Public Board Meeting

Thu 05 September 2024, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Erica Hermon.

13:01 - 13:02
1 min

2. Declarations of Interest

13:02 - 13:03
1 min

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

Decision *Russell Hardy*

3. PUBLIC BOARD MINS - JULY LF, KL.pdf (14 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

PUBLIC BOARD ACTION LOG -SEPTEMBER.pdf (1 pages)

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Glen Burley*

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

5.2. Integrated Performance Report

Discussion *Jane Ives*

6. WVT IPR Month 4 July 24.pdf (28 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 - 13:50
15 min

6. ITEMS FOR APPROVAL

6.1. Emergency Department Workforce Investment Business Case

Decision *Lucy Flanagan*

- Front sheet ED business case Board v2.pdf (2 pages)
- 20240829 ED Nursing Business Case BOARD August 2024.pdf (33 pages)

13:50 - 14:20
30 min

7. Items for Noting and Information

7.1. Integrated Care System and One Herefordshire Update

Discussion *Jane Ives/Jon Barnes*

- ICS and One Herefordshire Update - Septemner 24 Board.pdf (3 pages)

7.2. Trust Infection Prevention Annual Report 2023/24

Decision *Lucy Flanagan*

- 7.2 IPC Annual Report front sheet.pdf (2 pages)
- 7.2a IPC Annual Report 2023.24 - TIPCC final final LF.pdf (37 pages)

7.3. Perinatal Safety Report

Discussion *Lucy Flanagan*

- 7.3 August 2024 Perinatal Services Quality Safety Report PQSM.pdf (16 pages)

7.4. Committee Summary Reports and Minutes

7.4.1. Foundation Group Board Minutes and Action Log 7 August 2024

Discussion *Russell Hardy*

- 7.4 Draft Public FGB Minutes - 7 August 2024.pdf (17 pages)
- 7.4.1 Public FGB Matters Arising and Actions Update Report.pdf (2 pages)

7.4.2. Integrated Care Executive Report

Discussion *Frances Martin*

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

7.4.3. Quality Committee Report and Minutes 30 May 2024 and 27 June 2024

Discussion *Ian James*

- 7.4.3 QC Summary May 24 Public.pdf (4 pages)
- 7.4.3a QUALITY COMMITTEE MINUTES MAY.pdf (16 pages)
- 7.4.3a QC Summary June 24 Public.pdf (4 pages)
- 7.4.3 QUALITY COMMITTEE MINUTES JUNE.pdf (22 pages)

14:20 - 14:25
5 min

8. Any Other Business

14:25 - 14:30

9. Questions from Members of the Public

5 min

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 3 October 2024 at 1.00 pm

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

Present:

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

In attendance:

Jon Barnes	JB	Chief Transformation and Delivery Officer
Ellie Bulmer	EB	Associate Non-Executive Director (ANED) – Arrived during Item 5.2.1 due to technical difficulties
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED) – Arrived during Item 5.2.3 due to technical difficulties.
Lou Robinson	LR	Deputy Company Secretary
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Jo Sandford	JS	Freedom To Speak Up Guardian – For Item 7.5
Aime Symes	AS	Associate Director of Midwifery – For Item 7.3

Minute		Action
BOD01/07.24	**Apologies for Absence** Apologies were received from Glen Burley, Chief Executive, Russell Hardy, Chairman, Erica Hermon, Associate Director of Corporate Governance and Nicola Twigg, Non-Executive Director.	
BOD02/07.24	**Quorum** The meeting was quorate.	
BOD03/07.24	**Declarations of Interest** There were no declarations of interest noted.	
BOD04/07.24	**Minutes of the meeting held 6 June 2024** **Resolved – that the minutes of the meeting held on 6 June 2024 be confirmed as an accurate record and signed by the Chairman.**	
BOD05/07.24	**Matters Arising and Action Log** **Resolved – that the Action Log be received and noted.**	

BOD06/07.24 **Chief Executive's Report**

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

(a) Financial Regime Changes – This links deficit incentives and accountabilities under the current regime and how this affects the different members of the Foundation Group differentially. The Trust have a deficit plan of £31m which means that we have been penalised with a reduction in our capital allocation of around £600k. Equally, at the end of last year, we benefited from the capital incentive of around £2m which was around our Emergency Department (ED) performance in March. The Financial Regime is due for an overhaul, and the Chief Executive will seek to influence this with the new government.

(b) Urgent and Emergency Care (UEC) – This describes the link between the "overheated" Urgent Care system and the ability to fund additional capacity and manage that demand. This link is related back to the Financial Regime and the difficulties in funding additional emergency demand in the Regime that we currently have.

(c) Pathology Network – The new Pathology Network really does provide an opportunity to develop more resilience for our Pathology teams which are quite small. As we negotiate the terms of this Network, we need to ensure that we retain the flexibility and ownership that we have with our current teams and the way that we currently work. This was demonstrated with our recent technical difficulties where the system that links our Pathology System to our other systems had a technical failure which meant that we had to resort to paper based systems for 4 days. The ownership of the team is critically important in terms of making sure that we were able to keep patients safe during that time.

(d) MORE FROM OUR GREAT TEAMS – Update from the Clinical Support Division – This provides an update on a number of positive areas of improvement in the Division.

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

BOD07/07.24 **Integrated Performance Report**

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

a) There are continued pressures on Urgent Care pathways and the link to our financial pressures.

b) We continued to board patients through May and June and now into July we are in the same position. Our ED has also stayed congested. The quality impact of this for our patients and the impact on our staff is a continued focus for us. There is a lot of work continuing to try to improve our Urgent Care pathway. This is not just occurring within our Trust but across the whole System, eg referrals to GPs working with the Ambulance Trust, the Local Authority with discharge delays (which are improved) along with improvement plans in place. There is a link between this and having to staff additional areas.

c) Next Monday our Elective Surgical Hub opens. The Managing Director visited this last week and saw a fantastic state of the art building. There are 3 new Theatres which were designed by our clinical teams and Clinicians. This will not only provide a good patient experience but also improve our efficiency. The plan is to outperform our current plans with more opportunity to attract further income which will help with our financial position.

d) Financial Performance – We are £1.2m adverse to plan at Month 2 which we are concerned about. This is driven by under delivery of our CPIP and overspend on non-pay and agency staff. At Month 5 we expect an improved run rate and plan to deliver our CPIP target. There is clearly risk around achieving this.

e) In May we met our cancer performance targets which we believe we can sustain. This is good news for our patients.

f) There is continued good performance with recruitment and retention. From 1 July we have reverted nearly all of our Agenda For Change staff onto the national Agenda For Change terms and conditions.

g) Apex (Pathology) System – The Managing Director wanted to record her individual thanks. Our Chief Operating Officer (COO) was on leave so our Chief Transformation and Delivery Officer stepped in and led the response along with our Associate COO, Surgical Division who was on call. They all managed incredibly effectively due to our fantastic staff, some of whom came in on their annual leave and days off to support. Due to all of this they managed to deal with all the urgent tests received with very good turnaround times. Mrs Martin (Chair and NED) thanked, on behalf of the entire Board of Directors, everyone involved.

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

BOD08/07.24 **Quality (including Mortality)**

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

(a) The CMO advised that there is a national standard for all patients who are aged 16 and over who should have a VTE risk assessment on admission. This should apply to more than 95% of admissions. We have struggled as an organisation to reach this target. We now have an Improvement Plan which includes having live dashboards with compliance percentages so that key staff are able to quickly identify which patients require a risk assessment. It also includes a plan to link this with a risk assessment to our electronic prescribing to alert them, as our Clinicians are better at prescribing than carrying out the risk assessment. We are also going to be carrying out an awareness campaign and education training. We have also revamped the Thrombosis Committee with the leadership of the Deputy CMO who will be leading this work. Improvements will be monitored through the Quality Committee.

(b) Mrs Martin (Chair and NED) welcomed the focus on VTE – this is an incredibly important area and we need detailed updates next month on this as we are anticipating changes in this as other Trusts are managing to achieve this difficult target.

(c) Mortality – Our most recent SHMI (12 month rolling data) is still at 101.7. Our HED data is at 99, but this is always less than our SHMI.

(d) Mortality Outliers – Out SHMI has improved for our heart failure and fractured neck of femur patients. Our fractured neck of femur numbers are still higher than we want, but there has been significant improvement. A lot of work has been carried out to ensure that patients who present in ED get onto the ward in less than 4 hours. We are also ring fencing the bed for fractured neck of femur patients. There has been an increase in our stroke SHMI but this is still at 106 which is within the expected range. We audited the deaths of patients who presented with a stroke to the Trust over the last 5 months. The mortality rate following this audit is 6% which is lower than the national average. We are undertaking a deep dive which we will present to the next Board meeting. We have also met with our Public Health colleagues to review our stroke mortality in the community to understand the data and what we need to do to both prevent the number of people developing stroke and improve communications in the community before they come into hospital regarding early recognition.

(e) Our Medical Examiners are scrutinising 100% of deaths in the hospital and are now reviewing deaths in the community. The aim is to review all deaths in the community by September as this will then become mandatory. We have now embedded the Learning From Deaths Committee where deep dives are presented to try to understand the data and to learn lessons by sharing learning across the organisation.

(f) Mrs Frances (Chair and NED) highlighted that Safety In Sync has been shortlisted for a Health Service Journal Award. This is an incredibly innovative and important area where we, with our One Herefordshire Partners and the ICB, meet to discuss patient experience across the pathway and we collectively do everything we can to improve the quality and safety of our services.

(g) Mr James (NED) noted the good work that we have been doing to shift the focus from the Front Door to improving access to the GP out of hours service which will be of particular interest to members of the public. The COO confirmed that we are working closely with Taurus, our local GP Federation in terms of them ring fencing out of hours slots for our ED colleagues to stream appropriate patients directly to Taurus slots at Reception. This is part of our ongoing development work in valuing patient's time. Each weekend we are seeing an increase in the use of these slots and we are transferring this information digitally rather than over the telephone. This reduces congestion in our ED and allows our ED colleagues to focus on more serious conditions that present to our ED.

(h) The Managing Director noted the importance that members of the public understand where they can access urgent care. Generally in Herefordshire there is good access to Primary Care but sometimes the stories in the national media overtake this and people then think that they will not be able to access a GP appointment. We have seen a really big rise in attendances to ED. The other effect of this, other than using the funded capacity that is already available, is that we educate patients who come to ED to advise them of where there is a GP slot available for them. Mrs Martin (Chair and NED) also highlighted the availability of Community Pharmacists, Dentists, General Practice and NHS 111. The ED is for emergencies and we encourage people to ensure that they have considered alternatives if these are more appropriate.

(i) Ms Quantock (NED) acknowledged that some patients with chronic conditions or who are very unwell are worried and know that ED is open 24 hours to provide care. However, given the difficulty and strain on the systems, we really need to look at what is the most effective route to go down for more appropriate treatment which we they could receive a lot quicker.

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

BOD09/07.24 **Activity Performance**

The COO presented the Activity Performance Report, which was taken as read, and the following key points were noted:

(a) There was another period of industrial action from 27 May to Tuesday 2 June. The COO thanked all the operational and clinical teams for their hard work during this time. This prevented them dealing with other priorities whilst supporting during this period. During this time we continued to see high levels of ED attendees. This action resulted in the cancellation of 11 Day Cases and 130 Outpatient procedures. We will endeavour to get these patients rescheduled as soon as possible.

(b) We have continued issues with boarding patients and having escalation beds open in the Acute and community.

(c) Urgent Emergency Care levels of performance for our 4 hours Emergency Access Standard remain positive since our test for change month back in March. Improvements have remained broadly the same with slight improvements in May and June. There have been significant improvements in our Minors, Paediatric performance and a reduction in our non-admitted waits. This is a System wide issue with various pieces of work occurring both internally and externally to improve this.

(d) The COO reiterated that we have achieved the Faster Diagnosis Standard and the current 62 day standard for May and it appears that we have further improved in June. He thanked the teams for all their hard work in achieving this.

(e) Elective activity from May remained ahead of plan and in June we were ahead of plan and also year to date. We are ahead of 2019/20 pre pandemic levels but we need to ensure that this is delivered at the agreed cost or lower. Our value weighted activity is also performing high again and is one of the top performances in the Region. On average over the last 4 weeks up to mid-June we achieved 117.5% valuated activity compared to 2019/20.

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

BOD10/07.24 **Workforce**

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

(a) We have maintained good performance on most of our workforce KPIs and are taking active steps to reduce our sickness levels. We are focusing on high short term sickness and sickness over 100 days to ensure that we have the right support in place for individuals and managers.

(b) We are working with ICS colleagues with a new Cultural Inclusion Strategy. We are taking steps to address health inequalities to enhance the employee experience and to strengthen the Freedom To Speak Up culture across organisations within the ICS.

(c) We are supporting the drive for efficiency and productivity. There is a Workforce Opportunities Group in place and we are taking steps to terminate some long standing term pay arrangements which were not in line with Agenda For Change national terms and conditions.

(d) In partnership with Halo Leisure, we are holding a Family Fun Day on Saturday 6 July. We will pushing forward our Health and Wellbeing Programme at this event.

Resolved – that the Workforce Report be received and noted.

BOD11/07.24 **Finance Performance**

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

(a) We have an adverse variance to plan at Month 2 of £1.2m. This means that we have a year to date deficit of £7.1m overall. This is part of our Financial Plan, which is a revised deficit of £31.4m for the year.

(b) We spent £900k more than planned on pay. This is due to continued reliance on temporary working and some slower than anticipated savings from our CPIP Programme.

(c) In terms of agency spend, this was around 6% of the pay bill in month, but positively we are seeing a reduction in our framework usage through the first few months of the year. This is aligned to the National Policy around implementing a cessation of use of our off framework agencies from July.

(d) We have been able to maintain a strong elective performance through the first months of the year and this has meant that we have generated additional income of around £600k to date which has helped to partly mitigate the higher than anticipated costs on the expenditure side.

(e) Capital – Of concern is our overall allocation. This was small to start with at the start of the financial year given the range of challenges that we need to address. As a result of the overall planned deficit from a System perspective, allocation has been further reduced by around £600k. We therefore have a restrained capital position which is requiring close management and some difficult decision making around balancing our risk within this limited funding available.

(f) Cash – This is clearly a risk with a deficit plan and we continue to closely monitor and manage our cash position. The cash support from NHSE in line with the deficit is only available up unto the level of that planned deficit, so £31.4m and then any cash to support the Capital Programme. Where we have an adverse variance, that is not cash backed and we are expected to manage that ourselves.

(g) Mrs Martin (Chair and NED) noted that none of the Board of Directors under estimate the operational pressure that we have heard about and the ambition to treat more people and provide the best care that we can. We have as an organisation got to regain the financial grip that appears to be slipping slightly and it is positive that the Managing Director is expecting by Month 5 to have a clear plan in place. We also need to remember that our freedoms as an organisation and our ability to have opportunities such as building the Elective Surgical Hub and the diagnostic opportunities are predicated on our effectiveness as an organisation and being seen as an organisation that will deliver on our collective responsibilities regarding this.

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

ITEMS FOR APPROVAL

BOD12/07.24 **Digital Strategy**

The CFO presented the Digital Strategy and the following key point was noted:

(a) This builds on the previous Strategy that was developed in 2020 and this covers the period 2024- 2027. This is intended as an organic development from what we had already had rather than a stepped change.

(b) This has been in development for some time and in consultation and collaboration with stakeholders both internally and externally including Hoople as our delivery partner and our ICS partners.

(c) A Board Workshop was held last year as part of its development and it has been endorsed through the Trust Management Board.

(d) The CFO thanked all colleagues who have been engaged in its development.

(e) The Strategy is built around 4 key areas – Clinical Systems, Back Office and Infrastructure, Citizen Access and Benefits Realisation. At its core, the Strategy is intended to help us to select, deploy and run technology to help the organisation to achieve its objectives. Eg how do we use our digital tools to enhance what we do to increase efficiency and patient experience.

(f) The core is underpinned by a governance framework to ensure that we have robust plans to deliver those strategies. Delivery of the Strategy remains iterative in terms of aligning our digital capability and digital maturity with the organisations and our operational ambition.

(g) Over the next 3 year period we are taking stock of what we have already delivered over our digital journey and to optimise what we already have to make sure that this is working as effectively as it can and we are really realising the benefits, how do we broaden its internal appeal and make it as user friendly as we can for our clinical teams on the frontline and our workforce and our public reach in terms of how we use our digital tools to better engage with our patients and our population.

(h) The Managing Director noted that this was covered in the Board Workshop held this morning when we discussed the future of digital. As part of this next phase, it really is about driving the benefits from it, particularly driving productivity. This may mean supporting some staff to adopt new technology at a greater pace than they would perhaps want to but as long as the technology is proven and we have other teams using it and we have proven benefits, we really need to make sure that we are supporting all of our staff to adopt the technologies so that we do get the productivity benefits that we expect out of this very large investment that we have made.

(i) Mr James (NED) queried whether there is more that we can do to promote what we are doing digitally and to get people ready for the digital usage of access etc. This is something to consider for our patients and citizens to keep this digital message strong. The CFO confirmed that this one of the key parts of the Strategy. We are working with digital inclusion and communication with our residents as part of the partner work.

Resolved – that the Digital Strategy be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD13/07.24 **ICS and One Herefordshire Update**

The Managing Director and the Chief Transformation and Delivery Officer presented the ICS and One Herefordshire Update and the following key points were noted:

(a) The Managing Director highlighted the work with the Better Care Fund. This has been in place for a number of months and we are making real progress with more to come.

(b) The Chief Transformation and Delivery Officer noted that the Report includes a background to the Better Care Fund and our roles within the Memorandum Of Understanding. He advised that the Memorandum Of Understanding was the most important part of this. It has changed our relationship as an organisation with the Better Care Fund but also the One Herefordshire relationship so that we now work as a collective and design our delivery of the Better Care Fund Schemes. In the fore of this is the Discharge To Assess which has been a difficult problem in terms of patient flow and getting people home or to the most appropriate place following their hospital stay.

