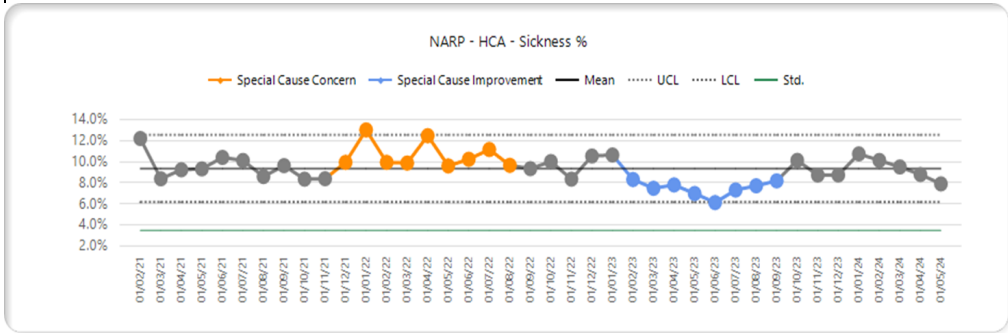
What the chart tells us:

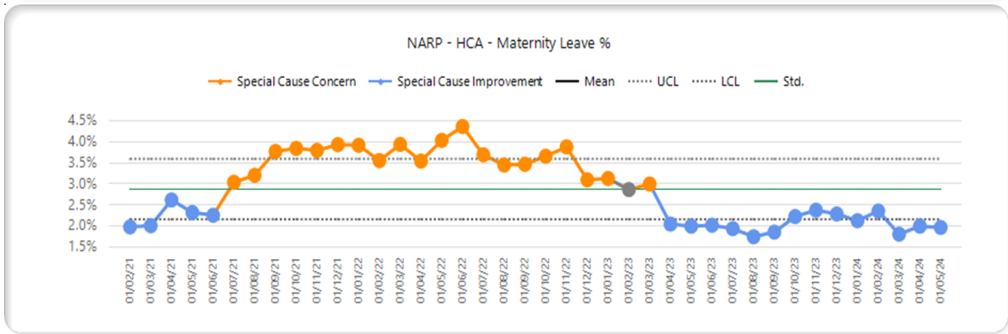
The charts tell us how we are performing against three specific KPI's and objectives of NARP

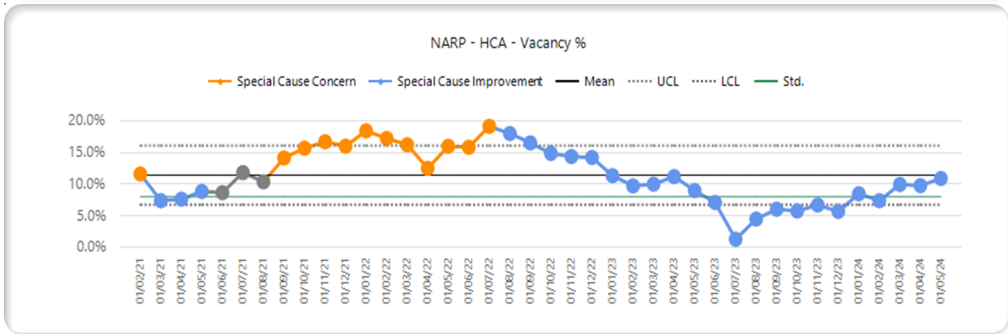
Overall workforce performance for nursing—1] HCA's

We are driving this measure because:

We provide and monitor this wider performance across nursing as this provides essential context. Not all nursing areas backfill with agency and this section provides the context of sickness, Maternity leave and vacancy information







Performance and Actions

It is concerning to note that sickness has been steadily rising, although now on a downward trajectory, yet still at 8% Sickness (HCA's). The target and expectation is shown in the green line at 3.5%. The 4.5% above budgeted establishment is likely to drive temporary workforce demand given the vacancy position.

Maternity Leave (HCA's) is being held at around 2% .

There are an increasing number of health care support worker vacancies and this is likely to increase further as the final budget adjustments are completed (we anticipate these changes to be fully reflected in month 3).

Any variation to the budgeted values below in ward staffing will result in a pressure (and ultimately potential use of commercial agency).

Planned and budgeted for Time out	
	RN's
Annual Leave	14.0%
Sickness	3.5%
Study leave	2.0%
Other (Maternity/Compassionate)	1.0%
Total	**21%**

Risks:

Once we have closed the gap on vacancies there is a risk that continued high levels of sickness and any increase in turnover will drive a continued demand for temporary workforce.

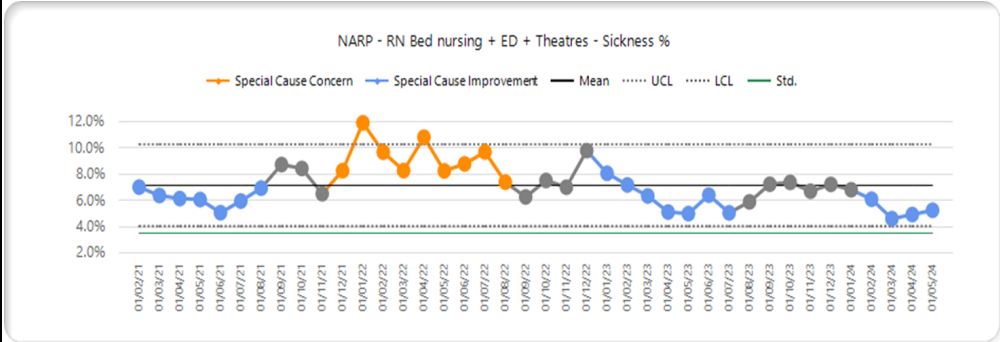
What the chart tells us:

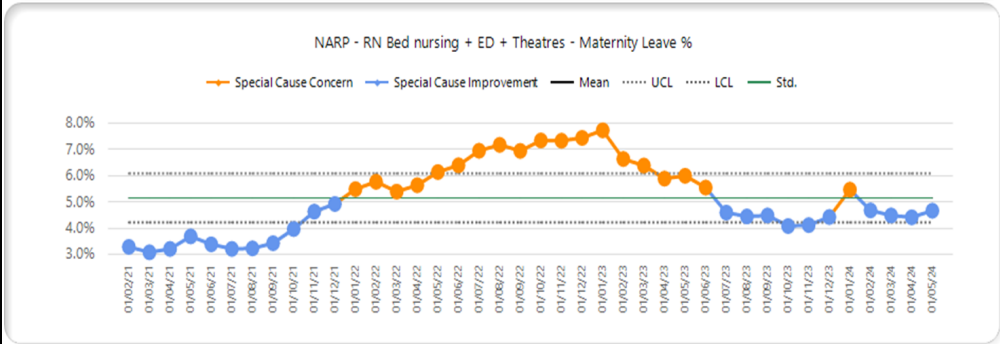
The charts provides context to all other information in this report as the key drivers for commercial agency use.

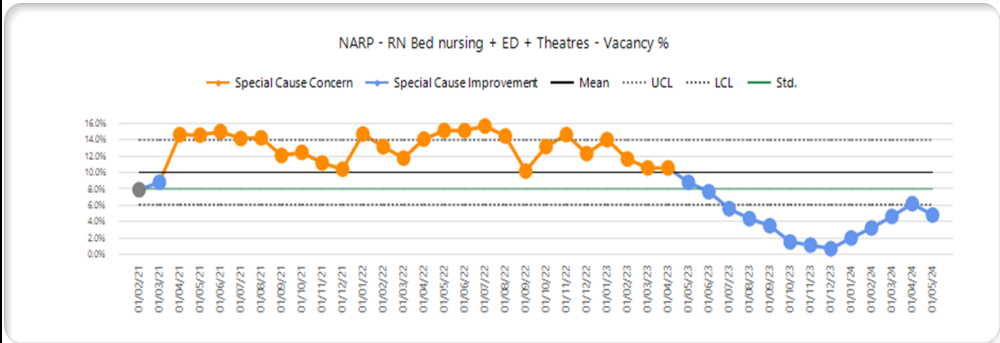
Overall workforce performance for nursing—2] RN Bed Nursing + Theatres + ED

We are driving this measure because:

We provide and monitor this wider performance across nursing as this provides essential context. Not all nursing areas backfill with agency and this section provides the context of sickness, Maternity leave and vacancy information







Performance and Actions

The reduced levels of sickness are positive and to be celebrated, current levels are only just in excess of the target and expectation is shown in the green line at 3.5%.

Maternity Leave (RN's) is fairly static. For band 5 and 6 roles teams are encouraged to recruit cover arrangements substantively given fixed term roles are unattractive. This does drive a cost pressure yet is better value for money.

Vacancies (third chart) have been on a positive downward trajectory earlier in the 23/24 financial year due to our highly successful international nurse recruitment programme. However, given service developments and the opening of the Elective Surgical hub the number started to increase from December 23. A business case for a further 77WTE internationally qualified nurses has been approved for 24/25.

Any variation to the budgeted values below in ward staffing will result in a pressure (and ultimately potential use of commercial agency)

Planned and budgeted for Time out	
	RN's
Annual Leave	14.0%
Sickness	3.5%
Study leave	2.0%
Other (Maternity/Compassionate)	1.0%
Total	**21%**

Risks:

What the chart tells us:

The charts provides context to all other information in this report as the key drivers for commercial agency use.

NARP - Efficiency Plan

We are driving this Efficiency because:

The NARP efficiency plan is incorporated into the wider Trust Plan for 2024-25 and is valued at £4.0m

We monitor delivery through the NARP programme and evidence it through a targeted reduction in expenditure of not spending more than £5.3m on Nurse Agency. This is a highly challenging target but would return us below the level of expenditure of 2021-22 (which was £8.5m).

	Type	Scheme Narrative	Risk	Total Efficiency Plan £000	Programme Total £m	R/NR	YTD Delivery at M2 £000	Total Delivery YTD £m
NARP	NARP	Displacement of Agency from Overseas Nurse recruitment from 23-24 (less element saved Rec in 2324)		**1,253.0**		R	-	
	NARP	Rate Card reduction as part of contract		**1,200.0**	**4.0**	R	-	**0.3**
	NARP	Eliminate off framework Agency nursing		**880.0**		R	-	
	NARP	Reduce Nurse Agency Spend		**667.0**		R	259.6	

Performance and Actions

The current level of agency spend has been circa 600k in month 1 and 2 and would put us on a trajectory of 7.2 million full year. This is not where we need to be and further controls are being developed.

A new rate card has been agreed with the master vend provider and will be introduced in June 2024 (based on last years demand the revised rate card would have achieved circa 0.5m£ reduction.

The Master vend contract is due for renewal later this year. The finance team are working with nursing colleagues to review the arrangements in advance of contract expiry. Options were considered and discussed with HTE colleagues and the plan is to present a high level options appraisal to TMB in early July with a fully costed options appraisal for consideration and approval at TMB in September.

Risks

We need to ensure gains from overseas recruitment are not being offset through higher turnover rates on UK nurses.