(c) Better Care Fund planning has been difficult this year. This was managed and planned by the Chief Transformation and Delivery Officer and our Commissioning and Social Care colleagues working with providers. There was a significant uplift in funding but there was also a significant down lift in available money. We used reserves last year and a one off grant as well, so we had a lot of non-recurring money that we used last year to provide care. This year effectively the big uplift was not there so we had a cost pressure on Discharge To Assess services but we have worked together. We have looked at length of stay and how this benchmarks compared to others, occupancy compared to others and created an ambition around this to try and get a length of stay and occupancy improvement with the 3 main providers we get to deliver this. The plan has been agreed and we are working with our Providers. We need to improve as a System how we use these beds and make this pathway more accessible and reduce our length of stay from an average 6 weeks to 4 weeks as this is the typical timeframe.

(d) The governance around our Discharge To Access Board is very important and we are starting to see this come through the Integrated Care Board with some more structured data coming through.

(e) The Chief Transformation and Delivery Officer acknowledged the fantastic work that our Commissioners and Local Council have done regarding the Domiciliary Care market within Herefordshire. There were over 150 people in various settings waiting for domiciliary care 12 months ago either at home, in a re-enablement bed or hospital, but this is now down consistently to single figures.

(f) We have seen a huge shift in terms of average length of stay for Pathway 1 (support at home) which is now down to 1 to 1½ days from 4½ days.

(g) We agreed a plan in June, rather than December, when we agreed it last year which is real progress.

(h) The Integrated Care Executive will be reviewing all of our services to ensure that we have a credible plan.

<u>Resolved</u> – that the ICS and One Herefordshire Update be received and noted.

BOD14/07.24 **Agency Reduction**

The CMO and the CNO presented the Agency Reduction Report and the following key points were noted:

MARP

(a) The aim of the MARP is to maximise our resources and improve productivity and efficiency. A key performance indicator is the amount of medical temporary staffing that we use. We have had some success in this area. We have had a 34% reduction in medical agency use when compared to the same time last year. However review of Medical Bank usage is about the same as last year. We are therefore increasing our medical establishment to match what we feel we actually need to reduce the use of Bank and applying more governance and control. We are also standardising the rates we pay for shifts rather than negotiating each time whilst we are improving our establishment. We have converted some of our Locums onto the Bank and to permanent staff.

(b) There is still a lot of work to do but we are in a better position than we were at the beginning of the year.

NARP

(c) Money – We have set an ambitious target to spend £4m less on nurse agency this year than last year. This means that we plan to spend no more than £5.3m on agency in the full year. In Months 1 and 2 we have had a strong performance and it is actually the best performance that we have had in the last 12 months, but we are still not where we need to be. We need to spend no more than £450k per month but have spent £660k and £620k in the first 2 months so lots more work to do. We will achieve this through our employed workforce. We have really strong performance overall with our vacancy position improving, our sickness management is improving but we do have some hot spots. For registered nurses we are in a really strong position with the best vacancy position since the CNO was in post and with sickness nearly in line with national best performance. However for our Health Care Support Workers we do have a deteriorating vacancy position and sickness levels at 8% which is above where we need this to be. We therefore will be targeting our efforts on recruitment and sickness management, to reduce our reliance on temporary workforce and therefore get down to the level of spend to meet the ambitious target that we have set ourselves.

(d) Agency Provision and Performance – We have a Master Vend contract and they are performing very well, the detail of which is in the report. The contract is due for review in September and we are working to consider our options moving forward.

(e) The Managing Director queried the trajectory for reducing the number of Health Care Support Worker vacancies. The CNO advised that we have reintroduced centralised recruitment, we do not have a final figure in terms of trajectory as we are just making some adjustments for those areas that had investment but we should have this detail by next month. **LF**

Resolved – that:

(A) The Agency Reduction Update be received and noted.

(B) The September NARP Report will contain the trajectory for reducing the number of Health Care Support Worker vacancies. **LF**

BOD15/07.24 **Perinatal Safety Report**

The Associate Director of Midwifery presented the Perinatal Safety Report and the following key points were noted:

(a) Mrs Martin (Chair and NED) advised that there is a national requirement for NHS Trusts that provide Maternity and Neonatal Services to have Board Level Safety Champions. Mrs Hill (NED) is sharing the NED Safety Role with Mrs Martin (NED).

(b) The report contains data from May and was presented to the Quality Committee for full oversight and assurance of the data.

(c) There are no areas of escalation or points of significance that need further discussion in the performance section.

(d) The minimum data set that is required to be shared contains sensitive and detailed information. In a small Trust such as ourselves this does mean that this is reported to the Private section of the Board of Directors to preserve confidentiality.

(e) The workforce staffing is in a positive position. Details of the maternity workforce are included in the report, which is a new template and a new mechanism of reporting in terms of the acuity tool. Acuity was met 85% of the time for midwifery staffing, 13% of the time being slightly short and 2% being slightly more than we would like in terms of our numbers. For each of these times, appropriate mitigations were put in place to maintain safety within the service.

(f) We recruited a Locum to cover sickness, which may be extended if possible. Our Obstetric team are getting back on track with staff returning to work. The Anaesthetic workforce is stable and there are no areas of concern.

(g) We are on track for our training for CNST standards. Compliance for our Maternity Support Workers is at 67%, lower than the 90% target. Previously they were not included in the number as essential. They have now been recognised nationally that their roles are crucial and as such they have been invited to participate in training. In order to meet the timeframe last year, we trained all these staff at the same time and we are on trajectory to meet this target for this year.

(h) Compliance with Saving Babies Lives – This is a quarterly oversight by the LMNS so there is no update in this paper as not yet due.

(i) There is a section in the report which highlights the Safety Champion work that is undertaken.

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

BOD16/07.24 **GUARDIAN OF SAFE WORKING REPORT**

The CMO presented the Guardian Of Safe Working Report and the following key points were noted:

(a) The aim of the role is to ensure that any issues of compliance with safe working or rotas that effect doctors in training are addressed. We appointed the Guardian Of Safe Working Lead in March.

(b) During the last quarter, he dealt with 14 exceptions, 11 of which are closed. There is a trajectory to close the remaining 3. Most of the issues are related to the Medical Division and working hours. He tried to address most of them with the Clinical Leads. This is around ensuring that we our right sizing our medical establishment. We are monitoring any trends or hot spots.

Resolved that the Guardian Of Safe Working Report be received and noted.

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD17/07.24 **Audit Committee Report and Minutes 23 April 2024**

Resolved - that the Audit Committee Report and Minutes 23 April 2024 be received and noted.

BOD18/07.24 **Quality Committee Report and Minutes 25 April 2024**

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

ITEMS FOR NOTING AND INFORMATION

BOD19/07.24 **Freedom To Speak Up Annual Report**

The Freedom To Speak Up Guardian (FSTUG) presented the Freedom To Speak Up Annual Report, which was taken as read, and the following key points were noted:

(a) The FTSUG was confident that speaking up is valued at the Trust by all senior leaders and is seen as an opportunity to learn and improve. We have had a 74% increase in cases over the last financial year. Once a case is resolved, a link is sent for an anonymous survey to staff for feedback on the service that they received. When asked if they would speak up again in the future, 98% responded yes and only 2% said maybe.

(b) The National Guardian Office has listed warning signs that suggest that a Trust is not promoting a healthy speaking up culture. Having a high volume of cases does not appear on this list, therefore the increase in cases should be viewed in a positive manner and is a reflection of staff feeling heard and appreciated.

(c) A contributing factor to staff feeling safe to speak up is the increased efficiency rate for achieving a resolution to each case. All of the previous year's cases were closed just 3 weeks into the new financial year.

(d) Cases for Quarter 1 have increased by 30% compared to the highest quarter last year.

(e) There are many barriers to prevent staff from speaking up. The 2 most common are being a member of a minority group of a lack of confidence in speaking up.

(f) This year, there has been a 78% increase in Champions recruited this year, 15% of whom are BAME staff and also a member from the LGBTQ+ and Disability Awareness Network.

(g) The most common myth is that Executives will not listen or support speaking up. To this end, a short film was produced to demonstrate how supportive they are.

(h) The Managing Director thanked the FTSUG for her leadership and energy around this which is making a huge difference. We want to have a lot of FTSU concerns being raised but the speed at which we are able to deal with the issues and close them down is also very important. It is positive that we are seeing more people speaking up.

(i) The Managing Director noted that a lunch was provided for the FTSU Champions this week which provided an opportunity for the Executives and NEDs to talk to the Champions. They felt well supported and that they were making a difference. They are a wise and mature group of staff who understood the role.

(j) Mr James (NED and Link NED for FTSU) noted the tremendous progress made which is reflected in the number of enquiries received along with the positive improvement in Champion numbers. He felt that there was more promotion and education needed for some of our leaders to further improve this.

(k) Mrs Martin (Chair and NED) noted that there is an "Open Door" for all of our Executives who are available to support staff.

Resolved that the Freedom To Speak Up Annual Report be received and noted.

BOD20/07.24 **Any Other Business**

There was no further business to discuss.

BOD21/07.24	**Questions from Members of the Public** (a) Mrs Martin (Chair and NED) noted that 2 questions were raised by a member of the public. The Managing Director advised that 1 was around their own personal experience in ED, with the response covered during the meeting. None of us are satisfied with the quality of experience that we are able to give to patients in ED due to the congestion. The second question he raised has been raised a number of times around the response to violence and aggression response incidents for our staff. The Chief Strategy and Planning Officer will contact the member of public directly as we felt that we have answered this previously to understand the background. If there is felt to be an ongoing concern we will bring that back to the meeting.	**AD**
	Resolved – that: **(A) The Questions from Members of the Public be received and noted.** **(B) The Chief Strategy and Planning Officer will provide an update to the outcome of the meeting held with the member of public around questions raised around responses to violence and aggression incidents for our staff.**	**AD**
BOD22/07.24	**Date of next meeting** The next meeting was due to be held on 5 September 2024 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 5 SEPTEMBER 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
BOD14/07.24 Agency Reduction 04.07.24	(B) The September NARP Report will contain the trajectory for reducing the number of Health Care Support Worker vacancies.	LF	NARP Reports now presented to the Finance Recovery Board.
ACTIONS IN PROGRESS			
BOD21/07.24 Questions from Members of the Public 04.07.24	(B) The Chief Strategy and Planning Officer will provide an update to the outcome of the meeting held with the member of public around questions raised around responses to violence and aggression incidents for our staff.	AD	The Chief Strategy and Planning Officer has arranged to meet the member of the public to discuss their concerns.

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
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 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*

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1. Emerging Priorities of the new Government

We are now around two months into the term of the new Government. Our new Secretary of State (SoS) Wes Streeting, the 34th in the history of the NHS, has started to signal some of his priorities. The pledge to return to meeting the constitutional standards in the life of this parliament is probably the most challenging. The plans to do so will be heavily influenced by the current 'Performance Stocktake' being undertaken by Professor Lord Darzi. I was recently invited to the first of two Expert Reference Group meetings where the extent of the challenge was discussed. Professor Lord Darzi is expected to feed back to the Government later this month and the findings will shape the components of a new NHS 10 Year Plan which is expected in the spring 2025.

One immediate issue for the new SoS is the dispute with Junior Doctors over last year's pay award and the more recent collective action by General Practitioners (GPs). In addition to these two formal disputes, the other NHS pay Review Bodies will have made recommendations to the Government about pay increases for 2024/25. The NHS is already facing a significant financial challenge and on top of these inflationary pressures there is also a likely requirement to accelerate the delivery of the Elective Recovery Plan if the pledge to return to the constitutional standards is to be met. The approach to these issues is therefore expected to feature in the October 2024 budget.

2. NHS Constitutional Standards

It has been some time since the NHS was even close to delivering the Constitutional Standards overall. I thought it might be helpful to provide a recap on what the main standards and targets are.

Urgent and Emergency Care (UEC) - whilst we have developed a number of new UEC indicators, the 95% 4-Hour Emergency Access Standard remains the key pledge. We are anticipating that this year's Winter Letter will be published very soon. It is expected that this will focus on safety including reducing very long Accident and Emergency (A&E) waits, introducing more consistent maximum waits for ambulance handovers and clarifying how best to ensure safety if corridor care is instigated to manage peak demand. This year's UEC 4-hours waiting times standard was set at a 78% minimum in the 2023/24 Planning Guidance. It is anticipated that there will be further capital incentives linked to whole year performance against this. There has also been a suggestion that there may be a partial return to Payment by Results (PbR) in UEC as part of the 2025/26 Planning Guidance. This would be welcomed in my view as the current disconnect between demand and income is not helping with the NHS drive to increase productivity or to move care into the most appropriate setting.

Elective Referral to Treatment Times - the Constitution pledged that patients should be treated within an 18-week standard. Recognising the complexity of some treatment pathways, this was measured against a 92% standard. I anticipate that an updated Elective Recovery Plan will soon be published. It is generally felt that the re-introduction of PbR has helped to increase the volume of elective activity undertaken. We can therefore expect further use of a tariff incentive. Patient choice and use of Independent Sector will also still feature. The plan will have to demonstrate how we can transition to full target delivery in a 4-year timeline. Waiting list validation will be strengthened, and I would also expect to see a plan to tackle of non-admitted diagnostic waits.

Cancer Access - the 62-day referral to first treatment 85% standard will still be the core indicator. The original Constitution focussed on 2 week waiting times, but this indicator has largely been replaced by the 28-day Faster Diagnostics Standard (FDS). The FDS currently is measured against a 76% standard and hence it is likely that this will be increased. I anticipate that there will be a desire to consistently deliver on the 62-day standard well before the end of this Parliament.

3. Introduction of a Financial Recovery Board

As the Integrated Performance Report sets out, we are materially off track against our financial plan. Whilst we always knew that the plan would be challenging it is important that we take whatever steps we can to rectify the position. We have therefore introduced a Financial Recovery Board which mirrors the arrangements that we have in place in are partner Trust Worcestershire Acute Hospitals NHST. The Board will report to our Trust Management Board (TMB) and, via TMB to the Board itself. It will meet on a fortnightly basis rotating between an Executive-only meeting and a meeting where Non-Executives are also present. The focus of this Group will not be to duplicate the content of Executive Finance and Performance Committee but will add value by assessing the pace of delivery, accountabilities and governance within the organisation to improve the plan delivery.

4. More From Our Great Teams – Update From the Medical Division

Since we last looked at the Division, the level of pressure has continued to be high. Increased attendances in ED have led to increased admissions and high bed occupancy. As in previous reports the team has responded with energy and creativity to meet the challenges and have continued with plans to improve services alongside the challenges of ensuring flow through the hospital continues.

We continue to have high numbers of patients in our Emergency Department a lot of whom have a high level of acuity. There is an ongoing increase in attendances, which has made the efficiency and safety of the department extremely challenged. Following the CQC visit in December the department implemented an improvement plan. This was further developed during March when there was the opportunity to secure additional capital funding based on performance. During this period, we developed a UTC/minor illness service in ED, put in a nurse navigator at the front door and developed a transfer team.

This contributed to a significant improvement in 4-hour performance from 53.7% in February to 64.9% in March. This has continued with 68.3% achieved in August. We have also seen our time to triage decrease. Our nurse navigator is working well and navigates patients to our in-house GP during the week. We have also increased our usage of slots provided by our Primary Care partners at the weekend. Business cases for both medical and nursing workforce to make permanent some of the changes from both the CQC report and March improvement work have been produced. The nursing business case was approved at TMB in August. The team now plan to focus on frequent flyers and reducing their attendances to ED. The Nurse Navigator role is also being expanded. Also, discharge to Pharmacy first will start in October. We are also undertaking improvement work with our Medical SDEC to improve the productivity and numbers of patients they are taking from ED.

Since last report our Stroke services have continued to hold a B score in the Sentinel Stroke National Audit Programme (SSNAP). This programme is a national healthcare quality improvement programme that measures how well stroke care is being delivered – in Q3 of 23/24 we actually went up to an A. We now have a local out of hours Thrombolysis advice service run by Worcester and are working on developing a contingency plan to support the current Hereford medical staffing which is run by two high-cost locum consultants.

Our Frailty Same Day Emergency Care (FSDEC) services continue work to improve the pathway for frail people, one success being an improved discharge pathway to our Community Hospitals. We are continuing to have success in recruitment in our Frailty service and have appointed to our 6th consultant; our Perioperative Medicine for Older People Having Surgery (POPs) Doctor has started with the Trust with the aim of improving the surgical pathway for our elderly patients. We are also working with some of our other specialities to set up joint clinics with our geriatricians to improve the pathways for older people, for example heart failure.

Our Diabetes team are building on the success of their work in primary case setting up a Practice Nurse champions network and are now rolling this out across the District Nursing Service. The team have appointed to the newly created Diabetes Nurse Consultant role and the post holder is due to start in the New Year (she is currently completing her PhD). In Rheumatology we have been successful in recruiting to our permanent posts and are continuing to work with shared care schemes in primary care. In Nephrology we have started to work with the team in Worcester to look at the future of services across the ICB. In Dermatology we have continued to meet the Cancer Performance targets despite the seasonal increase in referrals and the impact of the change in the Teledermatology referral system. We are continuing to work with on the Lead Provider programme – successfully providing a mutual aid service to patients in Malvern and recruiting to 2 Plastic Surgery posts. We have also agreed the model for the Lead Provider programme going forward. In specialty medicine we have successfully recruited to a lead for our Echocardiology service with the new post holder due to start in October. The team have also been successful in securing NHSE funding for a Practice Facilitator working across Hereford and Worcestershire which will support future 'grow our own' future staffing. The Gastroenterology team have been successful in getting funding for a staff member to set up an early health screening for liver disease.

5. GEMs Board September 2024 - Winners from Quarter 1

Team of the Quarter – Quarter 1 – Pathology Team

Following the unexpected APEX issues that disrupted our operations from Friday, June 21, until functionality was restored on Tuesday, June 25, every member of the Pathology department demonstrated extraordinary commitment and resilience.

Despite the severe challenges posed by this outage, staff across all disciplines worked tirelessly. Many team members extended their working hours significantly, and some even cancelled their annual leave to ensure that WVT could continue to provide a safe and reliable service. The willingness of team members to change their weekend plans at the last minute and provide mutual support in order to maintain our essential services was truly inspiring.

Their dedication to patient care ensured the blood sciences laboratories maintained a 24-hour service, delivering essential pathology results without the use of our central laboratory IT system. Their quick actions preserved samples, reduced the need for repeat collections, and prioritized processing those with the highest clinical urgency, which did not go unnoticed by clinicians. The Pathology Teams collective effort ensured our services remained operational and patient care was maintained with minimal disruption.

The dedication, resilience, and unity displayed by the Pathology team during this challenging time has been truly inspiring. Their ability to rise above adversity and work together as one cohesive unit is a testament to their professionalism and unwavering commitment to excellence.

Employee of the Quarter – Quarter 1 – Laura Moss

Laura Moss is our Urology Patient Stratified Follow Up (PSFU) lead. PSFU is a remote monitoring program for cancer patients. The PSFU program gives patients more agency within their health care, in a safe and holistic way with signposting and guidance if they should need to access extra support. PSFU benefits the trust freeing up clinical time thus easing wait times and accessibility for patients who need to be in the service. There is a cost reduction for the Trust.

Laura has taken the lead on the implementation, liaising with a wide variety of stakeholders, admin teams, IT teams and patients to ensure the smooth implementation and delivery of this new service. She has coordinated the implementation of PSFU with 60+ urology patients now established on the program saving 40 hours of clinic time a year. As the project is ongoing we do not have the final cost reduction / time savings yet, but through her hard work and dedication Laura has made strides to supporting this excellent new service.

Glen Burley
Chief Executive Officer

Integrated Performance Report

July 2024

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

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

The adverse variance to our financial plan is £3.2m at month 4, driven primarily by under delivery of our cost and productivity improvement plan (CPIP), has triggered a financial recovery programme overseen by a financial recovery board. This met for the first time last week and will oversee progress against a number of cross organisational work streams.

Across the organisation managers and senior clinicians are required to focus on development and delivery of CPIP schemes in their areas of responsibility to improve budgetary management including reduced cost of delivery and increased productivity. Broader transformation work across emergency and elective pathways will work across specialties and divisions to reduce the demand for acute and community beds and increase elective income. Improving planned procurement savings and cost saving through digital benefits realisation will also feature. The focus on reducing the requirement for and costs of temporary staff particularly for nurses and doctors continues under the leadership of CNO and CMO and is showing encouraging signs in August. The business case on the agenda today to substantively fund the nursing requirement in ED will enable a reduction in temporary staff costs but also highlights the level of funding needed because the ED is over-crowded which with better flow would be unnecessary.

As part of understanding the opportunity for income in the second half of the year an 'H2 reset' exercise is being undertaken in September now that the elective surgical hub is up and running. This will identify if we can deliver further activity to reduce waiting times for patients and improve the financial position from elective recovery fund income. Both out patient and theatre productivity improvement are needed to maximise this. Currently OPD utilisation is near its 90% target but theatres utilisation is still below the 85% target, that said the increase of cases per list from 3.1 to 3.5 is encouraging.

Whilst there have been glimpses of traditional summer reductions in demand these have been fleeting and the approach to demand reduction and improved flow through the One Herefordshire partnership is critical to improvement as we move towards winter. New and expanded community integrated services are being launched in September /October as well as a focus on reducing admissions from care homes. The situation will be particularly acute for a month from September 9th when facilitating long overdue lifecycle maintenance will necessitate ED moving to current SDEC and OPD areas.

A historical gap in our critical care provision to provide a 24/7 outreach team has been authorised and will enable us to fulfil the requirement to implement Martha's law where patients or their relatives can request a second opinion which will be accessed through the critical care outreach team. Whilst this is at additional cost the potential to catch the deteriorating patient before they require the intensive care unit or shorten their ITU stay should recover the upfront cost.

Staff turnover has reduced a little further and is now at 9.5% although variable by department and staff group it is encouraging that we are retaining staff more successfully.

Our Quality & Safety – Executive Narrative

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Critical Care Peer Review Visit

The Midlands Adult Critical Care Network carried our a peer review of our services in June 2024. A number of immediate concerns were raised during the visit and the Trust has provided the required evidence and detail to mitigate those concerns. The issues related to the lack of a 24/7 critical care outreach service,

A comprehensive response was submitted in July 2024 detailing evidence and our plans to mitigate these issues. This included;

- Trust approved business case for critical care outreach service
- Trust quality priority and safety priority in relation to the deteriorating patient and data to demonstrate improvement related to this.
- Mortality processes and SHMI
- Governance arrangements for the Deteriorating Patient Committee and related work streams
- Research participation and audit data

There is a clear plan in place to implement Martha's Rule and this incorporates a number of the aspects raised by the network. The Deteriorating Patient Committee has oversight of progress of this plan and associated work streams.

The full report from the peer review was received by the Trust last week and the full report and associated response will be shared with Quality Committee in September.

Food Safety Improvement Summit

During Quality Engagement and Executive visits to a number of acute inpatient areas, the quality of food has been noted as a theme of concern. As a previous quality priority, and an area that frequently scores poorly in the national inpatient survey, a summit was convened to jointly discuss the concerns with Sodexo colleagues. There is a clear drive for improvement in the food service provision which was agreed to be a joint endeavour between clinical and non-clinical services to ensure patients receive the correct nutrition whilst in our care. A working group is being established to;

- Ensure the food service meets the needs of individual areas
- Identify improvements to the food service process in all areas
- Improve communication between clinical and non– clinical staff to ensure food provision meets individual patient needs
- Improve communication with patients to ensure their needs are met whilst in our care.
- Review the food monitoring processes to better identify issues for timely resolution

NHS Inpatient Survey

The national survey results were published on 21st August 2024. Progress against the standards is not progressing at the pace we would like or expect. The survey results and our quarterly patient experience report will be presented to Quality Committee and Board next month.

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

Latest SHMI Data:

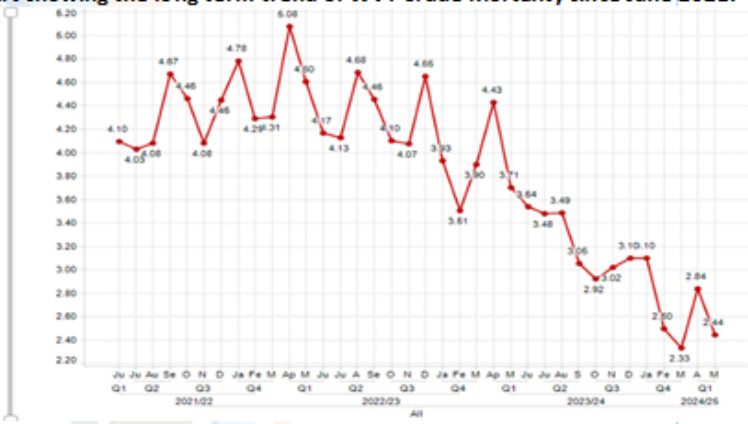
Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	March 2023 - February 2024	100.3	-1.8

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	May 2023 - April 2024	96.8	-0.2
SHMI (in hospital)			91.2	-0.3
SHMI (out-of-hospital SHMI)			109.8	-0.07

Outlier Group Update:

CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	May 2023 - April 2024	99.86	27.04	27	-1.07
Congestive Heart Failure		107.97	72.24	78	-3.77
Fractured Neck of Femur		131.62	32.67	43	8.51
Pneumonia		94.07	203.03	191	-4.79
Septicemia		121.87	105.03	128	3.70
Stroke (Acute Cerebrovascular Disease)		105.65	84.24	89	-6.42

A line chart showing the long term trend of WVT Crude Mortality since June 2021.



Monthly Headlines:

- Latest **SHMI** (*HES-based*) from May 2023 to April 2024 shows another reduction to **96.8** for Wye Valley NHS Trust, which now sits under the national average of 100 and continues a positive downward trend. The NHS Digital 12 month rolling SHMI (*March 2023 –February 2024*) reported at **100.3.**
- The latest SHMI (HES) data reports a generally positive month for our **mortality outlier groups** with many of our key areas reporting significant reductions.
  - ⇒ **Heart Failure** reported another monthly reduction with a further 3.7 drop to 107.9. This is part of much longer term change in the rates.
  - ⇒ **COPD** also reported a reduction of 4.3 this month and now sits under 100.
  - ⇒ **Pneumonia**, which is our biggest cohort of deaths, has reported a further significant reduction of 4.8, remaining at lower than expected mortality rates at 94.07.
  - ⇒ **#NOF**, there is continued work on developing and implementing a fast track pathway for our #NOF patients, which would entail ring fencing a dedicated bed on the trauma ward. Following the recent rises in our #NOF mortality, we have received an external outlier alert from HQIP, which will require an initial Trust response by the 30th August. The response will outline the steps and actions taken so far, along with our plan to address the concerns.
- **Crude mortality** rate for July 2024 was **1.04%** for all admissions, which includes both planned and unplanned admissions to the Trust, equating to 66 deaths. This is a marked drop in comparison to previous months, which average around 80. Please note that this does not include any deaths occurring in the Emergency Department deaths.
- During July, 100% of hospital site deaths received a **Medical Examiner** review, with 9 cases escalated for further review. In addition, there were a further 45 cases reviewed by the service from the community or home setting, which equates to approximately 50% of all community deaths. The service has been working with Primary Care over the past few months, which has allowed the team to streamline and refine the new community death certification process for their area.
- **Extended perinatal mortality** and **Stillbirth** mortality rates remain at 'lower than the expected' levels with the latest data (*July 2023 – June 2024*) both reporting rates are at **2.39 deaths** per 1000 live births. This remains on track to achieve the national ambition by the end of 2024.

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.; **Inpatient falls in patients with dementia, delirium or a known high risk of falls.** In addition a risk has been identified with the incorrect use of bed rails linked to falls with moderate or above harm. A recent deep dive audit into falls incidents and the quarterly assurance audit are highlighted below with the actions planned to mitigate this risk. This issue was also highlighted in a recent Regulation 28 notice from the coroner where a fall involved bed rails contributed to the patient death.

Data– Compliance with bed rails assessments and bed rails position

Community hospitals- Bed space audit results		
	February 2024	July 2024
Completion of risk assessments	76%	93%
Compliant bed rail position	88%	97%

Acute wards- Bed space audit results		
	February 2024	July 2024
Completion of risk assessments	66%	93%
Compliant bed rail position	90%	95%

Deep dive falls relating to use of bed rails audit

The audit reviewed all falls between November 2023 and July 2024. The findings of the audit were presented to the Patient Safety Committee in August.

- 160 falls incidents relating to use of bed rails were reported (129 acute, 31 community hospitals); 85 no harm, 69 low harm, 3 moderate, 1 severe and 1 death
- 130 (81%) were unwitnessed falls
- 151 (94%) had a falls risk assessment completed prior to the fall
- 135 (84%) bed rails were in the correct assessed position at the time of the fall
- Where bed rails were not in the correct assessed position (25); 13 cases the bed rails were raised, 8 cases the bed rails were down and in 4 cases position is not documented.

What the data tells us:

- The bed space audit data tells us that there is an improvement with the completion of risk assessments and compliance with bed rails position in both acute and community inpatient settings.
- The deep dive audit tells us that there are a small proportion of falls where the bed rails were not in the correct assessed position. However it is more common in these cases that the bed rails are raised. This presents a higher risk of harm should be patient fall from their bed.

Key Actions:

- Improved communication of patient falls risk and bed rail position on nursing handover sheet and verbally communicated between shift/staff changes
- Bed rails posters for all bed spaces
- Improvement project in place to secure rails in the lowered position and only to be removed by a registered nurse if the assessment indicates their use (if not the bed rails will remain in a secured position—meaning they cannot be inadvertently used)
- Digital nurse noting improvements aligning supervision/enhanced care assessments and bed rails assessments into one place for ease of use and to avoid duplication

Quality and Safety – Staffing

Fill Rate and CHPPD Data

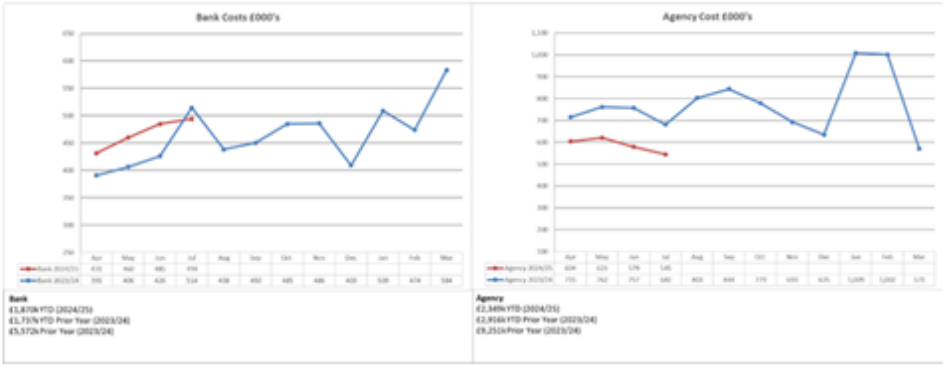
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	101%	89%	98%	95%	16.6
Maternity Ward	81%	81%	77%	90%	6.0
Children's Ward	115%	92%	82%	73%	18.1
Lugg Ward	105%	106%	102%	125%	7.2
Wye Ward	122%	72%	117%	93%	7.2
Cardiac Care Unit	100%	90%	100%	93%	11.8
Leominster Community Hospital	155%	100%	100%	164%	6.9
Bromyard Community Hospital	127%	142%	111%	171%	8.3
Ross Community Hospital	98%	105%	100%	113%	7.1
Teme Ward	140%	60%	100%	48%	11.9
Redbrook Ward	99%	114%	101%	103%	5.0
Special Baby Care Unit	78%	-	97%	-	15.9
Intensive Care Unit	110%	-	89%	-	25.2
Gilwern Ward	100%	114%	98%	120%	16.6
Acute Medical Unit	129%	78%	97%	114%	7.7
Ashgrove Ward	105%	89%	100%	113%	6.9
Dinmore Ward	124%	81%	100%	99%	6.7
Garway Ward	129%	82%	99%	116%	6.8
Frome Ward	124%	84%	99%	103%	6.6
Arrow Ward	150%	73%	147%	87%	7.9
Women's Health	119%	79%	100%	-	9.6

The NHSE staffing return is detailed above. This has been updated to reflect investments and changes to establishments for some of our wards. The fill rates are better aligned than in previous months.

In many instances where the RN fill rate is over 100% and the HCA is lower, this relates to the backfill of nursing associate roles with registered nurses where it is deemed clinically necessary to do so.

The excessive fill rates for Leominster and Bromyard community hospital relate to the additional staff required for the additional beds.

Arrow ward have had a high number of patients receiving non invasive ventilation.



Month 4 has seen the lowest level of agency spend this financial year. The agency master vend provider introduced a rate card reduction during July. The rate card reduction, reduced agency demand and the cessation of off framework agency use have all contributed to the improved position.

Despite the improving trajectory we remain off track in the delivery of our 4million cost productivity improvement target. To recover this position requires the trust to spend no more than 375k per month for the remainder of the year. This will be particularly challenging as we enter the winter period.

NHS England requested that the use of all non-framework agency to stop by July 2024 other than in exceptional circumstances. As can be seen in the chart above reliance has reduced significantly since January 2024 and during month 4 (July) only 3 off framework shifts were booked.

Our Performance – Executive Narrative

Andy Parker

Chief Operating Officer

Despite the summer months our Emergency Department still remains congested and we continue to have patients boarding on our wards in unconventional care beds / spaces. As we count down to the traditional winter period faced by the NHS there remains a significant focus to improve our in order to manage the inevitable increased pressure we will face.

In recent weeks we have seen periods where we have managed to reduce high numbers of additional patients on our wards, along with reduced use of corridor care in ED. Even so we saw continued high levels of ED Type 1 attendances, 300 more than December 2023 and 350 more than January 2024, and Ambulance conveyances at consistent levels since the Winter months.

Although our 4 hour Emergency Access Standard for admitted patients, on our Urgent and Emergency Care [UEC] pathways, shows marginal improvements we continue to provide excellent performance for minor and paediatrics patients and, overall, our ability to see patients and start their treatment in our ED remains one of the best in the Midlands Region.

Within our ED we have had the summary from NHS England's Missed Opportunities Audit, which was undertaken on a Tuesday post a Bank Holiday weekend and when our ED and UEC pathways were under significant pressure. Pleasingly the majority of recommendations from the audit showed that all the areas of improvement are being covered under our UEC Valuing Patients' Time Agenda, including ambulance conveyances that should have been managed in the community, strengthening our Same Day Emergency Care pathways through improved referral processes and developing clearer pathways, and awareness and training of staff, on access to community services to reduce unnecessary attendances and admissions.

This work will be followed up in August and September with a Criteria to Admit audit to understand some of the drivers that have seen an increase in the number of >0 day length of stay emergency admissions.

September will be a challenging month for the Trust's UEC patient flow, and our ED team, as we undertake a "decant" of our ED majors areas which requires various ED functions, including minors, paediatric ED, Same Day Emergency Care [SDEC] areas, to be re-provided in other estates whilst essential cleaning, maintenance and lifecycle works are undertaken across our ED. Our Operational teams have been working through the mitigation plans, including discussions and awareness across Herefordshire/Powys partners and the wider Integrated Care System including the Integrated Care Board.

Our wider plans are progressing with system partners around Discharge to Access [D2A] ahead of the Winter.

Improvement actions continue to progress around the operational, commissioning and financial elements of D2A. The system continues to see a reduction in delays , particularly around Discharge Pathway 1 patients. This has been delivered due to all system partners addressing issues around:

- Pre discharge assessment
- Maximising capacity in P1 service
- Improvements around commissioning to strengthen the market and prevent overstaying patients. The focus is now looking at length of stay across all providers and pathways

On the 8th July our Elective Surgical Hub [ESH] became operational. This gave us two additional Theatres and a Cataract Theatre which meant we were able to stop the use of our temporary Vanguard Theatre.

During July our teams have been becoming accustomed to the new ESH environment, but the early signs are that we have already seen an increase in the number of cases treated in Theatres by almost 150 cases compared to June and 190 more cases than July 2023, along with an increase in the number of cases per list.