Appendix A

Master Vend Performance Table—Price Compliance and Fill:

Master Vend Contract Compliance Performance - (for graph data scroll down)

HCA	01/01/2024	08/01/2024	15/01/2024	22/01/2024	29/01/2024	05/02/2024	12/02/2024	19/02/2024	26/02/2024	04/03/2024	11/03/2024	18/03/2024	25/03/2024	01/04/2024	08/04/2024	15/04/2024	22/04/2024	29/04/2024	06/05/2024	13/05/2024	20/05/2024	27/05/2024	03/06/2024		Performance Flag	Must Be
Our Demand	266	252	304	285	255	245	260	260	219	206	174	160	177	194	173	124	136	154	129	150	132	186	154			
Fill Rate %	82%	91%	90%	86%	93%	95%	93%	96%	96%	94%	96%	96%	94%	94%	95%	97%	99%	94%	97%	99%	100%	98%	99%			> 85% overall (70% against shifts demand within same week)
Tier 1 %	72%	72%	77%	77%	78%	82%	82%	82%	83%	84%	89%	86%	83%	81%	1%	92%	96%	92%	96%	95%	91%	97%	95%			=> 35%
Tier 2 %	28%	28%	23%	23%	22%	17%	18%	18%	17%	15%	11%	14%	17%	19%	99%	8%	4%	8%	4%	5%	9%	3%	5%			=> 60% (but only if Tier 1 @ 35%) or Tier 1 & 2 =>95%
Tier 3 %	0%	0%	0%	0%	0%	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			<= 5%
General	01/01/2024	08/01/2024	15/01/2024	22/01/2024	29/01/2024	05/02/2024	12/02/2024	19/02/2024	26/02/2024	04/03/2024	11/03/2024	18/03/2024	25/03/2024	01/04/2024	08/04/2024	15/04/2024	22/04/2024	29/04/2024	06/05/2024	13/05/2024	20/05/2024	27/05/2024	03/06/2024			
Our Demand	156	165	174	174	153	138	202	153	155	152	127	138	153	118	100	95	114	106	113	114	140	176	123			
Fill Rate %	78%	94%	98%	92%	95%	97%	95%	96%	96%	97%	98%	99%	98%	98%	95%	92%	90%	96%	97%	96%	97%	99%	98%			> 85% overall (70% against shifts demand within same week)
Tier 1 %	63%	60%	55%	53%	58%	62%	58%	63%	64%	75%	79%	78%	73%	77%	84%	93%	98%	89%	96%	99%	95%	98%	96%			=> 40%
Tier 2 %	37%	40%	45%	46%	42%	38%	42%	37%	36%	25%	21%	22%	27%	23%	16%	7%	1%	11%	4%	1%	5%	2%	3%			=> 55% (but only if Tier 1 @ 40%) or Tier 1 & 2 => 95%
Tier 3 %	0%	0%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	1%			<= 5%
Critical	01/01/2024	08/01/2024	15/01/2024	22/01/2024	29/01/2024	05/02/2024	12/02/2024	19/02/2024	26/02/2024	04/03/2024	11/03/2024	18/03/2024	25/03/2024	01/04/2024	08/04/2024	15/04/2024	22/04/2024	29/04/2024	06/05/2024	13/05/2024	20/05/2024	27/05/2024	03/06/2024			
Our Demand	187	190	156	171	166	148	175	147	154	126	130	152	162	123	119	147	151	120	92	98	146	137	107			
Fill Rate %	69%	69%	74%	81%	86%	90%	85%	93%	91%	94%	95%	93%	94%	97%	98%	92%	93%	93%	97%	94%	95%	92%	97%			> 85% overall (70% against shifts demand within same week)
Tier 1 %	95%	96%	96%	95%	94%	93%	96%	96%	96%	97%	93%	95%	93%	97%	99%	99%	99%	98%	99%	99%	98%	98%	97%			=> 75%
Tier 2 %	3%	3%	4%	4%	3%	6%	4%	3%	4%	3%	3%	4%	5%	0%	0%	1%	1%	1%	0%	0%	2%	2%	2%			=> 20% (but only if Tier 1 @ 75%) or Tier 1 % 2 => 95%
Tier 3 %	2%	1%	0%	1%	3%	1%	0%	1%	0%	0%	3%	1%	2%	3%	1%	1%	0%	1%	1%	1%	0%	0%	1%			<= 5%
All Agency Fill %	77%	85%	88%	86%	91%	94%	91%	95%	95%	95%	96%	96%	95%	96%	96%	93%	95%	94%	97%	97%	97%	97%	98%			

Performance

This appendix provides a performance overview of the metrics which are monitored weekly on the Master vend contract. Fill % is shown either as green (as compliant), or amber. Compliance has improved significantly in line with less demand being generated by the Trust.

Contractual price compliance is far more straightforward and binary and particular attention is placed when the 5% cap on Tier 3 is contractually breached, (although on these occasions it is the Trust which has reluctantly had to authorise the breach in week).

Report to:	**Public Board**
Date of Meeting:	**4th July 2024**
Title of Report:	Perinatal Safety Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Attached as appendix, Perinatal Dashboard

1. Purpose of the report

To provide oversight and assurance of the safety and efficiency of the Perinatal service; providing detail to meet local and national reporting standards.

2. Recommendation(s)

Board is asked to note the contents and pursue any key lines of enquiry.

3. Executive Director Opinion[1]

The report has been scrutinised and discussed in full 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

☐ ***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.

Perinatal Services Safety Report – MAY 2024

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. This report features data from May 2024, and 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 135 births in May, a stable rate in keeping with our annual trends.

Midwife to birth ratio (<1:24)	1:25

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 May are recorded as:

		May
Red Flags	Delay in Induction >2hrs	0
	Delay in Catagory 1 delivery >30mins	1
	Delay in administering medication	0
	Delay in starting syntocinon/ARM >30mins	0
	Delay in Suturing >60mins	0
	Unable to provide 1:1 care in labour	0
	Delay in Triage >30mins	0
	Community midwives on call covering maternity unit	0
	Any movement of midwifery staff from any area to provide midwifery cover	0
	Delayed recognition of and action on abnormal vital signs	0
	DSC lost - supernumerary status	0

There was 1 case in May where a Category 1 delivery took longer than 30 minutes. The case has been reviewed and an issue with the catheter being blocked was the main contributory factor. The case was called as a Category 1 delivery, to allow a trial of instrumental in theatre before reverting to Caesarean Section if required. The lady had a successful forceps delivery with a time of decision to delivery being 43mins. Baby apgar and cord gases were normal.

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	0	N/A	
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%	There was one case of a PPH 2.9L, Consultant notified at 1.8L and moving to theatre but no evidence Consultant attended. Passed to Obstetric CL to discuss case with 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, and is restricted to the 'private' section of Board.

3.1.2 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
May	3	0	0	0	0	0	0

3.1.3 **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 potentially patient identifiable and is therefore restricted to the minimum data set, allowing us to summarise the numbers of concerns and complaints in this section.

	Concerns	Complaints
May	1	0

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 June, and a follow up meeting with the family.

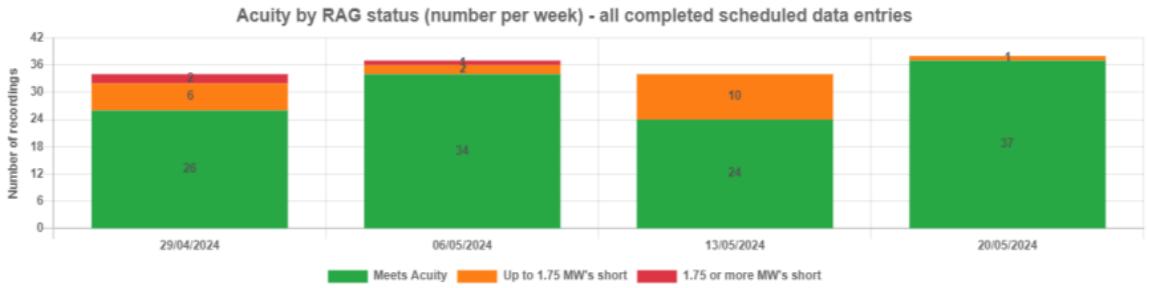
4. WORKFORCE

4.1 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

4.1.1 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 85% of the time. For 13% of the time the service has been short by up to 1.75 midwives and for 2% of the time the service has been more than 1.75 midwives short.



4.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 31 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 were 0 occasions where community were redeployed to support Delivery Suite acuity which has been a considerable decrease since 2023. There was 1 occasion where specialist midwives supported clinical acuity and this is a positive practice, they all participate in a standby rota which supports them to retain clinical skill whilst meeting the needs of the service. There were 7 occasions where acuity was escalated to the manager on call for support.

4.1.3 There were 0 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 0 staffing red flags reported in birth rate for the period.

4.1.4 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	75.29%	0%	0%	75%	11.9%	4.76%
Community	81.61%	3.83%	0%	94.03%	2.99%	0%
Delivery Suite	95.08%	3.63%	2.07%	91.94%	0%	1.61%
Maternity Ward	98.79%	0%	0%	87.90%	1.61%	7.26%
Triage	98.39%	2.02%	2.02%	56.45%	3.23%	33.87%
DS Co-ordinators	100%	0%	0%	N/A	N/A	N/A

4.2 Obstetric workforce

The obstetric rotas have been covered throughout May as outlined below.

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	170/210hrs	80.95%	0hrs	0%	40/210hrs	19.04%
Consultant: on call	432/537hrs	80.45%	60/537hrs	11.17%	45/537hrs	8.38%
Consultant: cold week	120/150hrs	80.00%	20/150hrs	13.33%	10/150hrs	6.67%
Consultant: antenatal clinic	38/64	59.38%	0hrs	0%	24/64hrs	37.50%
Middle Grade: delivery suite	189/189hrs	100%	0hrs	0%	0hrs	0%
Middle Grade: antenatal clinic	128/160hrs	80.00%	32/160hrs	20.00%	0hrs	0%

4.3 **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	27	87%	31	100%
Anaesthetist extra hours	4	13%	0	0%

4.4 **MDT ward rounds**

	08:30	20:30
Anaesthetist	96%	93%
Obstetric Consultant	96%	87%
Ward round completed	100%	100%

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.

The findings of the audit have been shared with the Obstetric team to facilitate action for improvement.

4.5 **Neonatal Nursing**

The Neonatal Nursing workforce is outlined as:

Nursing position	Budgeted WTE	Contracted WTE	Maternity leave	Long term sickness
Band 7 WM	1	1	0	0
Band 7 Practice Education Lead	1	0	0	0
Band 6	5.16	5.5	0	0
Outreach	1.26	1.26	0	0
Band 5	10.5	9.75	0.92	1.22

During April/May the Practice Education Lead was working as B6 waiting Job Matching for B7 JD. Now complete and interview completed. Post filled at B7 from 01.07.24.

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. 1 x awaiting transfer to School Nursing Team – waiting for pre-employment checks to be approved.

Date	Qualified in Specialty workforce (expected standard 70%)	Qualified in Specialty on shift
May 2024	**49%**	**49% (100%)**

Staff were available for QIS for 49% of shifts which is the data reported to the Network. The service uses other staff members to support the QIS shifts meaning that 100% of shifts are filled. Mitigation to reduce the issues with QIS – 3 staff to commence QIS course from September 2024.There were no unit closures during May 2024 and capacity was low.

5. COMPLIANCE

5.1 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.

Improvement	**Progress in achievement of CNST /10**	
	Training compliance in PROMPT: Midwives	**96%**
	Training compliance in PROMPT: Obstetric Consultants	**100%**
	Training compliance in PROMPT: Obstetric Middle Grades	**93%**
	Training compliance in PROMPT: Anaesthetic Consultants	**100%**
	Training compliance in PROMPT: Anaesthetic Middle Grades	**100%**
	Training compliance PROMPT: Maternity Support Workers	**67%**
	Annual NLS update compliance: Paediatric Consultants	**100%**
	Annual NLS update compliance: Paediatric Middle Grades	**100%**
	Annual NLS update compliance: Paediatric Juniors	**91%**
	Annual NLS update compliance: Midwives	**96%**
	Annual NLS update compliance: Neonatal Nurses	**94%**
	Fetal Wellbeing update day: Obstetrics	**100%**
	Fetal Wellbeing update day: Midwives	**98%**
	Midwifery update day (Core Competency): Midwives	**97%**
	Midwifery update day (Core Competency): Support Staff	**88%**

5.2 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	70%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	81%	Partially implemented	81%	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.

5.3 **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.

5.4 **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 7th May, four Safety Champions were present including both the Executive and Non-Executive Directors. Areas that were visited included Maternity Triage, Maternity Ward, Delivery Suite, SCBU and Antenatal Clinic. All areas visited were clean, tidy and it was noted that all patient notes were away as had previously been an issue; no safety concerns were identified. A small number of estates jobs were logged, but none affecting Infection Prevention standards.

During the walk round the Safety Champions had discussions with staff about the oxygen masks and tubing on the Resuscitaires. NHSE IPC Team had previously queried the kit being set up with tubing attached. An MDT meeting identified that for the safety of babies these do need to be connected, however a Risk Assessment is required to support the decision making process. The lead for Neonatal Resuscitation has been tasked with this.

The Safety Champion's Board is now out of date given some changes of personnel in the team and therefore this requires updating. Some changes were made to the privacy screen in the Women's Health Outpatient area and these have been well received by staff.

During the visit to SCBU, it was confirmed that some charitable funds had been raised for artwork in the patient bays, similar to that in children's ward. Some queries were raised about the overtime payments and enhanced specialist rates which were answered by the Chief Nursing Officer.