With the "Go Live" of the ESH we have been undertaking maintenance across our Main Theatre Suite and therefore we have had one Theatre unavailable to use from the 8th July until the 6th September.

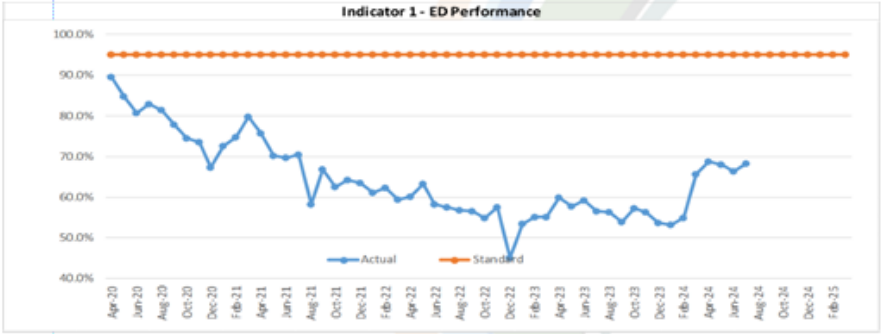
Now we have increased our operating capacity we need to ensure that our Theatres and elective efficiency deliver a *direct and material impact* on making the very best use of the resources we have. By increasing our activity further we have a beneficial impact on meeting waiting list targets within the core funded capacity we have available.

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



% Admissions treated on a Same Day Emergency Care [SDEC] Pathway

% Patients Spending More Than 12 Hours In ED

Performance and Actions

- 6,286 Type 1 patients attended ED in July. The range of all attendances varied from 182 to 238 with 200 being the average daily attendances. Average daily Type 1 ED attendances in June 2024 was 203.
- 1,740 ambulances conveyed to the Trust in month. The same volume as December 2023. The range in month was 40 to 69. This includes 11% from Powys [175]. An increase of over 130 conveyance compared with last month.
- Ambulance handover delays over 1hr were 16.2% [282] of all conveyances and 66% [992] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,175 of all admissions [46% of all admissions] via a Same Day pathway within no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard ranks 50/128 Type 1 Trust in England

Our Valuing Patients Time Programme Board [VPTB] has oversight of the current UEC improvement schemes:

- ED Processes improvement. Continued focus on streaming at the Front Door through Senior Nurse Navigation. Steady improvement in the number of patients being streamed to Primary Care out of hours services along with internal streaming to minor illness and minor injuries pathways.
- Our improvements in our minors and urgent care pathways through the use of a General Practitioner [GP] during weekdays has seen c400 patients treated via pathway in July with almost 90% being discharge home within 4 hours.
- Transformation team support in reviewing our SDEC pathways and processes. Key to success is the Navigation and Streaming criteria and the ability of ED. Community Services and Paramedics to refer directly to all our SDEC areas without the constraint of physical capacity.

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.
- System patient flow constraints due to workforce and capacity.

What the chart tells us:

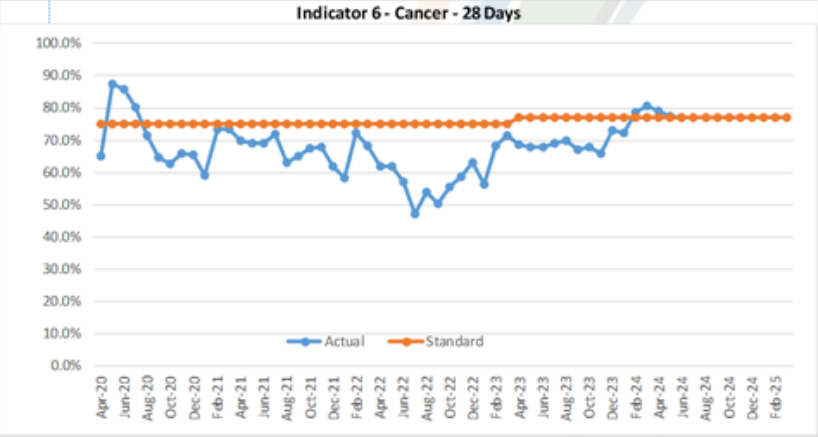
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
April 4 hour Emergency Access Standard [EAS] Performance was 68.3%

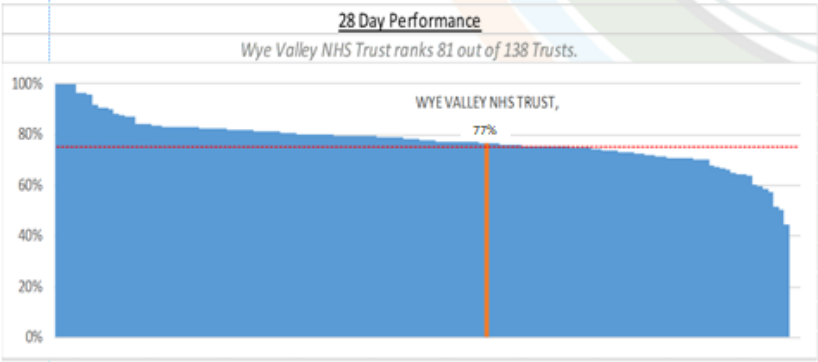
Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [June 24]

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





Performance and Actions

Referrals:

- Cancer referrals remain high with a 27.8% increase compared with 3 years ago which equates an additional 2623 patients.
- Recent FIT audit has shown improved quality of lower GI referrals and the enforcement of FIT results as part of the referral has seen a 13.6% reduction in Urgent Suspected Cancer (USC) referrals.

Main Issues impacting on 28 day performance and actions:

- Challenges remain within Gynaecology services due to administrative delays caused by workforce shortages. A working group is actively seeking solutions to mitigate these delays including applying for funding to improve backlog typing. Further improvement is expected with the implementation of the Post Menopausal Bleeding (PMB) Pathway, in Quarter 3, reducing the number of referrals from primary care to the Trust, as previously reported.
- The position of the navigator posts being fixed term has led to the team being further reduced, from 3 to 2 (reduction form 6 in January). A business justification to create 4 substantive roles is due to be presented at Trust Management Board following confirmation of financial position in relation to Cancer Alliance funding.

Improvements:

- 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.
- There have been process improvements implemented, following data submission issues in April and May, meaning greater oversight within the cancer services team, Divisional Management Teams and Business Intelligent leadership over our National submissions.
- The Non-Specific symptoms (NSS) pathway went live in May, with a referral being received on the first day. Work is continuing to improve referral rates which should see a reduction in inappropriate referrals to site specific pathways, improving specialties capacity for managing their current demand.

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:

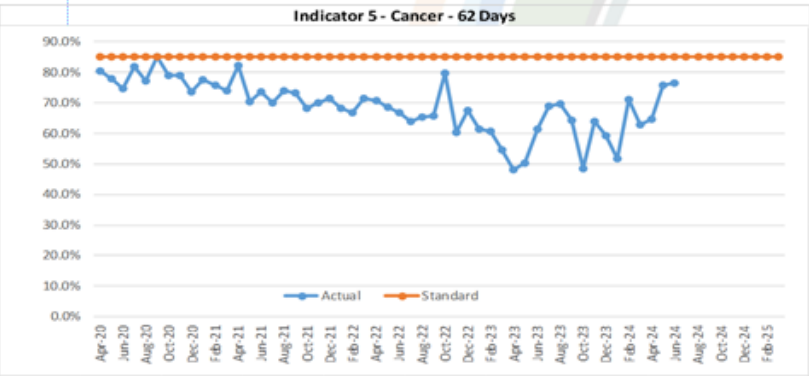
- 28 Day faster diagnosis = Performance against this target was 77% and remained below the target of 75% and below our trajectory for the month

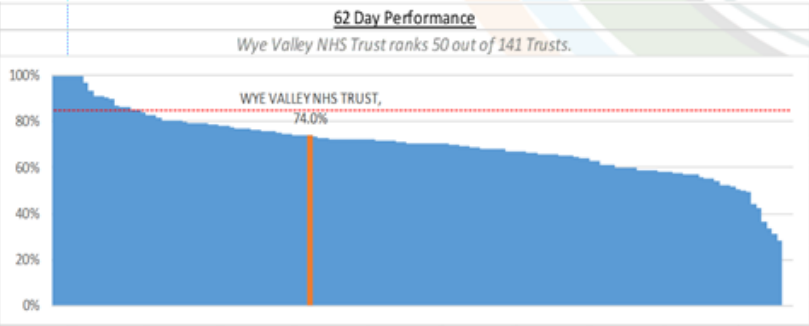
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [June 24]

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 June, the Trust's compliance with the 62-day cancer referral target of 85% was 77%, with 23 patient breaches. Breaches are being contributed to by the delays facing the 28 day target in particular specialties. Performance has improved over the past two months, with the expectation this will continue.
- With regards to the Trusts cancer backlog position, in June we maintained a strong position, averaging 57 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 continue to complete deep dives to understand the challenges.

Key Actions:

- The use of text messaging to reassure patients of benign results is in the process of going through governance, aiming for implementation at the end of August.
- Continue to work with teams regarding our escalation tool to ensure targets are met inline with Best practice timed pathway
- Best practice timed pathway dashboards developments are nearing completion. When live, the dashboards will show Wye Valley Performance in relation to targets set, and highlight bottlenecks impacting performance for specialties.
- Deep dives focussing on specialties struggling to meet performance targets to understand issues and develop actions plans.

Improvements:

- Two consultant histopathologists have been appointed and started in July 2024.

Risks:

- Gynaecology and Lung first outpatient appointments earlier in the pathway impacting on 62days treatment standard
- Contractual issues with Gloucestershire Hospitals NHS Trust mean we are unable to deliver robotic prostate surgery at WVT currently. This is being escalated and discussed at COO and Head of Contracting Level in September.

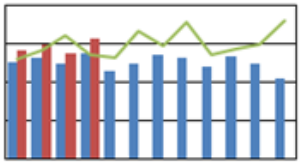
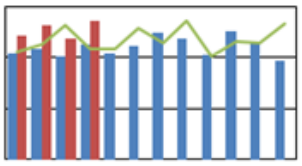
What the charts tells us:

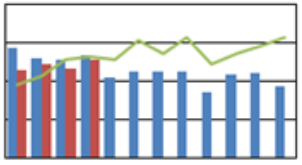
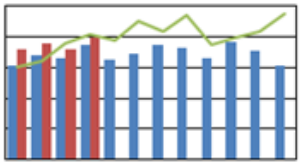
- 62 day Treatment standard = The Trust performance was 76.6% against a target of 85%.

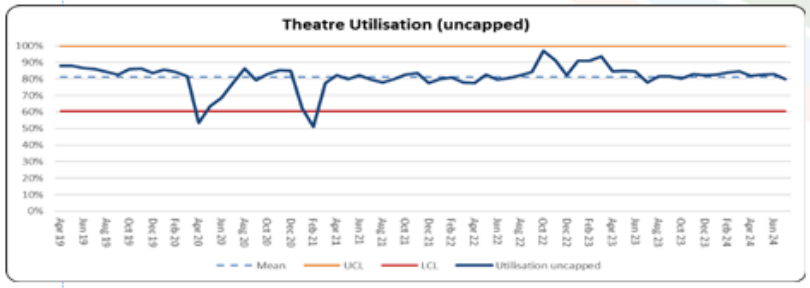
Operational Performance – Referral to Treatment Performance / Activity / Productivity

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	Charts
New	2019/20	20755	
	Plan This Year	22732	
	This Year	23459	
	Diff vs 19/20	2704	
	Variance	13%	
	Diff vs Plan	727	
	Variance	3%	
Follow Up	2019/20	42781	
	Plan This Year	45997	
	This Year	50850	
	Diff vs 19/20	8069	
	Variance	19%	
	Diff vs Plan	4853	
	Variance	11%	

Admissions		Year To Date	Charts
Elective Inpatient	2019/20	1073	
	Plan This Year	927	
	This Year	962	
	Diff vs 19/20	-111	
	Variance	-10%	
	Diff vs Plan	35	
	Variance	4%	
Elective Daycase	2019/20	6757	
	Plan This Year	7037	
	This Year	7484	
	Diff vs 19/20	727	
	Variance	11%	
	Diff vs Plan	447	
	Variance	6%	



Performance and Actions

Activity Summary:

- New Outpatients [OP] Year to Date [YTD] activity was 1% below plan
- 44.1% of OP were either new or a follow-up patients with a procedure. A slightly improved position on the first three months of the year.
- Elective inpatient was 4% above plan YTD / Elective Day Cases was 6 above plan YTD at the end of July 24.

Long Waiting Patients:

- 9 English patients and 5 Welsh patients were waiting greater than 78 weeks at the end of July 24.
- 65 week position at the end of July was 133 English and 45 Welsh patients.
- 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 325 at the end of July. A reduction in c1675 patients.
- Our current prediction for the end of September is that we will have 50 English 65 week waits and 10 Welsh patients with 3 English patients waiting greater than 78 weeks awaiting Cornea Tissue replacement. The biggest risk areas remain with Orthopaedics and Ophthalmology. We continue to manage our Theatre capacity dynamically to increase capacity for high risk specialities, mutual aid across the Region and Foundation Group and use of the Integrated Care Boards [ICB] contracts with Independence Providers in order to reduce the number of long waiting patients further.

Productivity

- Focus continues on patients who Did Not Arrive [DNAs], with deep dives and plans to utilise volunteers for phoning patients most likely to DNA. Patient Initiated Follow Ups [PIFU] is expected to increase in a number of key specialities in the autumn with changes to MAXIMs to make it easier for clinicians to use. 6-4-2 room scheduling has continued to embed across our Outpatient settings and benefits already seen in regard to room utilisation
- Theatre utilisation 76.9% in July, a fall on 79.7% in June . This was mainly driven by acclimatisation of the new Elective Surgical Hub by the new clinical teams getting familiar with their new environment. However, average cases per list has increased to 3.5 for July, up from 12 month average of 3.1.
- The number of elective cases completed in July has also increase in line with the opening of the Elective Surgical Hub from 746 in June to 880 in July.

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.

What the chart tells us:

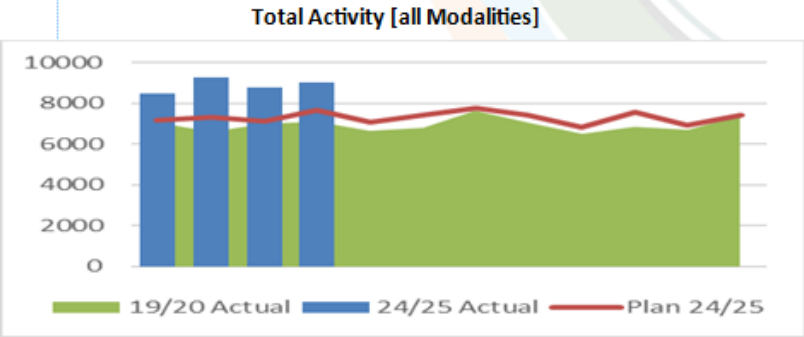
- Performance against English RTT standards in July was 55.7% / Performance against the Welsh RRT standards in July was 70.3%

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. For 2024/25 the Trust aims to achieve 95% of patients waiting less than 6 week for a Diagnostoic test by March 2025.

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 118% of July`s Activity plan and 128% of the same month 2019/20:

Imaging:

- Magnetic Resonance Imaging [MRI] achieved 156% of 2019/20, 115% of 2024/25 plan activity last month (146% and 119% respectively month prior).
- Computerized Tomography [CT] achieved 142% of 2019/20 and 104% of 2024/25 plan activity last month (155% and 129% respectively month prior).
- Non-Obstetric Ultrasound [NOUS] achieved 121% of 2019/20 and 122% of 2024/25 plan activity last month.
- Overall Imaging`s 6 week wait position at end of month was 82% compared to 84% month prior, driven by MRI contrast waits, now resolved. Currently zero CT waiting >13 weeks. MRI >13 week waits had increased in month 4 but have reduced with capacity plan in place, with trajectory of zero by end of month 5.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] were 10 and 9 days respectively.
- Average report turnaround times for MRI prostate and CTC were 4 and 5 days respectively.

Audiology:

- Audiology 6 week wait position improved significantly in month four to 94% in adult services, whilst paediatrics was 33%.
- Audiology patients waiting >13 weeks (driven by paeds) were an average of 57 in July compared to 52 the month prior. Three additional double up clinics are scheduled in August, increasing throughput. .

Echocardiography [Echos]:

- During 2024/25 we have seen a 10% increase on outpatient referrals and 12% increase on inpatient referrals. Agreed actions driving forward to support managing demand within the service and cardiology department.
- Additional insourcing commenced, average increase of 50 patients seen per week. July and August will have been impacted due to peak holiday time reducing core capacity and impacting the average increase in overall activity levels. We will also undertake an audit of insourcing clinics to ensure fully utilised and review DNA rates since commencing.
- Operational trajectory aims to clear patients waiting greater than 13 weeks cleared by the end of September and 6 week backlog cleared by the end of November.

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 July 70% of patients waiting less than 6 weeks for a diagnostic test. Deterioration from February 2024 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. 8% of patients were waiting greater than 13 weeks.

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

1 Page summary of key points

WVT will be part of a national study working with researchers from Kings College London to explore actions to reduce sickness absence in the NHS following a recent paper by the Nuffield Trust noting a rise in the number of days NHS staff were taking off work due to illness. Absence is 29% higher in the NHS than in 2019 with anxiety, stress and depression making up a quarter of the cases (25.5%).

The national position is reflected at WVT with sickness absence standing at 5.1% with mental health conditions being the largest reason for sickness absence over the past year. By participating in this study we will be able to review and acquire best practice methods in other to enhance our ongoing efforts in supporting staff to reduce sickness absence.

Staff turnover now stands at 9.5% 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 below 10%. Turnover for qualified nurses & midwives now stands at 7.26%. Staff turnover for band 2/3 hcsw staff has reduced from 14.94% to 14.10% and this is expected to reduce further as we have restarted the centralised recruitment process. Areas with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments.

In our efforts to contribute towards a more inclusive and tolerant society following recent riots, we have encouraged executive directors and senior managers to sign up to the NHS Inclusive Leadership pledge and take actions to promote good relations in their areas of influence, internally and externally. We also promoted and supported South Asian Heritage month at the Trust as part of our EDI programme.

We are still awaiting information from NHS Employers on when the new pay rates for 2024/25 are to be paid backdated to April 2024.

Our workforce opportunities working group is in place with HR, finance and service managers working closely together on potential costs reductions and enhanced productivity in back office areas over the coming year.

We have now terminated many local pay rates that have been in place over a number of years and reverted back to Agenda for Change pay rates as part of the efficiency savings drive for the Trust. Work continues with the Chief Medical Officer in reviewing and terminating long standing local arrangements for medical staff.

Discussions are taking place with the University of Worcester to run a first all day careers development event with career clinics for staff at the County Hospital site. This will highlight and promote opportunities for staff development using the apprenticeship levy and other NHS related CPD funds. Plans are being discussed for this to be an annual event for WVT staff in view of our ambition to grow and develop our employees.

Through concerted efforts and discussions with line managers over the past 3 months, we have seen a significant increase in the % of completed performance appraisals across the Trust to 80.2%. Mandatory training stands at 89.7% and this will continue to be reviewed at F&PE meetings

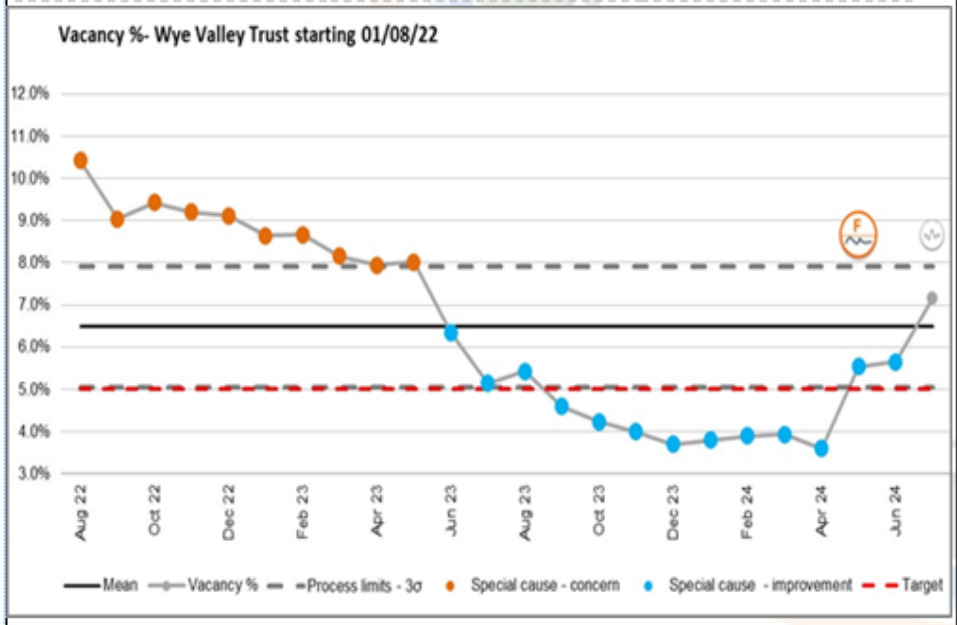
Our Workforce – Vacancy

We are driving this measure because:

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

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
5.1%	5.4%	4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	7.1%

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 with HR led fortnightly review meetings in place to ensure all avenues for recruitment including using international recruitment agencies are being pursued .Any delays in the process are being addressed with the appropriate service leaders.

The new monthly staff movement/budget report is now in place with HR and finance officers tracking and reporting on all staff movements to ensure they are appropriate and within agreed budgets .

HCSW - the centralised recruitment process for healthcare support workers is now back in place with regular interviews conducted by HR and divisional managers. We have reduced vacancies from 60 to 25 with offers made over the past month. New starters are being fast tracked with risk assessments in place to close the gaps.

Nurses - we are on target for our international recruitment nurse programme as since April we have welcomed 35 new nurses into the trust. By March 2025, 77 new nurses will have joined the Trust reducing our reliance on agency staff.

Surgical Elective Hub - we recruited and welcomed 32 new theatre nurses/ODPs to support the new hub. .

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

Pharmacy - through a combination of international recruitment and recruitment & retention incentives the vacancy rate is reducing and this is anticipated to fall to around 10% by December 2024 from a high of 52%..

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 were successful in ensuring all gaps for doctors in training were filled prior to the main change over of doctors in August.

Risks: Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us:

The rolling 12 month position remains fairly consistent, with a large improvement at the beginning of the 23/24 financial year down to a decrease in substantive budget along with an increase in staff in post which has continued for the first 10 months of the year, with a slight increase in the last 2 months of 23/24. Decreasing again in April 24, before an increase in May 24 due to an increase in substantive budget and reduction in staff in post, a further slight Increase in June 24 and an increase in July 24 mainly due to an increase in substantive budget related to the elective surgical hub.

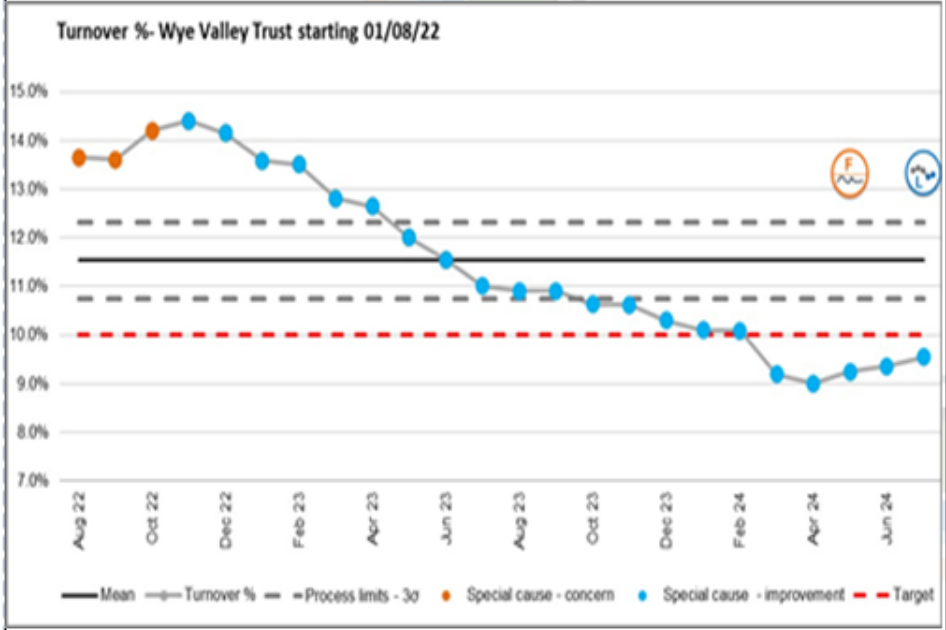
Our Workforce – Turnover

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.

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
11.0%	10.9%	10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	9.2%	9.0%	9.2%	9.4%	9.5%

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

The overall rolling 12 month turnover at Trust level is at 9.5% for August 2023 to July 2024, with an average for the previous 12 month's turnover being 10.0%.

Clinical support workers at band 2/3 level continue to have the highest turnover rate at the Trust. We have restarted the central recruitment process to ensure that vacancies can be kept at below 20 on an ongoing basis. Active recruitment and fast tracking new starters has reduced turnover from 14.94% to 14.10% and we are on track to reduce this further over the next 3 months.

Turnover rates for qualified nurses at band 5 level remains steady at 7.26% and there are no major areas of concern. We will have 77 new international nurses at the Trust by April 2025 and this will reduce our reliance on agency and temporary staff.

All divisions have local recruitment & retention working groups 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 is overseeing exit interview surveys and recruitment & retention areas of concern to ensure actions are being progressed in a timely manner to aid recruitment & retention of staff across the trust.

The Trust continues to be actively engaged in ICS wide workforce recruitment & retention events. We are also working in partnership with the DWP/Jobcentre plus officers in filling our support and admin related vacancies.

Risks: Growing staff turnover

What the chart tells us:

The rolling 12 month position shows an improved position over the past few months.

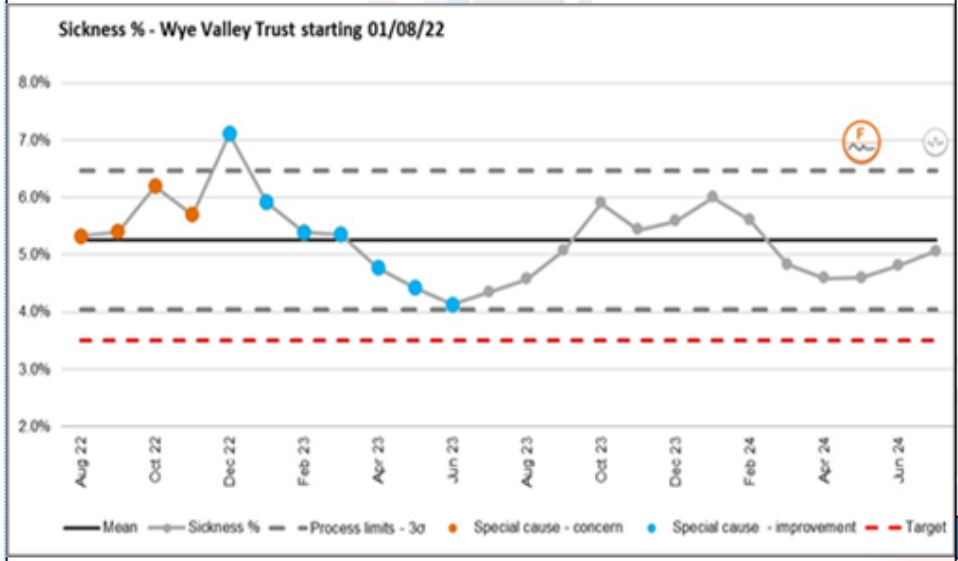
Our Workforce – Sickness

We are driving this measure because:

Due to increased scrutiny and higher levels following the pandemic, we are aiming to reduce absence so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staffing / agency staff.

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

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

During this month, overall sickness at Trust level has increased to 5.1%, and the main reasons for absence are colds/winter ailments, mental health issues, msk and long term conditions. WVT will be part of an NHS wide study (Kings College London) looking at sickness absence over the next 6 to 12 months as there has been an increase in absence NHS wide since the covid pandemic.

At F&PE meetings, divisions with high sickness absence have been asked to focus on departments and staff groups with high absence and present deep dive reports outlining actions being taken to reduce absence in accordance with the absence policy.

HR teams will support divisions in ensuring compliance with the absence policy and ensure that appropriate sanctions and support are in place for those above the trigger points. Considerable work continues to be done to promote health & wellbeing at WVT and the wide range of health & wellbeing initiatives (Hereford & Worcestershire recovery college, 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.

Risks:

What the chart tells us:

The rolling 12 month position shows an increase in the first 6 months of the period, with a fluctuating pattern following due to winter pressures and an increase of mental health and flu cases. The was a reduction in the last quarter of the financial year, which has remained consistent for the first 2 months of this year, increasing slightly in months 3 and 4.

Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Month 4 Income and Expenditure position

Overall Month 4 has resulted in a YTD adverse variance of £3.2m against the revised deficit plan, largely driven by an underperforming CPIP programme.

The Month 4 position resulted in an overall YTD deficit of £15.1m. This was behind the current planned deficit of £11.9m, with an overall adverse variance of £3.2m. Whilst the large challenge facing the organisation is recognised, we have yet to see the step up in both delivery of CPIP and a reduction in run rate spend, which is required across the Trust in order to achieve the plan. Significant focus through Finance and Performance Executives is targeting delivery of existing plans and identification of mitigations. Further enhanced measures are being introduced.

At Month 4 there were overspends against planned pay costs of £1.5m, (a deterioration of £0.6m in month), non-pay £1.6m (a deterioration of £0.6m in month) and excluded drugs of £0.6m. These were partially offset by additional income of £1.1m, achieved through an over performance in ERF and contractual gains. The primary reason for the overall overspend relates to the under delivery of CPIP (£2.7m YTD). The majority of the variance relates to planned CPIP schemes that are still in the opportunity phase, requiring further action to result in deliverable schemes. There is also a £0.7m adverse variance YTD driven by a technical adjustment to the control total for historical accounting changes on PFI.

The Trust continues to forecast the exit 2024/25 position to be on plan, acknowledging there are known risks as well as mitigations. The forecast includes currently unmitigated risks relating to the unidentified element of CPIP, £2m relating to the technical PFI adjustment and £6m of out of system income risk. Therefore it is even more critical we continue to monitor and reduce our spend and deliver on our plans.

Capital

The capital available to the Trust was reduced by £0.6m to reflect a CDEL reduction due to the planned deficit. Savings on the Elective Surgical Hub (ESH) scheme have partially mitigated this reducing the over-commitment to £0.3m which is being addressed via our Capital Planning and Equipment Committee. The restrained capital position continues to require close management and difficult decision making to balance risk within the limited funding available. To date we have invested £5.2m of capital spend.

Cash

Cash remains a risk which continues to be closely managed. If the adverse variance isn't rectified this will become a real risk to the Trusts ability to pay suppliers on time. The process to access cash is still evolving with the focus being on System solutions. Due to close cash management, support is no longer forecast for Q2 but is expected to be needed in Q3. It is more difficult to access additional cash support where the requirement is driven by being off-plan.

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 4 - 31st July 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	291,512	94,436	95,616	1,180	823
Excluded Drugs	12,801	4,267	4,450	183	(72)
Non Contracted Activity (NCA's)	1,714	571	607	35	(3)
Other Income for Patient Care	9,911	3,809	3,542	(267)	(346)
Donations For Non Current Assets	4,168	3,074	3,074	(0)	0
Other Non Patient Income	7,248	2,468	2,405	(63)	(48)
COVID Funding	0	0	0	0	0
6.3% Superannuation	0	0	0	0	(194)
Total Operating Income	**327,354**	**108,626**	**109,694**	**1,068**	**160**
Pay Expenditure	215,552	71,287	72,831	(1,543)	(570)
Non Pay Expenditure	90,740	29,659	31,218	(1,558)	(630)
Excluded Drugs	23,934	7,978	8,574	(596)	(163)
Total Operating Expenditure	**330,226**	**108,924**	**112,622**	**(3,697)**	**(1,363)**
EBITDA	**(2,872)**	**(298)**	**(2,928)**	**(2,629)**	**(1,203)**
Depreciation	14,130	4,757	4,663	94	39
Gain or loss on asset disposal	5,141	0	0	0	0
Interest Receivable	1,116	649	649	(0)	(0)
Interest Payable on Loans	262	87	60	27	8
Interest Payable on PFI	1,993	664	664	0	0
Dividends on PDC	4,244	1,288	1,288	0	0
Operating Surplus/ (Deficit)	**(27,526)**	**(6,445)**	**(8,954)**	**(2,508)**	**(1,156)**
Donated Assets Adjustment	3,335	2,797	2,796	(1)	0
Net impact of asset impairments	(5,141)	0	0	0	0
IFRS16 2425 PFI re-measurement adjustment	(2,490)	0	0	761	708
Impact of IFRS16 Implementation of PFI Contract	8,214	2,607	3,368	0	0
Adj. financial performance retained Surplus/ (Deficit)	**(31,443)**	**(11,922)**	**(15,118)**	**(3,196)**	**(1,864)**

Performance and Actions

The position at the end of Month 4 (July) was a deficit of £15.1m. This was behind the current plan with an overall adverse variance of £3.2m.

- Income shows a positive variance of £1.0m. Within this, £0.7m is in relation to ERF over performance, £0.2m for excluded drugs/devices, £0.4m contract income gains, offset by (£0.3m) other risk.
- Pay was overspent overall due to high use of temporary staffing, undelivered CPIP and Divisional WLI usage, this has been partially offset by some slippage on recruitment linked to capacity and unfilled vacancies. The net position includes agency — 6.40% of total pay costs in month which is a slight increase from 5.5% in the previous month. Medical bank use at premium rates further increases this to 12.15% of overall pay, driven by volume and price.
- Non Pay overspend of £1.6m YTD largely due to undelivered CPIP, increasing MSSE spends, Clinical Services contracts, excluded Drugs and phasing of Private Sector usage. Some of this overspend is partially offset by the additional ERF income.
- PFI £0.7m adverse variance driven by a technical adjustment to the control total for historical accounting changes on PFI

In additional there are significant income risks later in the year, including £5m of Welsh income.

Risks:

Key Financial risks

- Stretch target (£1.2m CPIP not delivered).
- CPIP Cost Efficiency delivery recurrently
- Level of Agency (as % of pay)
- Income includes £500k from the ICB for diagnostics and £150k for ERF from 23/24 which are yet to be agree and received
- Change in performance adjustment regarding PFI accounting

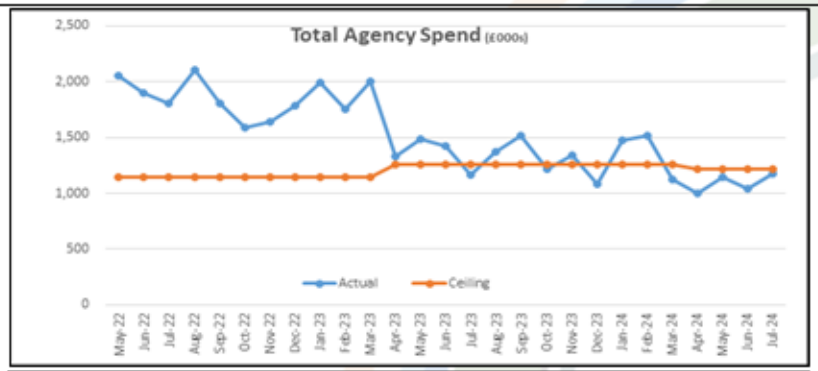
What the chart tells us:

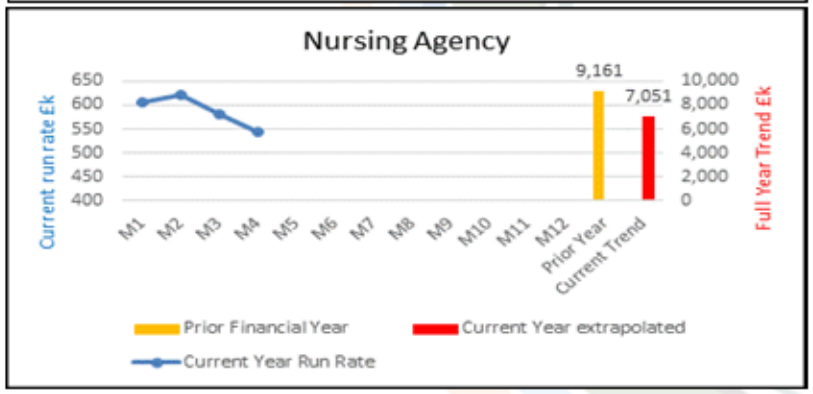
Known financial risks are putting greater pressure on delivery of our planned financial position.