5.5 NEONATAL SERVICE

5.1 **Avoiding Term Admissions into Neonatal unit (ATAIN) – Quarterly Report**

Wye Valley NHS Trust ATAIN Quarter 4 2023/2024 review

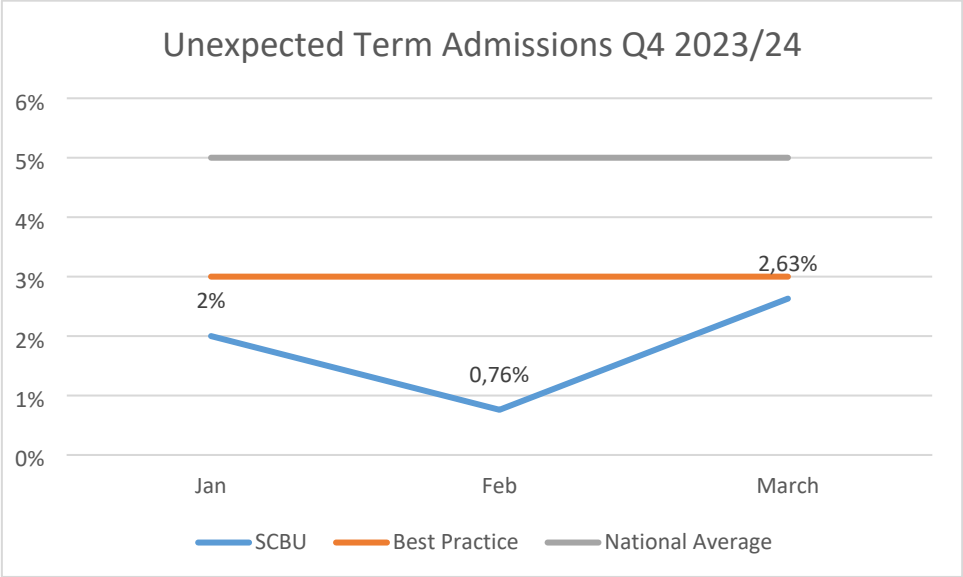
NHS Improvement Reducing harm leading to avoidable admission of full-term babies into neonatal units, Target Rates: National Average = 5%, Best Practice=3%

Quarter 4 – January 2024 – March 2024

Term Admission Data Review:

Month	Unexpected term admission to SCBU	Total Live Births	Included in ATAIN data	Unexpected term admissions to SCBU as % of all total live births.
January 24	5	143	3	2%
February 24	4	131	1	0.76%
March 24	6	152	3	2.63%

(Table 1)



Graph 1

Reasons for Admissions in Q4

Reason 1	Reason 2	Reason 3	Reason 4	Reason 5
Respiratory Support x 5	Observations following resuscitation x 1	IVAB and feeding support x 1		

(Table 2)

Mode of Delivery – Q4

Normal Vaginal Delivery	Cat 1 C-Section	Cat 2 C-Section	Elective C-Section	Instrumental delivery
3	1	2	0	1

(Table 3)

Reasons for C-Sections

Emergency C-Section:

- Decelerations on CTG

Category 2 C Section:

- CTG Concerns and Meconium stained liquor
- Failure to progress

Summary of Quarter 4 Reviews:

There was a total of 6 unexpected term admissions to SCBU during Quarter 4 (2023/2024) with a total of 426 live births which was a slight increase from Quarter 3 when the total of live births was 416.

In Quarter 4 the % of unexpected term admissions to SCBU were below both the national average (5%) and the expected best practice target of 3%, which is consistent to the % in Quarter 1 and 2 in 2023/2024. In Quarter 3 we did not achieve the expected best practice target of 3% for any of the months reviewed.

The primary reason for admission of these babies to SCBU during Quarter 4 was for respiratory support, a pattern which has been consistent throughout 2023/2024 financial year.

One baby was admitted to SCBU for observation following resuscitation but did not require any additional respiratory support.

Ventilation	CPAP	Nasal High Flow 02	NP Low Flow O2
0	0	1	4

(Table 4)

There was one baby admitted for feeding support which and antibiotics and required assistance to feed via a nasogastric tube feed. The baby also had raised infection markers and required a 5 day course of antibiotics.

January 24 Review Summary

There were 5 unexpected term admissions to SCBU during January 24 with 2 excluded from the review process as they did not meet the ATAIN review criteria. The review panel concluded that from the 3 remaining unexpected term admissions, all were unavoidable, with two requiring a short period of low flow oxygen therapy, and the third baby required IV fluids before feeding was established.

Reasons for Exclusion

There were two babies excluded from the review process, one was an admission on Day 6 and was transferred with mum for feeding support into one of the TC beds on SCBU and the second one was transferred to the TC Beds on SCBU because of capacity pressures on postnatal ward.

February 24 Review Summary

There were 4 unexpected term admissions to SCBU during February 24, with 3 excluded from the review process as they did not meet the ATAIN review criteria. The review panel concluded that the one admission was unavoidable, as there was differential in pre and post ductal oxygen saturations at 6 hours of age and the baby required NP02 for 24hrs.

Reason for Exclusion

Of the three babies excluded from the review process two were readmissions from home, one for feeding support and one for parental support due to parental anxiety. The third baby was admitted from the review process as they were admitted to the TC beds with mum for continued feeding support and because of capacity on PNW.

March 24 Review Summary

There were 6 unexpected term admissions to SCBU during March 24 with two being excluded as they did not meet the criteria for ATAIN review.

Following the review of the 4 unexpected term admissions, it was concluded that all 4 admissions were unavoidable. Two babies needed additional respiratory support via High Flow or Low Flow Oxygen, one required IV fluids and one was being observed on SCBU following resuscitation at delivery.

Reason for Exclusion

Both of the babies that were excluded from the review were admitted because of capacity issues on PNW and both mother and baby were admitted to TC cots on SCBU.

Good Practice identified from Quarter 4 reviews:

- Minimising separation of mother and babies wherever possible.
- Prompt escalation of concerns by Midwifery team

New Action from Quarter 4

- Audit the use of the Coloured cot cards on Maternity ward which are used to identify babies at risk of hypothermia, hypoglycaemia etc.

CONCLUSION

In conclusion all of the unexpected term admissions throughout Quarter 4 were considered as unavoidable.

The learning will be shared across various forums including Friday Feedback, staff notice boards, circulation of ATAIN reports and team meetings.

The ATAIN action plan has been updated as at the end of March 2024 and the detail provide to Quality Committee.

APPENDIX 1 – PQSM Dashboard

	Area	Dashboard	Framework	Indicator Description	May
Antenatal	Booking	LMNS	LMS	Total bookings	132
		LMNS	LMS	Women who were booked before 12 + 6 weeks	124
		LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	93.9%
		LMNS	LMS	Women who were booked after 12 + 6 weeks	8
		LMNS	LMS	% Women who were booked after 12 + 6 weeks	6.1%
		LMNS	LMS	Midwife led care at booking	19
		LMNS	LMS	% Midwife led care at booking	14.4%
	Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	41
		LMNS	LMS	% Women with BMI of 30 and over at booking	31.1%
		LMNS	Better Births	% Antenatal Personalised Care Plan completed	97.6%
		LMNS	Better Births	% Intrapartum Personalised Care Plan completed	63.2%
		WVT		% Portal Access Consent	99.2%
		LMNS	LMS	% Portal Access - Women who registered and logged in	88.5%
		LMNS	Ockenden	% Contacts were place of birth suitability was recorded	13.7%
		LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	50.7%
		LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	79.7%
		LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	30.7%
		LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	92.9%
	Smoking	WVT		Recorded Smoking Status at Booking - Yes	7
		WVT		Recorded Smoking Status at Booking - No	125
		WVT		Recorded Smoking Status at Booking - Unknown	0
		WVT		% of mothers with a recorded Smoking Status at Booking	100.0%
		LMNS	Saving Babies Lives	Women who were current smokers at booking	7
		LMNS	Saving Babies Lives	% Women who were current smokers at booking	5.3%
		LMNS	Saving Babies Lives	Smokers who were referred to smoking cessation services	7
		LMNS	Saving Babies Lives	% Smokers who were referred to smoking cessation services	100.0%
		LMNS	Saving Babies Lives	Smokers who accepted CO screening at booking	7
		LMNS	Saving Babies Lives	% Smokers who accepted CO screening at booking	100.0%
	Carbon Monoxide	LMNS	Saving Babies Lives	Women who were screened for CO at booking	126
		LMNS	Saving Babies Lives	% Women who were screened for CO at booking (of total bookings)	95.5%
		LMNS	Saving Babies Lives	Women with CO reading of 4 ppm or more at booking	9
		LMNS	Saving Babies Lives	% Women with CO reading of 4 ppm or more at booking (of total bookings)	6.8%

NHS
Wye Valley
NHS Trust

	Area	Dashboard	Framework	Indicator Description	May
Intrapartum	Deliveries	LMNS/PQSM	Contractual	Total births (deliveries)	135
	Delivery Method	WVT		Home Births	2
		WVT		BBA's	0
		LMNS	Contractual	Vaginal births (deliveries)	62
		LMNS/PQSM	LMS	%Vaginal births (deliveries)	45.9%
		LMNS	LMS	Ventouse & forceps births (deliveries)	22
		LMNS/PQSM	Contractual	%Ventouse & forceps births (deliveries)	16.3%
	C-Section Deliveries	LMNS/PQSM	LMS	RG*1 having a caesarean section with no previous births	3
		LMNS/PQSM	LMS	RG*1 Deliveries	26
		LMNS/PQSM	LMS	RG*1 %C-section deliveries	11.5%
		LMNS/PQSM	LMS	RG*2 having a caesarean section with no previous births	15
		LMNS/PQSM	LMS	RG*2 Deliveries	36
		LMNS/PQSM	LMS	RG*2 %C-section deliveries	41.7%
		LMNS/PQSM	LMS	RG*5 having a caesarean section with at least one previous birth	19
		LMNS/PQSM	LMS	RG*5 Deliveries	20
		LMNS/PQSM	LMS	RG*5 %C-section deliveries	95.0%
		WVT		Total Elective C-Sections	23
		WVT		Total Emergency C-Sections	28
		LMNS	LMS	Total Caesarean births (deliveries)	51
		LMNS	LMS	%Total Caesarean births (deliveries)	37.8%
		LMNS	LMS	%Grade 1 C-Sections within 30 minutes	71.4%
		LMNS	LMS	%Grade 2 C-Sections within 75 minutes	80.9%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	33
		LMNS	LMS	%Midwife led (low risk care) births	24.4%
		LMNS	LMS	Home births (deliveries) - midwife led only	0
		LMNS	LMS	%Home births (deliveries)	0.0%
	Births	LMNS	Contractual	Total number of babies born	136
		LMNS	Saving Babies Lives	Babies born preterm (singletons born 36+6 or less)	9
		LMNS	Saving Babies Lives	%Babies born preterm (singletons born 36+6 or less)	6.62%
		LMNS	LMS	Singleton babies born 26+6 or less	1
		LMNS	LMS	%Singleton babies born 26+6 or less	1%
		LMNS	LMS	Babies (multiples) born 27+6 or less	0
		LMNS	LMS	%Babies (multiples) born 27+6 or less	0%
		LMNS/PQSM	LMS	Stillbirths	1
		LMNS/PQSM	LMS	%Stillbirths	0.7%
		LMNS	LMS	Stillbirths rate per 1,000	0.136
	Breastfeeding	LMNS	National	Live births where breastfeeding initiated (first feed = breastmilk)	114
		LMNS	National	%Live births where breastfeeding initiated (first feed = breastmilk)	85.7%
	Smoking	WVT		Women who were current smokers at booking (delivered mothers)	9
		WVT		%Women who were current smokers at booking (delivered mothers)	6.7%
		LMNS	Saving Babies Lives	Women who were current smokers at birth (delivery)	7
		LMNS	Saving Babies Lives	%Women who were current smokers at birth (delivery)	5.2%
		LMNS	Saving Babies Lives	%Women with CO measured at 36 weeks	98.4%
		LMNS	Saving Babies Lives	%CO >= 4ppm at booking and below 4 ppm at 36 weeks	7.3%
	Risk Management	LMNS	Saving Babies Lives	Late pregnancy loss (singletons 16+0 - 23+6)	0
		LMNS	Saving Babies Lives	%(as a %of all singleton births)	0.00%
		LMNS	Saving Babies Lives	%Detection rate for FGR (below 3rd centile)	15%
		LMNS	Better Births	Women who had a PPH of 1,500ml or more	11
		LMNS	Better Births	%Women who had a PPH of 1,500ml or more	8.1%
		LMNS	Better Births	Women who sustained a 3rd or 4th degree tear	1
		LMNS	Better Births	%Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.2%
		LMNS	Better Births	%Induction of labour rate (of all births)	34.8%
		WVT		Routine Enquiry Domestic Violence - Asked	87
		WVT		Routine Enquiry Domestic Violence - Unable to ask	45
		WVT		Routine Enquiry Domestic Violence - Unknown	3
		WVT		%routine enquiry domestic violence	97.8%
		WVT		Midwife to birth ratio	1:25
	Red Flags	WVT		Delay in Induction >2hrs	0
		WVT		Delay in Catagory 1 delivery >30mins	1
		WVT		Delay in administering medication	0
		WVT		Delay in starting syntocinon/ARM >30mins	0
		WVT		Delay in Suturing >60mins	0
		WVT/PQSM		Unable to provide 1:1 care in labour	0
		WVT		Delay in Triage >30mins	0
		WVT		Community midwives on call covering maternity unit	0
		WVT		Any movement of midwifery staff from any area to provide midwifery cover	0
		WVT		Delayed recognition of and action on abnormal vital signs	0
		WVT		DSC lost - supernumerary status	0
	Reduced Fetal Movements	WVT		Number of women presenting to service with reduced fetal movements	174
		WVT		Number of women presenting with RFM who are recorded as having a CTG	172
		WVT		%of women presenting with RFM who received CTG	98.9%