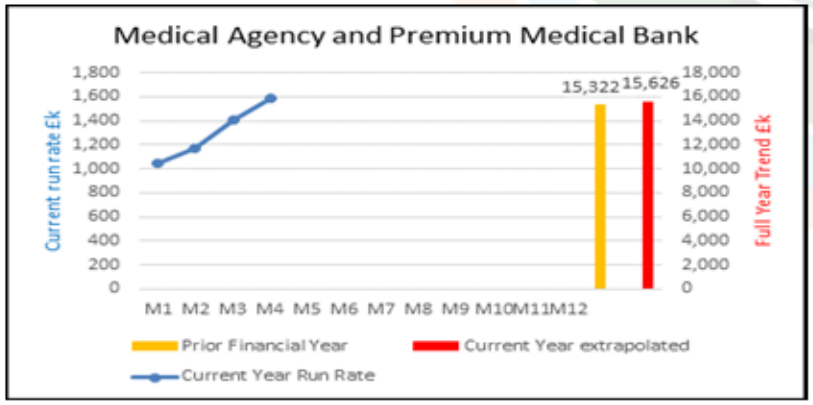
Our Finance – Agency Spend

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 6.4% of total pay costs year to date, 3.2% above the national target of 3.2%. There is still a considerable way to achieve a sustainable baseline trend. Total agency spend year to date (excluding premium cost medical bank) is £4.3m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** The trend shows a reduction in spend annually, as well as month on month, with increased control actions delivered through NARP. YTD spend extrapolated to full year would result in a projected full year spend of £7.1m. The Trust's target spend for the year, including the NARP target, is £5m. Approved rate changes initiated throughout the Trust from July 24, should further reduce nursing agency spend, other plans are also in place to further improve the trend. The Trust spent £14.0m on nurse agency in 2223 which reduced in 2324 to £9.2m which was more in line with 2122.
- **Off framework Nurse Agency** - there has been a significant reduction in off framework use with only 3 shifts booked in July, and a total of 36 shifts YTD. This is a significant reduction on the 2324 booking level.
- **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, with 2425 target spend being £11m. The current trend for 2425 is £15.6m demonstrating that more work is needed to address the increased spend trend.

Risks:

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

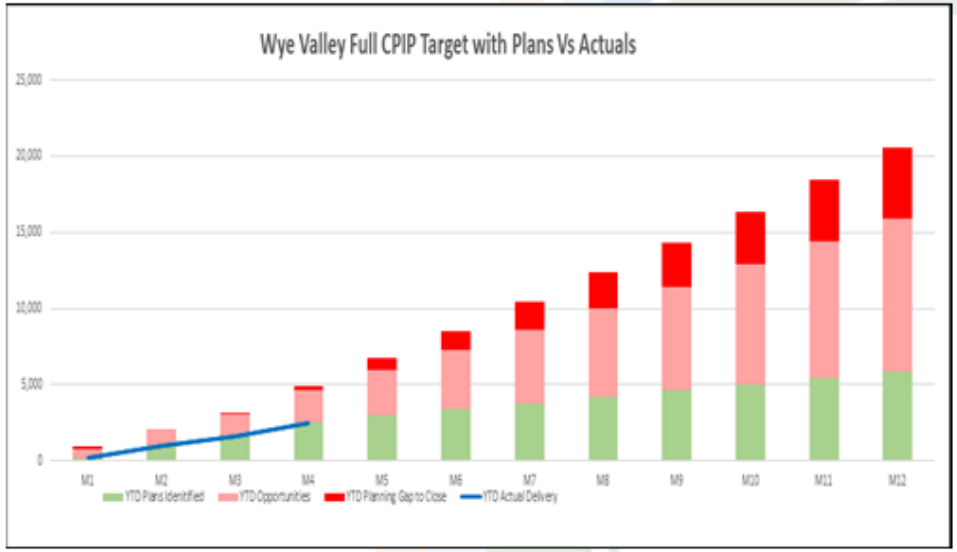
What the chart tells us:

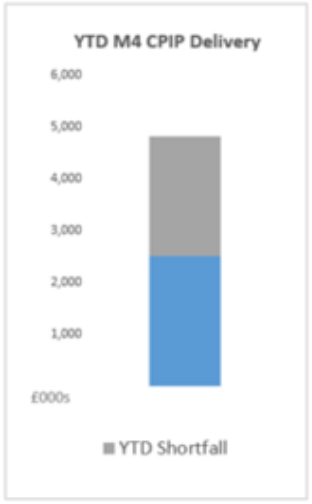
Although there is good progress in targeted areas, agency (and premium medical bank) use remains at an unsustainable level and poses a threat to achievement of the plan.

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 NR items, and of which we are targeting a £8.0m agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

The current position on CPIP delivery YTD reflects a plan of £5.2m with a Trust delivery of £2.5m resulting in a £2.7m variance to plan.

The majority of the variance relates to planned schemes that are still in the opportunity phase, requiring further action to result in deliverable schemes.

As at Month 4, the annual total of identified schemes (including MARP & NARP) amount to £13.2m, phased to deliver more as the year develops.

Work is continuing to develop CPIP schemes, deep dives have taken place as part of F&PE, with further development of opportunities expected along with providing updates in future F&PE's.

Further strengthening of CPIP governance is being initiated in order to further monitor, measure and manage a large scale programme.

Risks:

- Under achievement of Cost Improvement (CPIP)
- Achievements relying on non recurrent delivery.
- Unidentified and Opportunity schemes not developing at pace needed for full delivery

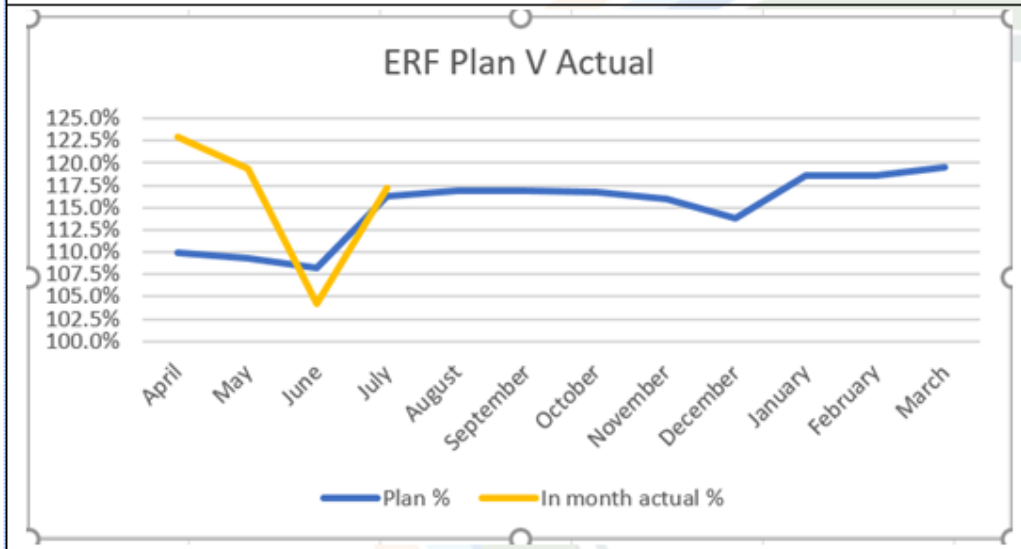
What the chart tells us:

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

For 24/25 there has been a continuation to the way we are paid for our English Commissioned elective activity

- Baseline: We have been given a price in the contract for our elective income which is based on activity x price in 19/20 ,
- Target: uplifted for new 24/25 tariff's (Value weighted activity - VWA), increased to 106%. We are given a set amount of £7m to achieve that target. The value is based on a 'fair share' of the income given for this purpose to the ICB. Out plan was to achieve greater than that at 117.5%.
- For H&W ICB our internal estimate YTD (end of M4) reflects performance of 115% of 19/20 activity (see chart). For Gloucestershire, Shropshire and Specialised commissioning we have continued to use national data.

We are seeing increases in spend on over and above plan and further analysis is ongoing to match spend and income at a specialty level. In addition H2 activity reviews are commencing in late August 2024 to drive 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. Non budgeted spend to achieve the elective activity
- Mitigation - 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.

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	129	0	129	411	65
ICT - Hardware	Owned	782	106	4	102	782	(0)
ICT - Software	Owned	52	8	0	8	52	(0)
Clinical Equipment	Owned	0	0	0	0	0	0
Estates Works	Owned	807	293	89	204	659	148
ESH 2324 Underspend	Owned	615	462	615	(153)	615	0
CDC 2324 Underspend	Owned	1,408	384	493	(109)	1,408	(0)
Clinical Equipment	Owned	333	93	22	71	305	28
ESH - Local Funding	Owned	2,924	0	0	0	1,400	1,524
23/24 Cfwd	Owned	0	0	547	(547)	547	(547)
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*0*	*(924)*
System Capital Over-commitment	*Owned*	*(633)*	*(119)*	*0*	*(119)*	*(339)*	*(294)*
Total - Local CDEL funded		**5,840**	**1,356**	**1,770**	**(414)**	**5,840**	**0**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	2,991	2,291	700	10,972	0
Donated assets	Owned	240	36	0	36	240	0
Clinical Equipment	Owned	33	0	0	0	33	0
Total - Grant funded and Donated		**11,245**	**3,027**	**2,291**	**736**	**11,245**	**0**
National funding							
Clinical Diagnostics Centre	Owned	11,352	3,109	0	3,109	11,352	0
ESH - PDC Funding	Owned	2,161	1,723	1,143	580	2,161	(0)
ICT - Clinical Systems	Owned	750	122	0	122	1,750	(1,000)
Total - National PDC schemes		**14,263**	**4,954**	**1,143**	**3,811**	**15,263**	**(1,000)**
Leases							
Vehicle	Lease	10	3	0	3	10	0
Clinical Equipment	Lease	400	67	5	62	400	0
Total - IFRS16 Leases		**410**	**70**	**5**	**65**	**410**	**0**
Total Capital Programme		**31,758**	**9,407**	**5,209**	**4,198**	**32,758**	**(1,000)**

Performance and Actions

The lines in yellow reflect over-commitments within the capital position. The over-commitment of £633k (resulting from a CDEL reduction due to having a deficit plan) has been mitigated down to £339k to reflect a saving identified on ESH. The £924k risk element relating to ESH has also been removed.

Changes on last month

The changes to the forecast have been minimal. ICT hardware forecast now reflects the plan and the Estates works forecast has reduced.

Variance- Year to Date

Expenditure on schemes scoring against local CDEL is ahead of plan, mainly driven by the amount of schemes which were carried forward from last year.

Expenditure on CDC and IES is slower than the planned profile but still expected to meet the plan by the end of the year.

Variance - Full Year

£1m of variance to plan is funded via FLD, subject to bid approval. The balance of over-commitments is to be addressed through further savings. It is projected that further savings will be made from ESH which may address a proportion of the remaining forecast variance.

Risks:

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

Financing Risk

£3.484m of system capital PDC is required to part-fund local capital schemes and is built in to the financial plan.

£1,750k FLD - National PDC programme has been included and is now confirmed subject to bid approval.

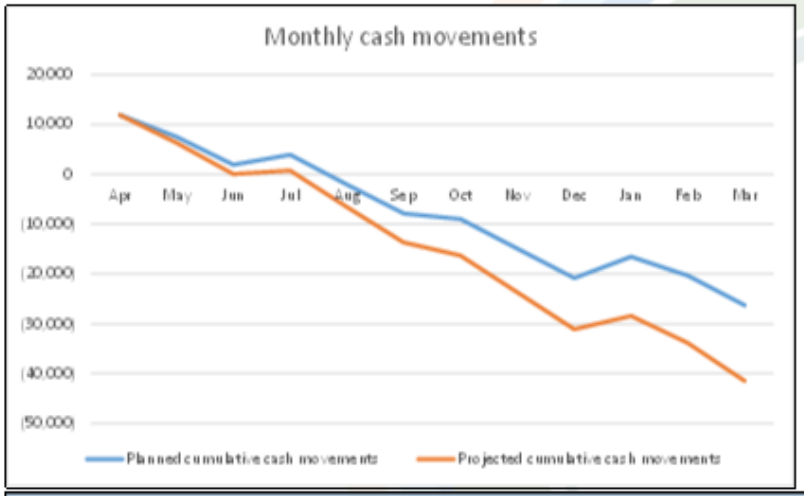
What the chart tells us:

The Capital forecast is broadly in line with plan apart from the additional FLD allocation of £1m.

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
May	30.2	28.1		
June	23.0	30.2		
July	21.7	30.2		

The cash balance at the end of July reduced compared to month 3 and is lower than planned. The main reason for this decrease is continued pressure from the I&E deficit, payment of our creditors and increased debtors. As cash balances reduce further in the year, management will have to consider reducing the prompt payment of creditors and the risks to our BPPC performance.

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
May	99.0%	95.0%		
June	98.6%	95.0%		
July	99.3%	95.0%		

In July, the Trust paid 99.3% of invoices within 30 days. This equates to 98.7% by invoice value. This is the seventh month, in a row, that we have achieved the 95% (by volume) target. See above comments concerning potential future action taken to maintain cash balances.

Performance and Actions

Funding sources are expected to cover the planned deficit of £31.4m and the overall capital plan (see capital section for specific capital funding risks). Although the process to access the cash is still evolving and becoming more closely linked to confidence around delivery of plans.

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.

The requirement for revenue cash support is no longer forecast for Q2, mainly due to invoiced income being received in a more timely manner. Cash support is forecast to be required during Q3. In the first instance, the Trust will seek cash support from the System with application to NHSE being the fall-back position.

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 CPIP delivery continues at the lower than required levels seen YTD, alternative sources of cash will be required.

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

As cash balances reduce further in the year, management will have to consider reducing the prompt payment of creditors with associated risks to our BPPC performance.

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

July 2024	2023/24	2024/25			2024/25 Full Year		
	Accounts £000s	M4 Plan £000s	M4 YTD £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	151,182	157,202	153,353	3,849	167,117	167,117	0
Intangible Assets	14,359	13,046	12,737	309	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	408	408	0
TOTAL Non Current Assets	**165,949**	**170,656**	**166,512**	**4,144**	**178,445**	**178,445**	**0**
CURRENT ASSETS:							
Inventories	4,878	4,878	4,963	(85)	4,878	4,878	0
Trade and Other Receivables	35,635	21,456	28,225	(6,769)	28,856	28,856	0
Cash and Cash Equivalents	26,228	30,167	21,712	8,455	27,447	27,447	0
TOTAL Current Assets	**66,741**	**56,501**	**54,900**	**1,601**	**61,181**	**61,181**	**0**
TOTAL ASSETS	**232,690**	**227,157**	**221,412**	**5,745**	**239,626**	**239,626**	**0**
CURRENT LIABILITIES							
Trade and other payables	(37,101)	(38,691)	(39,209)	518	(37,275)	(37,275)	0
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(9,282)	(3,411)	(12,693)	(12,693)	0
Provisions	(192)	(192)	(46)	(146)	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(51,576)**	**(48,537)**	**(3,039)**	**(50,160)**	**(50,160)**	**0**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**4,925**	**6,363**	**(1,438)**	**11,021**	**11,021**	**0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**175,581**	**172,875**	**2,706**	**189,466**	**189,466**	**0**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(53,916)	(47,430)	(52,889)	5,459	(42,935)	(42,935)	0
Provisions	(1,619)	(1,619)	(1,774)	155	(1,619)	(1,619)	0
Total Non-Current Liabilities	**(55,535)**	**(49,049)**	**(54,663)**	**5,614**	**(44,554)**	**(44,554)**	**0**
ASSETS LESS LIABILITIES	**127,165**	**126,532**	**118,212**	**8,320**	**144,912**	**144,912**	**0**
TAXPAYERS EQUITY							
Public dividend capital	306,421	311,792	306,421	5,371	351,694	351,694	0
Revaluation reserve	22,047	22,047	18,107	3,940	22,047	22,047	0
Income and expenditure reserve	(201,303)	(207,307)	(206,316)	(991)	(228,829)	(228,829)	0
TOTAL	**127,165**	**126,532**	**118,212**	**8,320**	**144,912**	**144,912**	**0**

Performance and Actions

General

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

Non-Current Assets

Non-Current assets are £4.1m lower than plan due to the capital programme being behind plan (per capital section of report).

Working balances

Net working balances (receivables less payables) have improved with debtors increasing by £6m compared to plan. £2m of this is PFI liability prepayment (see borrowings, below). While this improves the liquidity position, it has a detrimental effect on cash. Cash and cash equivalents are therefore lower than planned levels due to net working balances being higher and the deficit position being behind plan .

Borrowings

The total movements in borrowings, across current and long-term balances (plan versus actual) differ by £2m, due to accounting of the phasing of the PFI liability repayments between plan and actual.

Taxpayers Equity

PDC is lower than plan as no additional has been drawn yet.

The revaluation reserve has reduced reflecting a historical correction between the revaluation and the I&E reserve identified during the year end audit.

The income and expenditure reserve also reflects the deficit for the year to date.

Risks:

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

What the chart tells us:

Current assets outweigh current liabilities, but cash balances are lower than planned.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High		65.8%	72.9%	72.4%	78.6%	80.8%	79.0%	77.3%	77.1%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause	Yes	80.4%	88.3%	90.1%	96.9%	95.8%	86.9%	93.4%	88.4%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low	Yes	53.3%	90.5%	95.8%	83.3%	79.3%	47.6%	32.1%	20.0%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	80.0%	73.8%	69.1%	80.8%	89.2%	84.8%	85.5%	90.7%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause		9	8	12	4	12	14	11	10	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	64.0%	59.2%	51.7%	71.1%	63.0%	64.5%	75.7%	76.6%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		100.0%	100.0%	60.0%	100.0%		80.0%	100.0%	100.0%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		81.0%	73.9%	48.1%	76.9%	61.8%	72.4%	63.3%	65.5%	
	Cancer: number of urgent cancer patients waiting over 62 days	Cancer			Common Cause						71	72	93	85	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		104.9%	107.1%	121.7%	115.1%	102.8%	112.5%	113.7%	100.8%	114.1%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low	Yes	90.9%	91.1%	90.0%	89.7%	90.3%	86.9%	84.7%	85.6%	86.8%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		104.7%	103.0%	103.4%	109.3%	104.3%	107.7%	107.4%	99.6%	100.0%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Concern - Low		73.0%	73.6%	64.4%	65.8%	71.4%	73.3%	72.7%	66.4%	65.8%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		12.1%	13.2%	20.1%	17.0%	12.2%	10.2%	10.5%	15.4%	18.7%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		112.9%	113.9%	116.8%	123.3%	119.5%	114.5%	111.7%	112.2%	114.2%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		42.0%	41.0%	43.0%	46.0%	45.0%	46.2%	46.9%	47.5%	46.2%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	56.3%	53.6%	53.2%	54.9%	65.5%	68.8%	68.1%	66.4%	68.3%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High		16.0%	17.3%	19.1%	16.9%	12.2%	11.9%	11.7%	12.3%	12.4%
	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%	1.8%	1.7%	1.7%	1.7%	1.8%	1.8%	2.0%	1.9%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		253	230	305	306	250	292	318	291	330
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		8.6%	8.7%	7.7%	8.5%	8.2%				
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		59.6%	57.9%	57.2%	56.3%	55.4%	54.5%	55.6%	55.8%	55.7%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		67.4%	65.5%	66.8%	67.6%	68.3%	67.8%	68.2%	70.0%	70.3%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care			Improvement - High		26915	27031	26837	27256	27780	28130	28574	29179	28848
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Concern - High	Yes	1782	1636	1446	1287	1152	1171	1198	1285	1140
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		18	16	7	16	9	6	13	15	14
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		4	3	1	1	0	1	2	3	1
	GP Referrals	Elective care			Improvement - High	Yes	117.1%	97.7%	104.1%	119.6%	134.4%	115.6%	102.9%	90.8%	102.0%

Elective care	Outpatient Activity - New attendances (% v 2019/20)	Elective care			Improvement - High		112.9%	100.6%	111.5%	116.0%	129.1%	113.4%	113.8%	110.7%	114.1%
	Outpatient Activity - New attendances (volume v plan)	Elective care			Improvement - High	Yes	88.4%	121.2%	114.3%	112.6%	83.4%	110.0%	106.1%	85.1%	115.2%
	Total Outpatient Activity (% v 2019/20)	Elective care			Improvement - High		110.2%	101.2%	109.3%	109.2%	123.8%	115.9%	118.4%	114.2%	119.1%
	Total Outpatient Activity (volume v plan)	Elective care			Improvement - High	Yes	93.0%	132.6%	126.2%	120.0%	89.3%	113.2%	112.4%	88.2%	122.8%
	Total Elective Activity (% v 2019/20)	Elective care			Improvement - High		101.0%	91.5%	98.9%	106.5%	121.0%	112.5%	110.4%	98.9%	101.8%
	Total Elective Activity (volume v plan)	Elective care			Improvement - High	Yes	84.2%	112.2%	103.8%	112.6%	83.9%	119.2%	112.6%	86.0%	100.4%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause		78.6%	77.8%	76.7%	79.0%	79.8%	77.2%	77.9%	79.7%	76.9%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care			Common Cause		29	31	65	36	31	32	24	39	41
	Diagnostic Activity - Computerised Tomography	Elective care			Improvement - High		129.6%	119.4%	124.9%	111.0%	107.5%	111.8%	126.5%	129.5%	
	Diagnostic Activity - Endoscopy	Elective care			Common Cause	Yes	131.1%	158.0%	142.8%	150.3%	99.3%	130.4%	98.1%	76.6%	
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care			Improvement - High	Yes	180.9%	148.0%	113.6%	95.3%	148.8%	120.5%	130.6%	119.2%	
	Waiting Times - Diagnostic Waits >6 weeks	Elective care			Improvement - Low		17.2%	13.2%	17.9%	15.6%	21.5%	24.7%	24.8%	22.3%	
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Common Cause		92.9%	92.2%	91.3%	92.1%	93.8%	94.4%	93.9%	90.6%	
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause	Yes	22.9%	23.8%	24.3%	24.3%	19.5%	19.0%	16.0%	16.3%	
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Common Cause	Yes	66.0%	64.9%	63.8%	64.6%	62.9%	60.6%	55.5%	54.7%	
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Common Cause	Yes	92.6%	92.5%	88.4%	88.2%	87.0%	85.5%	87.3%	86.3%	
	Maternity Activity (Deliveries)	Elective care			Improvement - High	Yes	97.0%	95.1%	140.6%	115.0%	99.3%	99.2%	83.9%	113.3%	
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.5%	6.9%	6.5%	6.2%	6.0%	6.2%	6.3%	6.5%	6.5%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Common Cause		86.3%	83.6%	83.3%	86.5%	87.0%	86.7%	88.0%	87.6%	88.8%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation			Improvement - High		109.0%	101.5%	108.4%	106.2%	121.5%	117.2%	120.6%	115.8%	121.5%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation			Improvement - High	Yes	95.2%	138.6%	132.2%	123.8%	92.3%	114.8%	115.5%	89.7%	126.6%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Fail	Improvement - Low		20.7%	20.4%	21.1%	19.8%	19.2%	20.2%	20.6%	19.2%	18.7%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term			Common Cause		6.9%	8.1%	11.9%	8.8%	6.3%	11.2%	5.3%	10.1%	
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		99.6%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		100.0%	99.2%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<= 0	Variable	Improvement - Low		49	28	24	65	74	54	99	84	84
	Patient ward moves emergency admissions (acute)	Safe, high quality care			Common Cause		8.7%	8.2%	11.0%	10.1%	8.8%	8.5%	9.4%	9.0%	
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		7	6	7	7	7	6	6	6	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause		2	2	2	3	3	3	2	3	2

Safe, high quality care	Medically fit for discharge - Acute	Safe, high quality care		5.0%	Pass	Concern - Low	Yes	23.3%	21.0%	22.7%	21.4%	18.7%	18.8%	15.3%	14.1%	15.6%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Common Cause		39.4%	43.6%	50.1%	51.6%	50.1%	46.2%	42.6%	47.4%	48.9%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Concern - Low	Yes						4.2%	4.4%		
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Variable	Common Cause	Yes	104	101	101	100					
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		102	102	102	100	98				
	Never Events	Safe, high quality care		0	Variable	Common Cause	Yes	0	0	0	0	0	1	0	0	0
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Common Cause	Yes	0	0	0	1	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care				Common Cause		4	2	1	2	2	1	0	0	2
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care		44	Fail	Improvement - High	Yes	3	4	3	3	2	6	6	5	9
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause		5	3	2	2	1	1	4	2	2
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		89.8%	88.0%	87.4%	89.2%	89.3%	89.9%	88.8%	88.8%	87.3%
	WHO Checklist	Safe, high quality care	>=	100.0%	Variable	Concern - Low	Yes		99.4%			99.4%			98.0%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>=	60.0%	Variable	Common Cause		64.3%	48.1%	53.5%	66.7%	63.0%	64.4%	50.9%	63.2%	78.4%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within	Safe, high quality care	>=	90.0%	Variable	Common Cause		100.0%	0.0%	66.7%	60.0%	33.3%	0.0%	66.7%	20.0%	0.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		90.9%	90.6%	80.0%	78.0%	83.1%	77.8%	75.0%	78.3%	87.1%
	Number of complaints	Safe, high quality care				Concern - High		34	24	27	29	38	45	31	31	28
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Improvement - Low		0	0	0	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Fail	Common Cause		52.2%	17.6%	34.6%	37.9%	35.3%	44.8%	39.4%	51.7%	53.9%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	73.1%	72.9%	77.0%	75.7%	81.2%	81.0%	81.1%	78.7%	79.3%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low		87.9%	82.0%	85.7%	81.7%	88.6%	86.0%	82.7%	84.5%	80.7%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause		89.7%	87.2%	96.7%	92.6%	91.3%	96.9%	85.7%	96.6%	94.4%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Improvement - High		19.0%	19.0%	21.0%	21.0%	20.0%	19.0%	19.0%	20.0%	18.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High		15.0%	15.0%	18.0%	16.0%	17.0%	18.0%	16.0%	18.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause		32.8%	31.0%	23.0%	23.0%	16.0%	28.0%	25.0%	24.0%	31.0%

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low	Yes	7.1%	6.1%	7.9%	8.1%	6.0%	5.5%	6.3%	5.5%	5.9%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	70.9%	72.7%	70.6%	71.8%	70.8%	75.9%	79.2%	80.3%	80.2%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.1%	89.0%	88.8%	88.8%	88.4%	89.2%	89.8%	89.7%	89.7%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause		5.4%	5.6%	6.0%	5.7%	4.0%	4.7%	4.6%	4.8%	5.1%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		10.6%	10.3%	10.1%	10.1%	10.4%	9.0%	9.2%	9.4%	9.5%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Finance	I&E - Surplus/(Deficit) (£k)	Finance			Common Cause	Yes	£425k	(£2906k)	(£2430k)	£9902k	(£9316k)	(£3387k)	(£3387k)	(£3387k)	(£4957k)
	I&E - Margin (%)	Finance			Common Cause	Yes	£0k	(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance			Common Cause	Yes	£1720k	(£208k)	(£3427k)	(£3019k)	######	(£410k)	(£469k)	(£524k)	(£1793k)
	I&E - Variance from Plan (%)	Finance			Common Cause		£0k	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)
	CPIP - Variance from plan (£k)	Finance			Common Cause	Yes	(£862k)	(£841k)	(£708k)	(£830k)	£906k	(£370k)	(£409k)	(£566k)	(£844k)
	Agency - expenditure (£k)	Finance			Improvement - Low	Yes	£1382k	£1087k	£1482k	£1596k	£1127k	£1069k	£1027k	£1048k	£953k
	Agency - expenditure as % of total pay	Finance			Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance			Common Cause	Yes	(£366k)	£520k	(£2959k)	(£689k)	(£1572k)	(£14k)	£178k	(£522k)	£785k
	Cash - Balance at end of month (£m)	Finance			Common Cause		£19k	£24k	£23k	£23k	£19k	£22k	£30k	£23k	£22k
	BPPC - Invoices paid <30 days (% value £k)	Finance			Common Cause		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance			Concern - High		£1k	£0k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Emergency Department Nurse Staffing Business Case
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Trust Management Board
Lead Executive Director:	**Chief Nursing Officer**
Author:	Louise Weaver, Kate O'Shea, Sarah Holliehead
Documents covered by this report:	Emergency Department Nurse Staffing Business Case

1. Purpose of the report

To present the Emergency Department (ED) Nurse Staffing Business Case for approval

2. Recommendation(s)

Trust Management Board recommend the case for approval

3. Executive Director Opinion[1]

This case has been subject to extensive consultation and responds to the safety critical requirements for the Emergency Department, reflecting current level of activity and performance.

As our strategies for urgent and emergency care come to fruition there will be an opportunity to review the staffing establishment and achieve a Cost Productivity Benefit as some posts have been funded to address current pressures, which should not exist as our strategies are implemented.

The Emergency Department currently operates a two shift system (long day and night). Work is underway to review this and adjust shift patterns to profile staffing according to peaks in demand.

Update from Non-Executive Review Meeting 03/09/2024

The group considered the case and explored the following themes:

- The ability to recruit to the roles
- Ensuring that the financial effect of the case wasn't double counted
- At what point the case delivered the full financial benefit suggested
- Whether there was commissioner support for the scheme and the need for a review of the baseline non-elective activity
- The need to implement the scheme but that the cost was a level of expenditure beyond current resource
- Whether the figure 0f 21% budget headroom is adequate – the figure being selected based on a Group benchmarking exercise and in line with the rest of the Trust
- How the further possible financial benefits of improved flow in the Department outlined in the conclusion might be measured and how frequently it might be assessed
- Links to the forthcoming ED medical staff business case.

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

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

Wye Valley NHS Trust

BUSINESS CASE

Title:	WVT Emergency Department Workforce Investment Case: Establishment Review to Meet Safe Nursing Standards & Develop Emergency Nursing Career Structure
Ref. No.	WVTBC0131
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1. Introduction and Background Information

Emergency Department (ED) demand has grown consistently across the country for many years at a rate between 3-5%, despite numerous demand management and reduction initiatives across England, no trust or system has successfully reduced ED demand for a sustainable period.

Wye Valley Trust has seen rising attendance numbers, increasing acuity and complexity of the cohort of patients attending ED. Additionally, Herefordshire and Powys has a high population of elderly and frail patients, this cohort of patients are often more complex and require additional resource to meet their needs in the Emergency Department (ED). Patients are sometimes waiting long periods of time in ED for triage and assessment and on occasion are also spending more than 24 hours waiting for an inpatient bed. This is due to the lack of patient flow within the Trust and is being addressed through our wider strategies for urgent and emergency care.

These factors all have a significant and direct impact on nursing time which is the basis of building this case for investment. This case seeks to better match the nursing workforce to meet patient demand. This will ensure we can provide high quality and safe care for our patients at the same time as ensuring we are supporting and developing our nursing workforce to meet patient need.

The Care Quality Commission (CQC) inspection (December 2023) highlighted the requirement for urgent mitigation and action in relation to the nursing workforce to address quality and safety issues within the department. This inspection, alongside Emergency Care Improvement Support Team (ECIST) recommendations and Urgent and Emergency Care Test of Change outcomes underpins the rationale for this business case proposal.

The case also considers the impact of the Test of Change work streams which were implemented in March 2024 as part of the urgent and emergency care recovery plan which saw the introduction of a GP, nurse navigator, a health care assistant to support the GP and

the introduction of a transfer team. All these have made a significant contribution to the improved performance from March 2024.

This business case also aims to reduce reliance on high cost agency staff by investing in the substantive nursing workforce, increasing staffing levels, providing senior clinical oversight and making the department a more appealing and less stressful place to work, with the aim to improve recruitment and retention.

This case will detail the revenue investment that is required to deliver improved nurse staffing through the review of three options.

2. Current Position

ED attendances have peaked at 73,000 patients during the 23/24 financial year and also the number of patients who have higher acuity and have more complex needs. This growing problem of increasing demand is illustrated in the table below.

FY	Attendances	% Increase	Resus / Majors (Acuity)	% Increase
18/19	63,827	-	34,035	-
19/20	66,274	3.8%	38,416	13%
20/21	*Lockdown*			
21/22	68,554	3.4%	44,338	15.4%
22/23	69,552	1.5%	46,537	5%
23/24	73,000	4.8%	47,165	1.3%
Total % Increase (18/19 – 23/24)	**14.47%**		**38%**	

Table 1 – ED attendances Trust Care Quality Indicator (CQI) data

The combination of rising attendance numbers, increasing acuity and complexity of the cohort of patients within the department alongside the length of time they spend in ED all have a significant and direct impact on nursing time and on operational performance which is the basis of building this case for investment.

The ED also has a challenging functional layout due to the footprint having been changed over the years in order to increase the size of the department. The footprint has multiple small areas that are not easily observed making staffing requirements more challenging.

Although ED has been successful in attracting staff, it does have a high turnover. Some turnover has been for genuine career progression, yet also driven by high levels of burnout, due to the increasing pressures.

The prolonged waits in the ED for beds leads to additional pressure and congestion that the ED is not designed for. The ED team regularly manage patients waiting for 12-24 hours, delivering ward based care alongside emergency care. The demands are significantly higher than what has been traditionally required for short stay patients within an ED. In 2023/24, circa 70% patients waited more than 4 hours from the decision to admit to being admitted, this was an increase from 2022/23. Waiting time has also increased due to the lack of effective flow in the inpatient bed base.

The Trust does not meet the national Royal College of Emergency Medicine (RCEM) workforce standards, resulting in only being fully compliant in 9 of the 27 safety standards (Appendix 1). The Trust should seek to improve its compliance with these standards to improve patient safety and experience.

Current Workforce - Emergency Medicine Nursing Establishment 30/05/24.

The current ED nursing establishment is budgeted for 102.19 whole time equivalent (WTE). However, owing to a high volume of vacancies across the Band 5 registered nurse cohort the real WTE is 90.64 WTE. Given this, agency and bank spend is high as the shortfall must be covered in order to ensure patient safety is maintained. The department also routinely has to staff the external corridor to facilitate the offload of emergency ambulances, this is over and above base establishment.

ED Current Budget				
	WTE	Per wte		Cost
Band 7	4.56			290,987
Band 6	14.45			859,071
Band 5 registered nurses	48.80			2,370,024
Band 4	4.66			199,205
Band 3	9.00			364,345
Band 2	20.72			773,707
Total Cost	**102.19**			**4,857,339**

To note the Emergency Nurse Practitioners (ENP) are not included in this business case. They are a valuable part of the workforce working in the minors work flow. ENP requirements will be reviewed as part of the ED Medical Staffing Business Case.

3. Drivers for Change

There have been three significant reviews in the last 12 months of urgent care provision in the Trust.

3.1 ECIST Review November 2023:

The ECIST visited WVT in November 2023. Support was offered to review the nurse staffing model data within the department. This visit highlighted the need to address the service demand and capacity deficit.