NHS
Wye Valley
NHS Trust

	Area	Dashboard	Type	Indicator Description	May
Neonatal	Admissions	LMNS	Integer	Total admissions to neonatal care	5
		LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	1
		LMNS	%	% Unexpected admissions of full-term babies to neonatal care	20.0%
	SCBU admission temps	WVT	Born <34wks gest	Eligible Babies	2
		WVT		% taken within hour	50.0%
		WVT		Adm temp <36.5 degrees	0
		WVT	All babies admitted to SCBU	Eligible Babies	9
		WVT		% taken within hour	89.0%
		WVT		Adm temp <36.5 degrees	0
	Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	3
		LMNS/PQSM	Integer	Neonatal deaths	0
		LMNS/PQSM	%	% Neonatal deaths	n/a
		LMNS	Integer	Neonatal mortality per 1,000 births	0
		LMNS	Integer	Neonatal transfers for therapeutic hypothermia	0
		LMNS	%	% Neonatal transfers for therapeutic hypothermia	n/a
		LMNS/PQSM	Integer	Neonatal brain injuries	0
		LMNS/PQSM	%	% Neonatal brain injuries	n/a
		LMNS	Integer	Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	2
		LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	3
		LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	66.7%
		LMNS	Integer	Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0
		LMNS	Integer	Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0
		LMNS	%	% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a

	Area	Dashboard	Framework	Indicator Description	May
Postnatal	Risk Management	LMNS	Local	Obstetrics admissions to ITU	0
		LMNS/PQSM	LMS	Maternal deaths	0
		LMNS	Better Births	% Postnatal Personalised Care Plan completed	97.0%
		LMNS	LMS	Postnatal readmissions within 28 days (mothers)	16
		LMNS	LMS	Postnatal readmissions within 28 days (babies)	6
	Suspended Access to Service	WVT		Number of times Maternity Services Suspended per month	0
		WVT		Number of hrs Maternity Services suspended	0
		WVT		Number of times Home Birth services suspended per month	0
		WVT		Number of hrs Home Birth services suspended	0
		WVT		Number of times SCBU suspended per month	0
		WVT		Number of hrs SCBU suspended per month	0
	Insight	PQSM	Integer	Number of inphase incidents graded as moderate or above/PSII reported (total)	
		PQSM	Integer	New HSIB SI referrals accepted	0
		PQSM	Integer	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0
		PQSM	Integer	Coroner Reg 28 made directly to Trust	0
	Workforce	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	160
		PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	150
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	4
		PQSM		Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	0
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	
		PQSM		Datix related to workforce (service provision/staffing)	0
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%
	Involvement	PQSM		Service User feedback: Number of Compliments (formal)	*
		PQSM		Service User feedback: Number of Complaints (formal)	0
		PQSM		Staff feedback from frontline champions and walk-abouts (number of themes)	2
	Improvement	PQSM		Progress in achievement of CNST /10	
		PQSM	%	Training compliance in PROMPT: Midwives	96%
		PQSM	%	Training compliance in PROMPT: Obstetric Consultants	100%
		PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	93%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	100%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	100%
		PQSM	%	Training compliance PROMPT: Maternity Support Workers	67%
		PQSM	%	Annual NLS update compliance: Paediatric Consultants	100%
		PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	100%
		PQSM	%	Annual NLS update compliance: Paediatric Juniors	91%
		PQSM	%	Annual NLS update compliance: Midwives	96%
		PQSM	%	Annual NLS update compliance: Neonatal Nurses	94%
		PQSM	%	Fetal Wellbeing update day: Obstetrics	100%
		PQSM	%	Fetal Wellbeing update day: Midwives	98%
		PQSM	%	Midwifery update day (Core Competency): Midwives	97%
		PQSM	%	Midwifery update day (Core Competency): Support Staff	88%

Guardian of Safe Working (GOSW) Update :

Executive Narrative

Dr Chizo Agwu Chief Medical officer

New GOSW (Dr Akshay Lekhi) appointed 1st of March 2024 .

Exception Reports (ER) over past quarter	
Total number of exception reports received	14
Number relating to immediate staff wellbeing issues	1
Number relating to hours of working	13
Number relating to pattern of work	0
Number relating to educational opportunities	1
Number relating to service support available to the doctor	1

All the escalations relate to Medicine Division rota . 11 reports resolved and closed . Work ongoing on increasing Medical Es-

Report to:	**Public Board**
Date of Meeting:	**04/07/2024**
Title of Report:	**Freedom To Speak Up (FTSU) Yearly Report**
Status of report:	**☐Approval ☒Position statement ☒Information ☐Discussion**
Report Approval Route:	Chief People Officer
Lead Executive Director:	**Chief People Officer**
Author:	FTSU Guardian – Jo Sandford
Documents covered by this report:	Staff Survey Results National Guardian Report Civility Saves Lives

1. Purpose of the report

a. This report provides broad details of Speaking Up events for the year 2023/2024.
b. It provides an up-date from the Trust's Freedom to Speak Up Guardian (FTSUG) on progress, exceptions, any themes and learning and on-going plans to continue strengthening arrangements for staff to Speak Up and raise their concerns.
c. It also informs the board and public of National FTSU and Local developments that will influence WVT strategy and development and where FTSU objectives contribute to Trust objectives.

2. Recommendation(s)

The Trust has mandated the Speak Up Training. It has recently also very recently mandated Module 2 of the National FTSU eLearning training, Listen Up. This will become a mandatory part of the appraisal process for anyone who line manages a staff member. It will ensure that all line managers know what is expected of them when staff speak up and that staff know they will be listened to.

3. Executive Director Opinion[1]

Effective speaking up arrangements help to improve the experience of NHS workers and by default this will also improve the patient experience.

Having a healthy speaking up culture is also an indicator of a well-led trust.

Speaking up at WVT is taken as a positive and allows us to continually improve our service for patients and the working environment for 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.

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

This paper provides a summary of FTSU activity and themes of concerns raised with the Freedom To Speak Up Guardian (FTSUG) and FTSU Champions at WVT for 2023/24

A summary of FTSUG activity is detailed along with developments and actions that have been taken to further imbed the FTSU role and to encourage a culture of openness. As an example of WVT's commitment to FTSU the number of hours ring fenced for the FTSUG post was increased to 3 full days per week from April 2023. However, with the increased volume of cases and the development of the role, this is being reviewed as we are providing an excellent speak up service at WVT.

The role of the FTSUG touches many areas of the CQC Well-Led Framework. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question.

2. Summary of Speaking Up in 2023/24

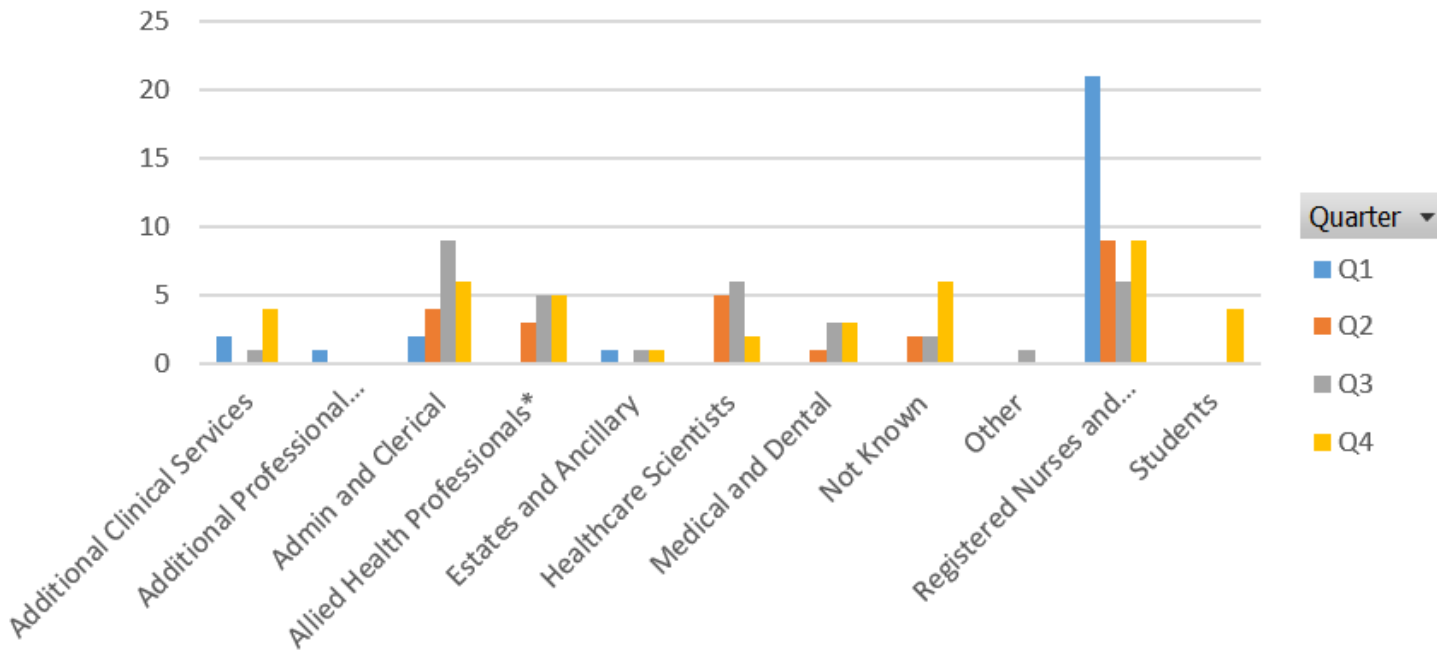
Speaking up has had a very successful year. The extra time given to the Guardian role has allowed significant amounts of promotional work resulting in not only a vast increase of cases but also a significant rise in the amount of Champions around the Trust. Cases are dealt with promptly and closed much quicker. Resulting in less stress and worry for those speaking up and an all-round positive experience that is giving FTSU an excellent reputation around the Trust.

2.1. Speaking up data in 2023/24

A total of 125 cases have been recorded in 2023/24. In the past 4 years cases have averaged 72. This year there has been an increase of 74%.

Financial Year	Number of Cases
2018/19	24
2019/20	73
2020/21	70
2021/22	74
2022/23	72
2023/24	125

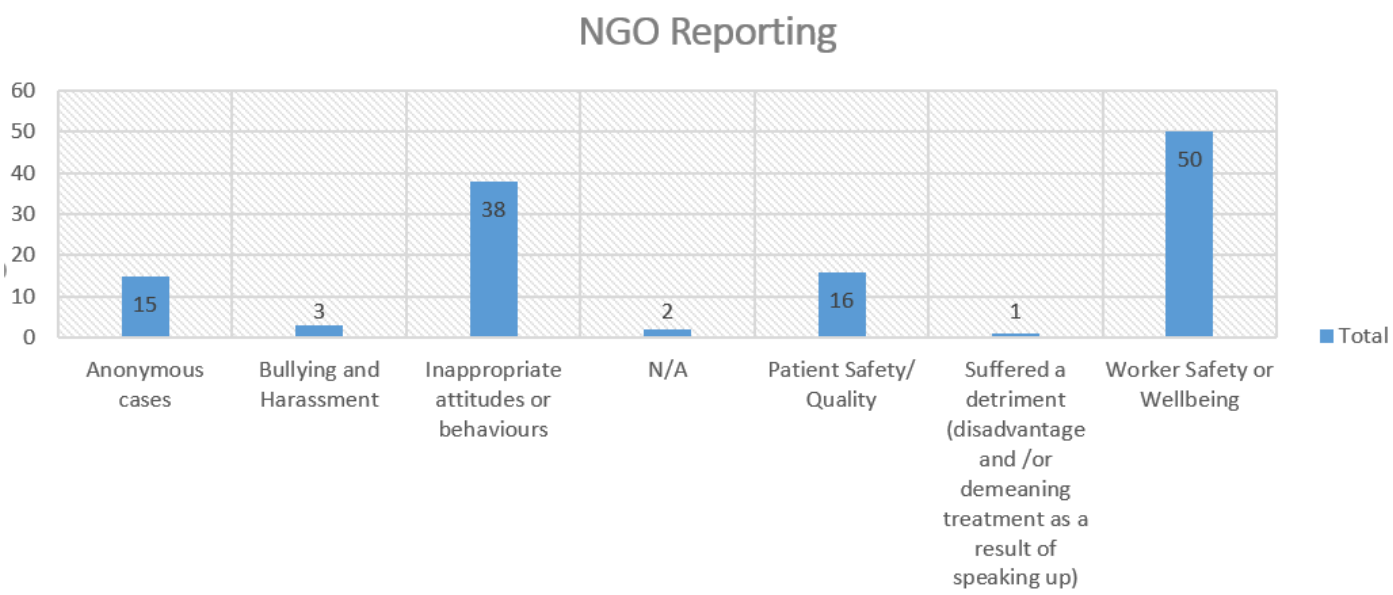
2.2 Speaking up Identified by Staff Group.



Administration and Clerical staff and registered Nurses and Midwives were the main groups of staff speaking up over the year. This is reflective of previous years. There has been a significant decrease in cases recorded as anonymous compared to previous years. These staff did not give their name when they approached the Guardian or they were comments/questions posed on the Trust's Rumour Mill anonymously that required a response from the FTSU Guardian or they were known to a FTSU Champion who acted as an intermediary. The decrease is hopefully a result of promotional work and communications demonstrating that concerns are acted upon and at WVT it is safe to speak up.

2.3 Data returns to National Guardian Office (NGO)

The six categories that are required within the NGO quarterly report are shown in the graph below.



Speaking up events are categorised from the perspective of the individual speaking up or subjectively by the Guardian from the information received and must be reported to the NGO quarterly. The categories are at times vague and if something relating to staff doesn't fall into any of the other categories it has to be recorded as worker safety/wellbeing. There have been numerous requests from Guardian Networks for the NGO to expand the number of categories to include things like trust policy and procedures not being adhered to.

Behavioural concerns from the three related categories (Detriment/ Bullying & Harassment / Inappropriate behaviours) shown in the chart above make staff relationships and interactions the subject of greatest concern (33.6%) Worker Safety or Wellbeing also adds to this where staff are suffering from stress or anxiety from incidents in the workplace. WVT is not an outlier in this. The NGO FTSU Annual report 2022/23 states, *"Poor behaviour remains a cause for concern, with the highest proportion of cases – a third **(32.3%)** – including an element of behaviours, such as **bullying/harassment.** This is a rise from 30.1% last year."* The 2023/24 report is due July 2024 but discussions within the Midlands FTSU Network reflect that the situation is likely to be similar.

"A recent study of people who experienced bullying in the workplace found that 75% reported a loss of concentration, memory and overwhelming anxiety, and over 80% felt the 'anticipation of the next negative event' – the feeling of constantly walking on eggshells" Tim Keogh – A Kind Life

While our clinical services are the key to WVT success, we can only maintain high standards of patient care if the welfare of all staff is made a priority. When concerns are raised we need to demonstrably show we are acting on them. Sometimes getting a timely response to action is difficult in the current climate. This then impacts on the staff speaking up and their mental health. To ensure an excellent FTSU service is maintained with a reputation that shows that WVT does listen and will act upon concerns raised, response times need to improve. Feedback to staff who speak up is always timely and comprehensive. The FTSUG works also side the HR team with their staff wellbeing agenda and promotions across the Trust.

2.4 Civility Saves Lives

In the past 12 months we have been able to deliver Civility Saves Lives (CSL) to 350 WVT staff. We offer a monthly team's session via the EDC and face to face sessions for individual teams that request it. Also we do sessions for the preceptorship programme, junior doctors and student nurses.

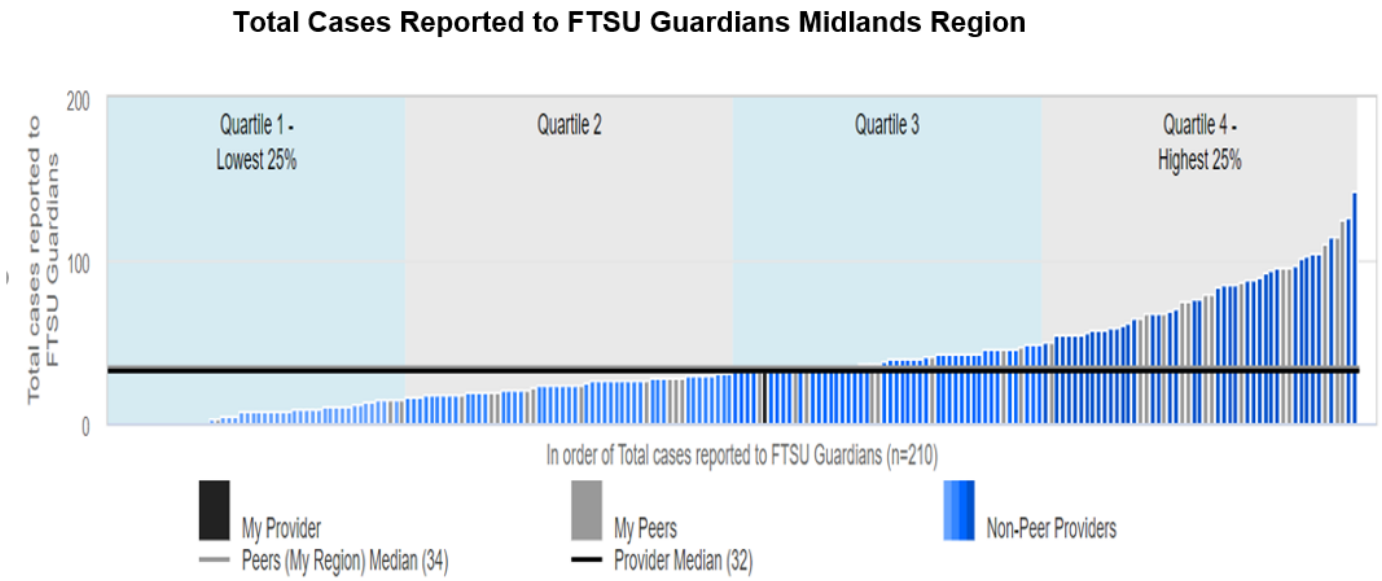
What is Civility Saves Lives?

- It's about developing and sustaining an open and positive culture, creating a place of physiological safety for staff to feel confident to Speak Up.
- It's about Civility in the workplace. As Chris Turner from the CSL campaign shouts from the roof tops is critical for patient safety. It also encompasses staff safety and wellbeing, removing poor behaviours, bullying and harassment and micro aggression that communicate some sort of bias.
- It's about throwing defensiveness out of the window and being curious to concerns and challenges when things are not right or could be better when someone speaks up to you.
- It is simply being kind and respectful to our colleagues to improve team work and patient outcome.

"We are a collective voice for the importance of respect, professional courtesy and valuing each other. We aim to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can understand the impact of our behaviours" Dr Chris Turner, Consultant in Emergency Medicine

2.5 National Comparisons

Model Hospital is always a quarter behind with reporting so the graph below is for Quarter 3 23/24 showing WVT into quartile 3 with 40 cases. Although there are many of our peer hospitals high into the fourth quartile it is not an accurate representation as some of those hospitals have 10,000 employees.



2.6 NHS National Staff Survey 2023

The questions that make up the People Promise section, we all have a voice that counts, raising concerns, is reviewed every year locally, regionally and nationally by all FTSU Guardians. This compares the Trust's performance nationally and is an indicator how safe staff feel to Speak Up and how confident they are the Trust will act. The 2023 Staff Survey published in March 2024 shows WVT score to be 6.3 in this section. This score is out of 10.

Foundation/ICS	2021	2022	2023
WVT	6.7	6.5	6.3
SWFT	6.9	6.9	6.9
George Elliot	6.4	6.2	6.2
Worcester Acute	6.4	6.4	6.4

Although there has been a very slight decrease in the results for Wye Valley, I am very confident that all of the time and promotion invested into FTSU will be reflected within the Staff Survey results in 2024.

2.7 Lessons Learnt

1. **The use of English Language within the workplace**

   There have been a number of cases throughout the year in relation to the use of the English language in the workplace. This has been addressed as the subject of a presentation to Medical Matrons and Sisters and within Theatres and the surgical directorate. The presentation is to be made available for managers to use when this issue arises with an aim to get staff on board and to be aware of the Trust Statement that covers three distinct areas of the work place. The aim is to assist staff to be aware of the many challenges to this subject and help them be compassionate and inclusive whatever their position is by putting themselves in everyone's position. Clinical areas is where English must be used so that everyone including patients are involved in communication. In staff communal areas a 'Read the Room' approach is suggested so that everyone feels included. There has been success from this approach with staff in Theatres who initially spoke up as they were told it was forbidden to speak their own language anywhere within the department.

2. **Responding to Speak up Barriers**

   The two themes that I hear as Guardian are that staff felt that their manager and the executives won't listen and even if they do they will not act upon the concerns raised. To try and combat these I firstly recommended to The Board that "Listen Up" training is mandated for any staff member who manages another. To give them awareness of how important speaking up is. This was agreed.
   Secondly we have produced a local film which highlights to staff that Executives do listen and are fully invested in the speak up service and that speaking up at WVT is actively encouraged. The film has had excellent feedback.

3. **Feedback to Staff**

The importance of keeping staff updated is vital to providing an exemplary speak up service. It is important that staff responsible for investigating a concern answer emails in a timely fashion. The person who has spoken up is very often very stressed and anxious. Speaking up can be a big part of a staff member going off sick which costs the trust money. The fast closure of cases this year has significantly reduced the sickness episodes of those speaking up.

4. Support and Development for Leaders

A common theme this year has been line managers not treating staff fairly or following the correct policy or procedure. The Guardian researched if there was a cause for this trend. Evidence suggests that new staff, especially those in an admin and clerical role are being promoted quite quickly within the trust and have no leadership or management experience. Although the trust offers a wide range of training courses and specifically a three day Leadership and management course, staff were not being sent on these courses to help them to develop within the role. The Guardian suggested to TMB in her last quarterly report that some kind of preceptorship programme is developed to help support new leaders which will then have a positive impact on their staff.

These are just a few of many learning outcomes as a result of staff speaking up and the Guardian continues to review themes and make suggestions for improvement within the trust.

3.1 Exception Reports

For the year 2023/24 there were no cases open for more than 3 months. All cases were closed by the end of April 2024 and a resolution achieved.

3.2 Mandatory Training for FTSU

Division	Directorate	Service	Assignment Count	Required	Achieved	Compliance %
⊞Clinical Support Services Division			595	595	556	93.45%
⊞Corporate Division			481	481	437	90.85%
⊞Integrated Care Division			658	658	604	91.79%
⊞Medical Division			928	928	830	89.44%
⊞Surgical Division			1,237	1,237	1,145	92.56%
Total			3,899	3,899	3,572	91.61%
			3,899	3,899	3,572	91.61%

WVT was one of the first Trusts in the Midlands to mandate module one, Speak Up via eLearning. It still remains one of the few trusts within the region that has made the training mandatory. The aim for all mandatory training is for the percentage is 85% or higher to be compliant. At the end of March 2023 FTSU was 91.61%. All divisions are currently achieving the recommended 85%.
The National Guardian Office is calling for all three modules of FTSU eLearning to be mandated following on from the results of the 2022 Annual Staff Survey.

"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters" Jayne Chidgey-Clark National Guardian

The Guardian has reported to TMB that staff feel that managers will not listen or act upon their concerns. It has been agreed to mandate module two, Listen Up training for anyone who line manages another staff member.

4. The WVT FTSU Team

The Guardian is contracted for 22.5 hours but due to the sheer volume of work is currently working 37.5 hours. At the beginning of 2023/24 there were only 22 champions trust wide. This was not enough to be representative of the current workforce and so on the FTSU Five Year Plan a target of 100 was set. This has been achieved by May 2024 and there are currently 105 Champions who have all received training. The aim is now to get one in every department across the trust. Work is ongoing to improve the visibility of Champions. This has included Lanyards, badges, a list available on the intranet and posters around the trust saying who the champion for that area is.

5. Breaking down Barriers

As part of the promotional work for this year I have tried to target minority groups who are reluctant to speak up. The BAME community is one of these groups and yet they make up more than a quarter of our workforce. I have recruited a lot of Champions and joined in with the monthly BAME meetings. The Chief People Officer and I have also been part of a video that went out to all of the Indian staff members on their What's App Group. We are hoping to widen this in the coming year to other nationalities that have formed communities because of their shared heritage.

I am also an ally of the LGBQT+ community and the disability awareness group in the trust. It is important that every staff member in the trust feels able to speak up and in a safe environment. There is an ongoing issue that there is no office for the FTSU team. Due to the sensitive nature and for confidentiality purposes it is vital that a private space is available for those speaking up. I am hoping this is rectified this year.

6. The Future of FTSU within WVT

The case load rose by 74% last financial and I was expecting that to plateau this year. However, already for Quarter 1 of 2024/25 we have 52 cases which is an increase of 30%. To maintain the successful Speak up Service that has been developed over the last 12 months consideration to making the role full time needs to be addressed. A question that I had last month from the audit committee asked what plans I had should the cases continue to increase to maintain the high level of service within the trust. My vision is for my admin assistant who I currently have for 6 hours per week to increase to 22.5 hours a week. She currently delivers training for CSL and this has allowed me more time for speaking up cases. This could be expanded and could also include promotional work and taking on the training for Sexual Safety in the Workplace and introducing a Second Messenger approach within the Trust.

I am looking forward to continually reviewing, improving and developing the FTSU Service within Wye Valley Trust over the next financial year.

Jo Sandford

Freedom to Speak Up Guardian

Wye Valley Trust

End of report

Version 1 22020304

Report to:	**Public Board**
Date of Meeting:	**04/07/2024**
Title of Report:	Audit Committee Summary Report 23 April 2024
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	Select Director
Author:	Nicola Twigg, Chair of Audit Committee/NED
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To brief the Board on the main issues arising from the Audit Committee held on 23 April 2024.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2022/23 Objectives the report relates to:

Quality Improvement

☐ Improve the experience of patients receiving care by improving our clinical communication

☐ Improve patient safety through implementing change as we learn from incidents and complaints across our system

☐ Reduce waiting times for diagnostics, elective and cancer care

☐ Develop a new integrated model for urgent care in Herefordshire improving access times and reducing demand for hospital care

Integration

☐ Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meets demand on the day

☐ Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level

☐ Improve quality and value for money of services by making a step change increase in the range of contracts that are devolved to the One Herefordshire Partnership

☐ Join up care for our population through shared electronic records and develop a patient portal to transform patient experience

Sustainability

☐ Create sufficient Covid-safe operating capacity by delivering plans for an ambulatory elective surgical hub

☐ Stop adding paper to medical records in all care settings

☐ Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain

☐ Increase elective productivity by making every referral count, empowering patients and reducing waste

Workforce and Leadership

☐ Improve recruitment, retention and employment opportunities by taking an integrated approach to support worker development across health and care

☐ Develop our managers' skills and system leadership capability

☐ Continue to improve our support for staff health and wellbeing and respond to the staff survey

☐ Further develop place based leadership and governance through the one Herefordshire Partnership and Integrated Care Executive

[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
Trust Board Meeting – 4 July 2024
Summary of Audit Committee (AC) meeting held on 23 April 2024

MATTERS FOR PARTICULAR ATTENTION

Internal Audit –
RSM, UK Internal Auditors (IA) presented 2 reports for approval Key Financial Controls, and the Board Assurance Framework. The Board Assurance Framework Audit received a year on year improved grading of Reasonable Assurance which reflected the hard work and actions taken in the previous 12 month by the Associate Director of Corporate Governance placing the Trust in a strong position to build on this further in future. Key Financial Controls were also graded as Reasonable Assurance. This was particularly pleasing as the General Office had not been reviewed for some time and secondly the Trust is now working with Financial Shared Services across the Foundation Group and this was an opportunity to test robustness of the processes.

Following the previous Sickness and Absence reporting graded as Partial Assurance a further update was provided by the Chief People Officer which fully address the previously raised concerns.

The IA Tracker showed signs that catch up is being made on actions following the acknowledged slow-down in the previous quarter and the IA reported that the Trust is meeting all of the Key Performance Indicators (KPI's) in terms of draft reports.

The draft Head of Internal Audit opinion is a positive above the line opinion confirming that the organisation has an adequate and effective framework for risk management, governance and internal control however the work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective which reflects our desire to ensure continual improvement in how we manage risk within the Trust.

The IA presented the Internal Audit Plan 2024/25 which were fully approved by the Committee.

Financial Update
No reports were presented at Audit Committee by the External Auditors at this meeting however The Associate Chief Finance Officer (ACFO) presented a turn page review of the Wye Valley Trust draft Accounts 2023/24 with contents scrutinised and recommendations made for further amendments prior to final delivery.

OTHER MATTERS

Report	Discussion / Recommendation
Internal Audit	A start date has now been agreed for the Medical and Surgical Junior Doctor's Rota Management with the Chief Medical Officer with an update due at the next Audit Committee meeting in June.
Financial Update	The risk assessment for 'not paying' PFI related invoices was discussed fully and associated actions noted.
Standing Orders	Were formally approved with an action to include both Standing Orders and PFI's in the Non-Executive Director Induction Programme

Prepared by:-
Nicola Twigg, Chair of Audit Committee

Report to:	**Public Board**
Date of Meeting:	**04/07/2023**
Title of Report:	Quality Committee 25 April 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 April 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. **Safeguarding Quarterly Reports** – Committee received the Q4 Safeguarding Reports and noted in particular the continued challenges for children's safeguarding due to changing leadership in the Council; also a reduction in children subject to child protection plans – which is welcome, but a reduction too in the number of early help plans which could be a concern. For Looked-After Children the key concern was availability of dental services and Committee asked the ICB representative to pick this up as an escalation.

2. **Audiology Review and Action Plan -** Committee received a report on a recent site visit by NHSE to our paediatric audiology services. This is part of a national programme following issues identified by an independent review of services in Scotland. Committee noted that while issues were identified, particularly around equipment and estate, the visit found that overall the Trust has a safe service. Committee agreed to continue scrutinising the action plan as part of the Clinical Support Division quarterly report.

3. **PQSM Maternity** – Committee questioned the number of women have an induced labour and whether Trust figures are benchmarked. Committee was advised that reporting is in the process of being standardised across the Foundation Group. Committee noted the positive feedback from the "15 Steps Challenge" which assesses a range of perspectives around how it feels to be in the department.

4. **Patient Safety Committee Summary Report –** Committee noted in particular the good uptake and positive feedback from the PSIRF training; also the work to improve visibility of VTE compliance through the Maxims upgrade and the new live dashboards.

5. **Patient Safety Walkabouts** – Committee noted the new process for NED and Executive walkabouts to service areas across the Trust and agreed to provide prompts for these based on Quality Committee reporting to enable focus for discussion and triangulation of any issues and improvement areas.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 25 April 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
Jane Ives	JI	Managing Director – Left during Item 4.1 and returned during Item 12
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Jonathan Boulter	JBo	Associate Chief Operating Officer, Surgical Division – For Item 12
Jo Clutterbuck	JC	Acting Associate Chief Operating Officer – Medical Division – Arrived during Item 4.1
Kirstie Gardner	KG	Named Nurse Children in Care – For Item 4.1
Dan Harding	DH	Associate Director Diagnostic Programmes - Left after Item 13
Helen Harris	HH	Integrated Care Boards Representative
Rebecca Heywood-Tibbetts	RHT	ICB Deputy Named Nurse, Adult Safeguarding – For Item 4.1
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division – Arrived during Item 4.1
Candice Lewis	CL	Perinatal Quality and Safety Matron – For Item 13
Sue Moody	SM	General Manager, Acute and Countrywide Services – Arrived during Item 4
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Caron Shelley	CS	Named Nurse Safeguarding Children – For Item 4.1
Emma Smith	ES	Associate Chief Nursing Officer – Surgery Division
Emma Wales	EW	Associate Chief Medical Officer, Medical Division
Bethan Webb	BW	Quality Matron – Left after Item 9

QC001/04.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Rachael Hebbert, Associate Chief Nursing Officer, Leah Hughes, Advanced Practitioner Radiographer, Kieran Lappin, Associate Non-Executive Director, Tony McConkey, Clinical Director, Pharmacy and Grace Quantock, Non-Executive Director.	
QC002/04.24	**QUORUM**	
	The meeting was quorate.	
QC003/04.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	

QC004/04.24	**MINUTES OF THE MEETING HELD ON 28 MARCH 2024**	
	QC018/03.24 – Divisional Quarterly Report – Clinical Support Division - To change the title of the Chief Operating Officer, Medical Division to the Chief Operating Officer, *Clinical Support Division.*	
	Resolved – that with the one agreed amendment, the minutes of the meeting held on 28 March 2024 be received and approved.	
QC005/04.24	**ACTION LOG**	
	(a) QC005/02.24 – (B) – Quarter 3 2023/24 Safeguarding Reports – The Chief Nursing Officer (CNO), ICB was not able to provide an update when she met with the CNO last week on the proposal around the Level 3 Safeguarding training. Awaiting local version of the Safeguarding Adult Policy. The CNO has asked the Associate Chief Nursing Officer how this is covered off in the local Report. (b) QC018/03.24 – (B) – Divisional Quarterly Report – Clinical Support Division – The Deputy General Manager/Governance Support, Clinical Support Division is working on whether we are able to progress introducing the I-Passport to the wider Trust. It was agreed to close this action.	
	Resolved – that the Action Log be received and noted.	
	BUSINESS SECTION	
QC006/04.24	**SAFEGUARDING QUARTERLY REPORTS**	
	The ICB Deputy Named Nurse, Adult Safeguarding, Named Nurse Safeguarding Children and the Named Nurse Children In Care presented the Safeguarding Quarterly Reports and the following key points were noted: Adults • The Domestic Abuse Lead has been in post for about 6 months. They are delivering a lot of training and upskilling of our workforce around domestic abuse. They are also working with Human Resources with staff who are victims of domestic abuse. • The Adult Safeguarding Practitioner is working with the local Safeguarding Lead to develop a more appropriate process regarding pressure ulcer damage. A lot of referrals are sent to the Local Authority but not all are appropriate. A process has been developed to ensure only appropriate referrals are sent. • The standard of referrals received by the team are still variable, with training around this continuing. Knowledge and understanding of DoLS and the Mental Capacity Act is variable. Teams are visiting wards to raise awareness. • Workforce capacity is still limited due to being a member of staff down.	

	• The Adult Safeguarding Policy is almost completed. • Mr James (Chair of the Quality Committee and NED) understood that the pressure of work makes it difficult to run supervision meetings but it can be counterproductive if these are not able to take place. The ICB Deputy Named Nurse, Adult Safeguarding, agreed that often this is the time that they are most needed. <u>Child Safeguarding</u> • The Emergency Department (ED) alert checks are remaining at above 99%. • NHS App – We are working with the information Governance team around patients being able to access more information. Maxims and EMIS contain a lot of information, some of which is sensitive and we need to ensure appropriate accessibility. • Training – We are above Trust targets for Levels 1, 2 and 3 and ED compliance is above 80% (the highest it has been). We are working on the lowest achieving staff groups. Level 4 and Board Level training are all up to date. • Two training dates for LADO have been arranged for staff. • The Band 7 MASH Practitioner post has been recruited to. We are now recruiting to the Band 6 position as this was an internal promotion. • The concern around the drop in Health Visitor supervision has been raised. There has been a number of changes in the Health Visitor structure regarding roles. The Supervision Policy is due to be updated. • The number of Child Protection Plans are down. If numbers keep reducing, this could be a concern. We need to monitor, there are concerns over the number of times the professional disagreements policy is being utilised and the number of cases being reopened. • Level 3 Training – We would like more face to face training but have an issue finding available rooms. • The current instability within the Local Authority is a challenge. The Lead of the Council has advised that there is an interim arrangement in place to provide more structure. • Mr James (Chair and NED) noted that the reduction in the of Child Protection numbers might be expected if the Early Help activity is increasing but this seems to be reducing too. The Named Nurse Safeguarding Children advised that we are not sure of the cause of this currently.	

	• The Managing Director understood the need to get numbers right, but noted we do have a high number of children on Child Protection Plans compared to other areas, so a reduction may not be a bad thing. Due to work changes, we would expect a reduction. Where are we reviewing this information? The Named Nurse Safeguarding Children advised that this is on the agenda for the Quality and Effectiveness Group along with an improvement plan looking at improving early health. • The Chief Nursing Officer (CNO) agreed with the need to be cautious and consider in the context of Early Help provision. She also confirmed that the data and practice is considered at the Children and Young People Board and Improvement Board. • The CNO advised that the new Director of Children's Services commences in post in July. The interim arrangements are very short term, hence the plan to wait until the permanent person is in post to discuss these issues. The new Director has already indicated that they want to meet to discuss team working and relationships. • Mr James (Chair and NED) queried if there is a concern around raising LADO issues as there are training dates arranged. The Named Nurse Safeguarding Children advised that last year we had a significantly higher number of referrals than previously. This was an action in the Section 11 Audit to provide more training. The training is aimed at Human Resources and Managers around the process and referrals for LADO. • The CNO advised that room availability in the Education and Development Centre is limited but suggested a number of alternatives. <u>Looked After Children</u> • This was a busy quarter – 83 children were seen in the previous quarter, 117 during this quarter. • Positively, 53% of children in care had their Statutory Health Assessment within the timeframe. • The number of Review Health Assessments has increased. The new system is working well and children are finding it a better experience. • The new structure for the Admin Team has been agreed and authorised. This will now go out to advert. • Staff sickness is putting pressure on the team. • There is a challenge around dental care for children in care. In future, we may not be able to provide 6 monthly appointments. There are discussions around how we can support this.	

	• There has been a drop in the number of children in care due to a number of children reaching 18 years of age, including a large group of siblings. We are seeing an overall reduction in the number of children in care. • The team are attending a significant number of Safeguarding Meetings – 44 Strategy Meetings were attended this quarter. • The CNO noted the difficulties around NHS Dentist availability and queried if there is anything we can do to ensure ability to offer appointments to prevent deterioration in dental health. The Named Nurse Children In Care advised there are less dentists available but all new children, and any child in care for over a year will receive a new patient examination to understand any issues a child may have. We will follow the recall advice for children with no dental issues. The KPI states a review every 6 months but we will go by the clinician's view. It was noted that we are struggling to recruit Community Dentists and recruit new Dentists into the service. • The Integrated Care Boards Representative will meet with the Named Nurse Children In Care to discuss escalating dental capacity issues to the ICB. • The Associate Chief Nursing Officer, Surgery Division offered support with the Health Reviews from School Nurses and Health Visitors.	**HH/KG**
	<u>Resolved</u> – that: **(A) The Safeguarding Quarterly Reports be received and noted.** **(B) The Integrated Care Boards Representative will meet with the Named Nurse Children in Care to discuss escalating dental capacity issues to the ICB.**	**HH/KG**
QC007/04.24	**<u>WVT SITE VISIT REPORT/ACTION PLAN AUDIOLOGY</u>**	
	The Associate Director Diagnostic Programmes (ADDP) presented the WVT Site Visit Report/Action Plan Audiology, which was taken as read, and the following key points were noted: • The background to the Site Visit was provided following an independent review of Audiology undertaken in Scotland where a number of issues were found. This caused concern for paediatric audiology services in England. Subsequently NHSE took the approach to manage the assessment of services via a Bronze cell incident process, with regional NHSE, ICB and Trust colleagues. • The ADDP thanked the clinical team for all their hard work and for the support from the CNO and the Chief Medical Officer (CMO). • The Site visit took place in February 2024. The focus is on pathway management and protocols. We are looking to include I-Passport for Audiology.	

	• Issues around equipment, governance and functionality were noted in the Report. We were successful in receiving monies from Capital Planning in relation to the equipment issues. The new equipment will help with capacity, quality and some waiting list times. • Estate – The ADDP identified that the department only has 1 testing room that meets the required 24m2 standard for the under 4 year old patient cohort. This is the longest waiting cohort, limited by physical room capacity, which is identified on the CSD Risk Register. The ADDP is exploring long term options, linking in with recent review paper on Child Development Centre and its current services. • Importantly, the ADDP confirmed that the external NHSE site visit and report thus far notes that paediatric audiology services at the Trust are a safe service. • The ADDP commented that the quality of ABR testing was a key concern within the independent Lothian Review. Retrospective and prospective data review of the Trust's ABR tests is an ongoing part of the Bronze cell incident management process. This will be an ongoing aspect that will come back to Quality Committee and via Divisional updates. • The CNO thanked the team for all their hard work to support the review, visit and ongoing requirements. • The CNO advised that the Care Quality Commission have recently written to all Trusts recommending that Trusts should plan to work towards IQIP accreditation and if not Board need to be sighted on this. She suggested this could be covered off with a Board Report next month with an update regarding the visit, outcome and our position and stance on this. Mr James (Chair and NED) agreed to this suggestion. • The Associate Director of Quality Governance (ADQG) noted that due to completion of the Action Plan to ensure that this is a safe service, there is a named clinician for the Paediatric Audiology Pathways. The ADDP advised that the Action Plan is in progress, and that historically a gold standard service was provided by a Consultant Paediatrician, now not sustainable. A Locum Paediatrician is seeing the patients, meanwhile discussion is underway regarding the named clinician model being an ENT Consultant. Agreement on named clinician model pending. • The Integrated Care Representative agreed that a significant amount of resource is needed regarding IQIPS with a national focus on this. The ADDP advised that IQIPS is not just for Audiology, we need to consider this for other physiological services as well.	

	• Mr James (Chair and NED) queried how oversight of this would be provided in the future. The CNO advised that the visit and subsequent clinical review will come to Quality Committee directly and thereafter updates against the action plan can come quarterly through Clinical Support Divisional Reports to the Quality Committee.	
	Resolved – that the WVT Site Visit Report/Action Plan be received and noted.	
QC008/04.24	**QUALITY COMMITTEE WORKPLAN**	
	The ADQG presented the Quality Committee Workplan and the following comments were noted: • This is largely following on from the plan from last year. Quality Priorities are regularly reported along with prioritising patient safety. The Patient Safety Committee reports on these areas which reports to the Quality Committee. The Board of Directors require oversight of our patient safety priorities. • Oversight and reporting on Childrens Services has been added in which is also a Trustwide Objective. • The Integrated Care Representative queried if reporting on Medicines Management and Medicines Optimisation will come to the Quality Committee rather than through the Patient Safety Committee. Mr James (Chair and NED) agreed that we need enhanced scrutiny through this Committee. The CNO suggested a meeting with herself, the Integrated Care Representative and the ADQG to review this given the existing reporting structures in place. • Mr James (Chair and NED) queried if there were any more suggestions strategic objectives for reporting in to Quality Committee. The CNO advised that she is the accountable officer for the Children's objective and felt it was important to report in to Quality Committee.	**LF/HH/ NO**
	Resolved – that: **(A) The Quality Committee Workplan be received and approved.** **(B) The Chief Nursing Officer, Integrated Care Representative and Associate Director of Quality Governance will meet to discuss the suggestion of adding Medicines Management and Medicines Optimisation directly reporting to the Quality Committee.**	**LF/HH/ NO**

QC009/04.24	**QUALITY PRIORITIES**	
	The ADQG presented the Quality Priorities and the following key points were noted: • The refreshed Quality priorities were presented, taking on board Feedback from the previous meeting; these also included the safety priorities and detail of where priorities aligned. • The Integrated Care Representative noted that the deadline for Martha's Rule is January. This feels very ambitious compared to the national timescale. The CMO felt that there was no harm in being ambitious. • Mrs Martin (NED) noted that we are adopting the principles as soon as possible with the ambition to get to a local position as soon as possible even if this then requires changes to meet the national plan.	
	Resolved – that the Quality Priorities be received and approved.	
QC010/04.24	**PATIENT EXPERIENCE COMMITTEE TERMS OF REFERENCE AND WORKPLAN**	
	The ADQG presented the Patient Experience Committee Terms Of Reference and Workplan and the following key points were noted: • These have been reviewed through the Patient Experience Committee and are being presented for ratification. • Mr James (Chair and NED) queried the attendance expectation of 6 out of 12 meetings which appeared low. The ADQG advised that deputies are encouraged to attend with attendance good with this remit. • Mrs Martin (NED) noted that it would be helpful if it was made clear who is being asked to send a deputy in their absence. • The CMO noted that the Medical Examiner Officers speak to all next of kin and collect data which is a rich source of information and suggested having a Report feeding into this meeting. The ADQG advised that the Mortality Project Manager has been invited to future meetings.	
	Resolved – that the Patient Experience Committee Terms Of Reference and Workplan be received and approved.	
QC011/04.24	**PATIENT SAFETY COMMITTEE TERMS OF REFERENCE AND WORKPLAN**	
	The ADQG presented the Patient Safety Committee Terms Of Reference and Workplan and the following key points were noted: • There are just minor amendments to the Terms Of Reference	

	• The Terms Of Reference and Workplan have been reviewed through the Patient Safety Committee and are being presented for ratification.	
	Resolved – that the Patient Safety Committee Terms Of Reference be received and approved.	
QC012/04.24	**MORTALITY REPORT**	
	The CMO presented the Mortality Report and the following key points were noted: • Our SHMI remains stable at between 101 – 102 for most of the month. HED puts us at 97.7. • The Learning From Deaths Committee is starting in May with training commencing next week. • We have rolled out the review of community deaths to a number of surgeries. This is mandated from September. Some Primary Care Networks want to pause until this becomes mandatory – discussions are occurring around this. • There are no changes to our outlier status groups. Heart failure and fractured neck of femur are priorities that we are jointing working with Primary Care around. • A Workshop with the Local Authority is taking place in May to look at the broader picture regarding mortality.	
	Resolved – that the Mortality Report be received and noted.	
QC013/04.24	**BOARDING REPORT**	
	The Associate Chief Medical Officer (ACMO), Medical Division presented the Boarding Report, which was taken as read, and the following key points were noted: • Boarding remains high, peaking at 33 last month. However, there was a slight reduction in total numbers. Discharge Lounge usage has fallen month on month – we are working on maximising usage. • There were 38 incidents, mostly reported on Frailty Wards, as expected. • We are running high numbers with delayed discharges. When these numbers drop, boarding numbers drop accordingly. • There is more evidence that this is affecting our ability to admit medical patients to medical beds. • The CNO advised that this is not what we want for our patients, but we must not forget the impact this is also having on our staff.	

	• Mr James (Chair and NED) queried what else we can do regarding the Discharge Lounge and reverse boarding. The ACMO, Medical Division advised that the Discharge Lounge does help to a degree but this is a small space with only a finite number of appropriate patients we can send. Regarding reverse boarding, this occurs some of the time but is difficult to achieve for all patients. The issues around boarders and discharging patients was discussed. • The CMO advised that the Chief Transformation & Delivery Officer is working with partners on the longer term strategy, along with utilising Same Day Emergency Care (SDEC), the Virtual Ward and Admission Avoidance. A workshop is planned for June regarding reconfiguration of our wards to ensure we have the correct balance of beds for medicine and surgery and a plan for use of the vacated day case space. We have also approved converting some of our locum positions into permanent staff. • The Acting Associate Chief Operating Officer, Medical Division advised that the Discharge Lounge does make a small difference. The Integrated Care Team and the Ward Representatives are meeting to discuss why usage has reduced. The Frailty team are working around what other options there are if the Discharge Lounge cannot be used. We are working cross divisionally to look at the discharge process and what we can do to improve. There is a lot that is not in our control but there are actions that we can take to improve. The next Boarding Report will include actions we are taking to improve this situation.	**JC**
	<u>Resolved</u> – that: **(A) The Boarding Report be received and noted.** **(B) The next Boarding Report will include actions being taken to improve to improve the position regarding Discharge Lounge usage.**	**JC**
QC014/04.24	**<u>DIVISION QUARTERLY REPORT – SURGICAL DIVISION</u>**	
	The Associate Chief Nursing Officer, Surgery Division presented the Division Quarterly Report, Surgical Division and the following key points were noted: • A new process for reviewing incidents is in discussion. Following the Patient Safety Incident Response Framework (PSIFR) training, it was suggested that a daily review of all incidents take place. Governance colleagues in the team are reviewing and a weekly meeting is taking place to look at incidents and draw out any themes. • A review of all outstanding Serious Incidents is being undertaken. A number have been submitted but there are still a few with Division to be closed.	

	• We have embraced and embedded PSIRF into our practice. There is a Round Table taking place today regarding Gynaecology incidents and complaints. A number of incidents have been raised around catheterisation over the years causing harm and we are looking at how PSIRF may help with this. • VTE Assessment – We have seen a small progression month on month. The main concern is around general surgery relating to SDEC as this data is now included in our figures. We are working with the Information Team to ensure that we are collecting the correct data. There is the same issue for same day Urology also been unnecessarily included. There was a focus on Gynaecology and we have since seen an improvement in figures with the removal of our Gynaecology Assessment Area data. • Complaints – This is an improving picture although we are still seeing high numbers. We have reviewed the process again and are telephoning patients once a complaint is received. The high backlog of complaints has been reduced with numbers now in the 30s. • The main areas of concern are Womens and Childrens, Gynaecology and Trauma and Orthopaedics. • Compliments – There was a 93% positive response rate from surveys sent via text message. We are also receiving a number of compliments, some of which are included in the Report. • Gynaecology Perfect Fortnight – This was to review services that we can improve. The focus was on Theatres and Outpatients (able to achieve 65 more clinic appointments). Improvement was seen in length of stay and Theatre utilisation. We are trying to achieve same day discharge for laparotomies and hysterectomies. • Work is undergoing regarding more weekend clinics for Gynaecology due to a lack of physical space on the top floor for Outpatients. This is a priority for capital planning and is on our Risk Register. • Ongoing work continues to support ED with an increasing number of patients being seen. During March, we held a test for change project to improve our 4 hour performance, SDEC has increased their operational hours and there is more ACP support at weekends. We have also improved our ENT emergency pathway with emergency clinic appointments in place rather than patients having to be seen in ED. We are also focusing on flow in the Gynaecology Assessment Area and ring fencing a bed. A Business Justification has been written to increase substantive staff for ENT weekend working. • A pilot Biliary Colic Pathway was implemented via Surgical SDEC. In March 13 patients were seen by a Clinical Nurse Specialist. The waiting time for patients has reduced from 54 to 11 days.	

	• Our elective surgical activity is increasing and this, alongside the opening of our new surgical hub in July 2024, means additional Pre-operative capacity is required. An observational and improvement event was undertake to support with the productivity and utilisation of Pre-operative services with an action plan developed to support the implementation of improvements. The key actions are included in the Report. • National Bowel Cancer Audit – Data is now being received quarterly rather than annually. The Trust has a reduced length of stay (under 5 days and 20% better than most Trusts), reduced admission rates and below average number of permanent stomas given to patients. Post-operative mortality is also lower for the Trust. • Performance Cancer Targets – There is a lot of scrutiny around 28 day diagnosis and 62 day performance. There have been a number of improvements in specialities, details of which are in the Report. • Teme Ward has received a Going the Extra Mile Award from a patient. Frome and Primrose Wards have adopted the Star of the Month Award for staff which patients, relatives and other staff can nominate a member of staff for. Details of the staff nominated so far are included in the Report. • Surgical SDEC have received the Staff Recognition Award for the work and time that the Unit and the Surgical Division have spent in getting the new Unit up and running and ensuring that it is working smoothly. The Award will formally be presented at the Annual General Meeting in September. • The long waiting position for surgical patients could potentially lead to physiological and physical harm. The 65WW and 78WW graphs in the Report show the reductions occurring in both of these areas. • Orthodontic Service – There was an Outsourcing Company supporting this fragile service but they served notice in February. A new Company started in April. The longer term plan is to move to an integrated service within Herefordshire and Worcestershire. • Womens Health – Themes have been seen from complaints and incidents received. This is around processes not being correctly followed and communication issues. Support has been put in for doctors as there was a gap with Middle Grade doctors in Obstetrics. A Round Table meeting is being held to look at the PSIRF process to see how this can be improved. The plan is to involve patients who have made complaints in this process.	

	• Day Case – This is a 12 bedded ward or for 14 trolleys. Due to winter pressures, Day Case has become, on occasion, an escalation area. Surgical and Medical outliers are placed here to spread the risk across the Trust. This environment is not suitable for long stay patients. Staff working here also have to cover the SAU as well. This has affected morale and stress levels for staff. A Round Table is being held to speak with staff on how they were feeling and to offer support and to meet with the Executive Team to ensure actions are put into place. Supervisory time is also being put in for the Band 6 staff and ensuring the appropriate number of beds are being used in this area. Further meetings with the team will continue to provide support and feedback. • Mrs Martin (NED) queried what the plans are to continue the changes made during the Gynaecology Perfect Fortnight. The Associate Chief Operating Officer, Surgical Division advised that we want to continue with a number of the changes, with some already in place. Getting scheduling correct for Theatre has continued to a large degree post this as well, with just over an 8% increase in Theatre utilisation in March for Gynaecology. Some other long term elements will need a review of our estates to implement. Mrs Martin (NED) noted that it would be useful to have the "so what" and the timing of the changes and the outputs for future Reports. • Mrs Twigg (NED) queried if the focus is on either complaints or concerns that the other then increases with less closures. The Associate Chief Nursing Officer, Surgery Division advised that more concerns have been received recently, hence the increase in numbers. Due to the complexity of concerns, it is not always possible to close these in 5 days. The ADQG noted that the process for complaints and concerns overlap and we use whichever one is most appropriate for the complainant. It can be misconstrued if we downgrade a complaint as the language used is not always clear. We will discuss with the Team how to improve on this to ensure complainants are clear on the process. We are aiming to ensure we follow PHSO best practice guidance in these areas. • Mr James (Chair and NED) suggested that the benefits we see from Maternity Voices Partnership giving a strong patient voice in Maternity Services could be replicated through similar approaches in other service areas eg Gynaecology and Womens Health"	
	<u>Resolved</u> – that the Division Quarterly Report – Surgical Division be received and noted.	

QC015/04.24	**PQSM – MATERNITY**	
	The Perinatal Quality and Safety Matron presented the PQSM – Maternity, which was taken as read, and the following key points were noted: • The CNO noted that the turnover and sickness data for the Maternity Support Workers has been red for 2 reports and queried if there was an issue with this workforce. The Perinatal Quality and Safety Matron advised that this was due to the Band 2 to 3 progression in other parts of the service leading to a query over their banding. The vacancies in other parts of the support team structure have provided an opportunity to review the roles in the team. Maternity apprenticeships are being considered from September. • The CNO asked if the percentage rates of women having an induction of labour were high and queried if we benchmarked these figures. The Perinatal Quality and Safety Matron advised that there is a reluctance to set a threshold as if a service user needs an induction this is offered. A deep dive review has been undertaken with no issues found. Each induction undertaken was warranted with discussion with the Consultant to ensure that this was correct. There were also no themes found. • High level feedback was received from the 15 Steps Challenge. This covered Maternity, Triage, Ante and Post Natal, SCBU, Delivery Suite and Outpatients. Positive feedback was received for all areas with only minor changes to make. We plan to undertake this again at the end of the year. The CNO confirmed that service users were very engaged with this visit, which they led on. • Mrs Martin (NED) advised that regarding the induction of labour rates, it would be helpful to get the standardised reporting for the Foundation Group so that we can look at any variations or trends.	
	Resolved – that the PQSM - Maternity be received and noted.	
QC016/04.24	**STAFFING REPORT**	
	The Associate Chief Nursing Officer, Surgery Division presented the Staffing Report and the following key points were noted: • We continue to see high volumes of patients through ED, well above 200 per day. Frailty and Surgical SDEC are now fully functional. They were unfunded, but from April are funded for their establishments. • Escalation beds remain open for the period, which has required increased nursing presence. Community Hospital additional beds are planned to reduce/close this month. • Boarding numbers remain high, up to 35 at times.	

	• The biannual acuity and dependency review has been undertaken this month. Staff require more training to ensure that they are correctly scoring patients. • There are still some unfunded areas – Day Case Unit for overnight stays and Sundays. • Fill rates remain over 100% in some areas but this has reduced. Vacancies and sickness has also improved. • Agency spend has reduced in month. There was a slight increase in Bank usage with more staff joining the Bank over the last few months. • We were 220WTE over establishment in March. An overview of one area is included in the Report each month to look at reasons for the over establishment, with Integrated Care highlighted this month. • Thornbury usage has reduced in month. From July, we will not be able to use any off framework agency – Thornbury is one of these. Paediatrics and SCBU are our mains areas of concern. We are planning on how to mitigate this. • The CNO advised that the budget for April 2024 has only just been issued. If the revised establishment is included in future reports, this would help ensure we are reviewing accurate information. Regarding Health Care Support Workers, we are going back to the use of central recruitment to reduce the vacancy factor and eliminate the usage of agency. Discussions are being held on how to get staff onto framework or ideally permanent staff with the Trust. • The Managing Director advised that we need to understand why we have not been using centralised recruitment. Regarding acuity reviews and change in staffing levels, we need to understand why we have so many additional 1-2-1 staff. The Associate Chief Nursing Officer advised that the Afloat Tool is used to decide if a certain level of 1-2-1 care is needed and this has caused some ambiguity potentially at the cost of professional judgement which is why the additional training and peer review process is essential to enhance staff understanding in this area. We are ensuring that staff are aware when they receive their establishment, this includes provision for 1-2-1 care. • The CNO advised that we are building in additional education for our Band 6 and 7 staff around staffing levels. Junior Band 6 nursing staff might need further support, hence this is being built into their Development Programme.	

	• Mrs Hill (NED) questioned whether we should be concerned around the 35WTE less staff used in Surgery than were required. The Associate Chief Nursing Officer, Surgery Division advised that numbers have been impacted by the amount of annual leave taken and having Community Services in the Division who do not cover the Easter Bank Holiday. This is not a safety concern.	
	Resolved – that the Staffing Report be received and noted.	
QC017/04.24	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The Deputy CMO presented the Patient Safety Committee Summary Report, which was taken as read, and the following key points were noted: • A presentation from Radiology was received which was a good example of improved governance. • There has been a significant reduction in the number of errors from Ordercoms. There are now only small numbers to sort out. • PSIRF Training – There has been good uptake and feedback. The Patient Safety Strategy is still in the embedding phase and the Panel are seeing less cases which is positive. There is a lot of work going on at Divisional Level which is appropriate. • VTE – We had expected the Maxims upgrade to come in sooner than it has. This is now due next month. This will enable a more robust way to ensure assessments are taking place. More work is required around education for staff. We need a better understanding on how we are achieving these numbers, which is being worked upon. • There is a live dashboard for wards, including VTE. We are hoping that this will enable improved compliance. • CD Drug Audits – There has been excellent compliance with these Audits.	
	Resolved – that the Patient Safety Committee Summary Report was received and noted.	
QC018/04.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Patient Experience Committee Summary Report and the following key points were noted: • There was good discussion and engagement around PLACE, with the need to improve results known. • A deep dive into plans going forward and a rolling plan of development for this year has been produced. We are engaging with patient representatives and expanding the number of patients attending these visits.	

	• There is continued frustration that we are unable to get the Friends and Family Test rolled out to Community Services. This has been escalated accordingly. There is an option of using QR codes instead, but when this was used previously there was low uptake. • Patient property work is delayed slightly due to the trialling of a new Disclaimer From. The Audit Committee are keeping a close eye on any losses we make. • The Integrated Care Boards Representative noted regarding the PLACE Audit Action Plan there is a national data downturn regarding disability and dementia scores and questioned if there were any themes. The CNO advised that some of these for the Trust are complex and beyond our control, eg the number of accessible toilets we provide, yet other areas are simpler fixes such as paint colour contrast and dementia friendly clocks for example.	
	Resolved – that the Patient Experience Committee Summary Report be received and noted.	
QC019/04.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	The CNO presented the Infection Prevention Committee Summary Report and the following key points were noted: • We are below our C-Diff trajectory which is very positive although further work to do to improve. • MRSA – There has been 1 case. A review of how this was acquired has been undertaken with some learning in relation to screening. There was wider learning in relation to the patient's journey as they were transferred to a tertiary unit – the pathway is being reviewed. This will be reported back through the Patient Safety Panel. • Surgical Site Infections – We are an outlier for knee and hip surgical site infections when compared nationally, each case is individually reviewed and there are no concerns, are outlier status is being driven by our low denominator. Benchmarking is not adjusted for case numbers hence we are more likely to be an outlier • There are a number of out of date Policies which has arisen due to changes in staff. The review is underway and additional support has been provided.	
	Resolved – that the Infection Prevention Committee Summary Report be received and noted.	

	CONFIDENTIAL SECTION	
QC021/04.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC021/04.24	**ANY OTHER BUSINESS**	
	• Mr James (Chair and NED) noted that the new Patient Walkabouts were in place with a NED and Executive Director. • The CNO advised that we plan to review the process following feedback and highlighted the high level changes including Revision of the schedule for the year to ensure that we cover all areas, including smaller areas. It has been agreed to look at how we provide some prompt lines of enquiry (not a script) to support those visiting to focus on Quality and Safety issues that Quality Committee are interested in. We have agreed to rebadge the walkabouts as Quality Engagement visits rather than safety walkabouts given their broader focus. • Mrs Twigg (NED) noted that it was difficult to know what we were trying to achieve and if we are adding value and taking away the right things. It is useful to know that it is around the Quality Committee remit. • Mrs Hill (NED) found that the key issue discussed on her visit did not fit into the remit of the formal visit. • Feedback on the new Patient Walkabouts with NEDs and Executive Directors to be provided to the CNO.	**ALL**
	Resolved – that: **(A) The Any Other Business be received and noted.** **(B) Feedback on the new Patient Walkabouts with the NEDs and Executive Directors to be provided to the Chief Nursing Officer.**	**ALL**
QC022/04.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 30 May 2024 at 1.00 pm via MS Teams.	

Acronym	
AAU	Acute Admissions Unit
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 Fund
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
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
GEH	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
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio

HV	Health Visitor
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
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
MOU	Memorandum of Understanding
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
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
OHP	One Herefordshire Partnership
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
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
RTT	Referral to Treatment
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
SLA	Service Level Agreement
SOP	Standard Operating Procedure
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
WAHT	Worcestershire Acute Hospitals Trust
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