ECIST Observations:

- *'There is no direct visibility of patients waiting on chairs in the waiting area'.*
- *'An area which is used for ambulatory majors was crowded and the high intensity of the work for staff was evident. Nurses described they were also responsible for providing oversight on the waiting room'.*
- *'Flow out of the ED is compromised, resulting in higher levels of occupancy and therefore an increase in the care demand.'*
- *'Whilst in the interests of time, staff found it necessary to physically move patients on trolleys, dedicated ED portering staff could release clinical time'.*

- *'Current ED staffing (incorporating breaks) shows a mismatch between registered staffing and demand from 1100 until 2000 when compared with the daily staffing allocation. This suggested that care demand was unlikely to be met across the busiest part of the day using existing staffing allocation. The SNCT spikes indicate that this period is particularly vulnerable to high workload demand. This is also the time when staff have their breaks.'*

3.2 CQC Inspection – December 2023:

Following the CQC inspection, the overall rating across all domains was "requires improvement", yet of most concern was an inadequate rating for patient safety. This was in part due to insufficient nursing staff to care for patients and keep them safe without using high numbers of bank and agency staff.

The outcome of the CQC inspection in December in 2023 highlighted the requirement for urgent mitigation and action in relation to the workforce and quality and safety within the department. This CQC inspection, alongside ECIST and local demand and capacity analysis underpins and informs the options for this business case proposal.

Following the CQC inspection some immediate staffing changes were implemented and these included:

- Extending senior nursing co-ordinator cover to cover 7 days between 0745 until 22:00
- Nominated senior nurse (governance) to address wider concerns identified by the CQC
- Additional staffing for the waiting room and additional support to the internal corridor to provide better oversight of patients waiting to be treated and those spending long periods in the department waiting for a bed.

CQC also raised concerns relating to paediatric nurse provision to paediatric ED. This has been addressed through separate investment for the paediatric ward to enable cover for the 24 hour period (previously 12 hours per day).

3.1. UEC/NHSE visit – February 2024:

Key recommendations from the UEC visit (relevant to this paper) were:

- Implementation of a Transfer Team to support with patient flow and timely transfers out of the department.
- Implementation of the Nurse Navigator B6 at the front desk and in conjunction with this, a HCA to support the Navigating GP.

These recommendations were enabled through the Test of Change Urgent and Emergency Care Workflows (see section below) during March 2024, when additional funding was provided from the Integrated Care Board (ICB) to improve the compliance with key performance indicators in the ED e.g. the 4 hour target, reduce time to triage and improve patient experience.

3.2. Agency and Bank Spend:

The ED 2023/24 bank and agency spend was £2.735m. This is likely to continue to grow without action, Q1 2024 spend was £595k.

3.3. Group Fit & Benchmarking - between other Trusts:

In developing this business case some benchmarking has been undertaken across the 4 trusts within the foundation group. The existing staffing establishment was lower in terms of clinical governance support, dedicated resource for practice education and WVT was an outlier in only providing senior band 7 nursing cover 12/7 rather than 24/7 as per the 3 other Trusts.

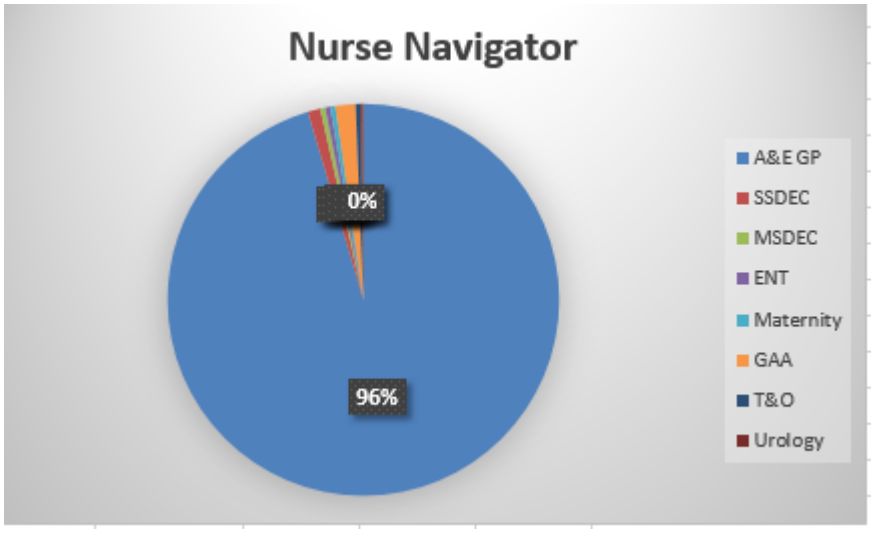
3.4. Urgent Care Demand:

National and ICB analysis shows that there is likely to be increasing demand in Urgent and Emergency Care (UEC) for the foreseeable future. It is also likely that due to an aging population much of this demand will be more complex, with higher acuity patients many of which have significant care needs. Therefore, the importance of having a sufficiently trained, skilled and educated ED workforce cannot be understated. Ensuring that WVT have the nursing workforce to deal with complex patients will allow the effective utilisation of alternative care pathways, both in and outside of the hospital.

4. Staff uplift during Test of Change Work Streams from March 2024

To support the test of change initiatives, the nursing resource was uplifted and included a nurse navigator (1wte B6) to triage patients to the GP in ED; supported by one health care assistant (HCA) to support the GP and a transfer team consisting of one registered nurse and a HCA.

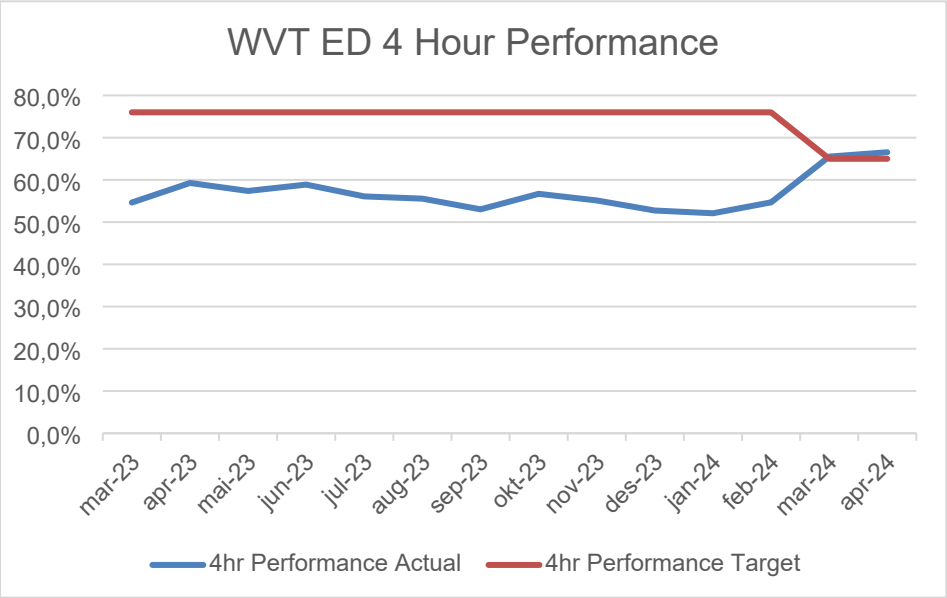
The nurse navigator was able to triage patients to other services as well as to the GP located in the Emergency Department which is demonstrated in the pie chart below:



Performance improvements following test of change:

Four Hour Performance March 2024:

The 4 hour performance improved significantly during the Test of Change period; at the end of March 2024 this was at 65.5% compared with 54% in February 2024.



The improved ED performance above was partly facilitated by the implementation of the GP in ED supported by the Nurse Navigator with the GP seeing an average of 16.4 patients daily.

Length of stay in ED during the Test of Change period:

The length of stay on average in the department during March was 05:57hrs compared with 07:00hrs in February.

Performance benefits of increased Registered Nurse and HCA workforce following implementation of test of change work-streams

The Test of change performance data below evidences performance has continued to improve in April: and May

KPI	Apr 2023	May 2023	April 2024	May 2024
4 Hour performance	59.3%	57.4%	68.9%	68.2%
Minors performance	89.4%	89.0%	94.4%	94.5%
Average time to triage	41 mins	37 mins	23 mins	21 mins
Average time to be seen	1hr 47mins	1hr 52mins	1hr 31mins	1hr 36mins
%Left without being seen	5.5%	5.3%	3.5%	3.6%
Time to Clinically Ready to Proceed	3hrs 21mins	3hrs 30mins	3hrs 6mins	3hrs 5mins
Nurse navigator triage to GP per month	N/A	N/A	466	459
ED GP attendances (daily average)	N/A	N/A	16.4	15.8

5. Expansion of Senior Nursing.

The uplift in Band 7 senior nursing workforce post CQC has enabled an increased presence of senior leadership and oversight over seven days a week. This has supported the more junior workforce with clinical guidance and safe allocation of patients within the department. It has also enhanced team working with the Clinical Site Manager and senior nurses on the wards.

The increased leadership provided by the senior nursing role, particularly at the weekend, has supported governance processes regarding patient concerns and complaints, predominantly involving direct phone calls and response times and face to face conversations with patients and relatives in the department.

It has also allowed opportunity for career progression within the team and staff retention at a senior level.

Appraisal compliance has increased from 47.6% to 88.1% and mandatory training compliance and essential to role training has also improved. Training compliance in relation to Level 3 Children Safeguarding has also improved significantly which was highlighted by the CQC as a “Must Do” action.

The improvements that have been seen by extending the B7 cover have been clear. Given our benchmarking across the group and relatively junior workforce there would be benefit in extending this cover 24/7 to support patient flow, staff wellbeing, shift coordination, clinical oversight and liaison with wider services

The senior nurse governance lead role was established following the CQC visit when it was highlighted that there was a lack of robust governance processes, this role has been integral to improving the performance in this area, yet does represent a single point of failure. Through discussion with the wider foundation group the benefit of a band 7 sister “of the week” would seem more sensible and provide the opportunity for rotation across the whole band 7 workforce thus avoiding single points of failure. This role would deal with governance, rotas and staffing management similar to that of a ward manager and is deemed critical for a workforce in excess of 100WTE

Practice education was also highlighted to insufficient given the size of the nursing workforce and associated competencies required. This also benchmarked low compared to the foundation group and this case seeks to address this.

There are clear role descriptions for the practice educator role, the band 7 senior clinical coordinator (24/7) and the manager of the week.

These proposals would provide the following senior nursing cover:

	B7 clinical Long day 0730-2000	B7 Clinical Night 1930-08:00	B7 manager of the day/ week 0745-1545	B7 Education support 0900-1700
Monday	√	√	√	√
Tuesday	√	√	√	√
Wednesday	√	√	√	√
Thursday	√	√	√	√
Friday	√	√	√	√
Saturdays	√	√	√	
Sunday	√	√	√	

6. Project Objectives, Critical Success Factors (CSFs) and Benefits

6.1. Objectives:

The key objective and vision of this proposal is to provide safe and effective care to the patients within our Emergency Department, provide senior clinical oversight to support both patient safety and staff support. Additionally, the proposal should create a sustainable ED nursing workforce and career structure that allows the ED to grow talent, support the development of the nursing workforce and provide staff sustainability to reduce the turnover rate.

6.2. The key ambitions:

- Improve the quality of care and patient safety in the Department;
- Improve patient experience;
- Meet the 4 hour target of 78 % by the end of March 2025;
- Increase compliance with RCN/RCEM ED staffing standards
- Improve and maintain workforce KPI's e.g. appraisal compliance;
- Provide 24/7 leadership support within ED;
- Improve skill mix and support to the junior workforce;
- Deliver 'value for money';

6.3. Critical success factors:

The key critical success factors are;

- Improve quality and patient experience in an overcrowded department;
- Reduce avoidable patient harm;
- Achieve and maintain revised national targets specific to emergency care - for example 4 hour performance standard and ambulance offloads;
- Maintain a consistent co-ordinator/leadership role in the department over a seven day period;
- Ensure there are robust governance processes and compliance

- Provide dedicated educational support for ED staff in order to increase training compliance;
- Implement key roles to improve flow across the department and improve patient safety
- Reduce nurse vacancy rate
- Reduce agency and bank spend by 35% in 2024/25 (23/24 agency spend was 2.116k; bank spend 619k). April 2024 24.79 WTE agency & 12.51 WTE bank –cost 227k;
- Reduce staff sickness rates:
- Increase the compliance of the Department against the RCN/RCEM staffing standards;
- Reduce staff turnover and improve staff morale;
- Reduce number of concerns, complaints and incidents;
- Reduce high scoring risks currently on the risk register;

6.4. Benefits to be achieved:

Improve staff satisfaction by enabling effective team model:

This model will allow the continuation of the ED nursing staff to be managed in an effective team model. The team model is key to ensuring that every member of staff has sufficient access and support from their line manager.

Maintain / Improve staff survey results:

The investment in having a safe level of staffing in the department, a clear career / development structure, education support and sufficient line management will ensure that our staff continue to feel valued and improve their experience at work.

Reduce sickness:

Evidence suggests that proper line management of individuals, improved working conditions led to reduced levels of absence.

Increase productivity by using our own staff, opposed to agency:

Currently a high proportion of staff in the ED are agency, due to their lack of familiarity and investment in the department, this leads to less effective working especially between staff and reduces productivity.

Support Nurse Recruitment:

Currently the registered nurse recruitment trajectory is positive, whilst the current vacancy is 13.03wte (B5) the forecast by the end of the year indicates a fully recruited position based on existing establishment in Option 1. Given successful recruitment we anticipate ongoing success with any establishment increases associated with this business case.

Support the delivery of key performance indicators:

The case will support with the delivery of achieving the 4 hour target of 78% by the end of March 2025.

	Key SMART Objectives	Current Performance Measure / Baseline	Target	Responsible Staff Member
1	Achieve national target of 78% Four Hour performance by March 2025	66.8%	78% (end of March 2025)	Directorate Tri
2	senior nurse oversight 24/7	60%	100%	Matron Emergency & Acute Medicine
3	Maintain Nursing Staff Appraisal compliance	88%	85%	Matron Emergency & Acute Medicine
4	Increase ED specific training compliance to 85%	B7 100% B6 84% B5 53%	85%	Matron Emergency & Acute Medicine
5	Reduce sickness rates	5.70%	3.5%	Matron Emergency & Acute Medicine & Senior Sisters
6	Ensure 100% rota fill with substantive workforce	85%	100%	Matron Emergency & Acute Medicine
7	Reduce agency spend in 2024/25 and 2025/26 (in line with Trust KPI)	£2.375m (23/24)	£339k contribution	Matron Emergency & Acute Medicine
8	Allow each team to attend 'skills stations' Spring 2025	0 per quarter	1 per quarter	Matron Emergency & Acute Medicine
9	Compliance RCN/RCEM staffing standards by April 2025	9 of 27	19 of 27	Matron Emergency & Acute Medicine
10	Meet 95% Care Quality Indicators	Time to triage 20 mins	Time to triage 15 mins (95%)	Directorate Tri
11	Reduce staff turnover and improve retention	9.32% (March 24 data)	3.5%	Matron Emergency & Acute Medicine
12	Improve overall CQC rating	Requires improvement	Good	Directorate Tri

7. Options Appraisal

In order to reduce the departmental delays and improve patient waits, ensure minimal patient harm/risk, improve compliance with RCN standards and improve performance care quality indicators, the directorate has considered mitigating actions. This section describes the options considered and the assessment of the benefits provided.

The budgeted establishment is below*:

ED Current Budget				
	WTE	Per wte		Cost
Band 7	4.56			290,987
Band 6	14.45			859,071
Band 5 registered nurses	48.80			2,370,024
Band 4	4.66			199,205
Band 3	9.00			364,345
Band 2	20.72			773,707
Total Cost	**102.19**			**4,857,339**

*this establishment does not support the current staffing arrangements as posts have been added to mitigate risks as highlighted by external visits and inspections

The Acute and Emergency Care Directorate has three options

Option 1: Do minimum and revert to the original staffing levels from November 2023 covered by the budget above

Option 2: Do the maximum and implement a staff model according to RCN/RCEM standards.

Option 3: Invest in the staffing model with selected staffing changes post CQC and Test of Change evaluation.

OPTION 1: Do nothing and revert to the staffing model November 2023

The table below details the staffing establishment as of November 2023 prior to the CQC inspection and test of change work streams.

Option 1- Do Nothing ED Current position		
	WTE	Cost
Band 7	4.56	290,987
Band 6	14.45	859,071
Band 5 registered nurses	48.80	2,370,024
Band 4	4.66	199,205
Band 3	9.00	364,345
Band 2	20.72	773,707
Total Cost	**102.19**	**4,857,339**

Pay type	M8 YTD Budget	M8 YTD Actuals	M8 YTD Variance
Agency	-	1,400,818	- 1,400,818
Bank	-	388,313	- 388,313
Substantive	3,312,073	2,396,269	915,804
Grand Total	**3,312,073**	**4,185,400**	**- 873,327**

The WTE of nurse agency/bank in 23/24 was an average of 26.65WTE per month for agency and 10.24WTE for bank (36.89 WTE total).

As shown in the table above, the run rate at Month 8, prior to any described interventions was £4,185,400. On a straight-line basis, this would have resulted in a total expenditure of £6,278,100 in 2023/24.

- The ED consistently has 60-80 patients during most of the day and the evening, but this may increase to over 100 during times of extreme demand. With the level of staffing as of November 2023, this leads to operational pressures and an increased risk of compromised safety and quality of care
- This model results in 9 of the 27 National Nursing Standards being achieved
- The Emergency Department experiences overcrowding on a daily basis. When staffing levels do not align with current demand, this leads to further delays completing assessments and diagnostics, which in turn leads to more overcrowding
- This staffing model is likely to drive a deterioration of performance metrics, ongoing overcrowding and risk to patient safety. Ambulance offload challenges (including the requirement to regularly monitor those patients unable to be offloaded), increased length of stay and may contribute to the system level excess mortality.
- This option does not address the findings of external reviews and inspections

Option 1 although likely to reduce agency spend, does not meet many of the critical success factors of this case.

OPTION 2 Do maximum: uplift nursing workforce to facilitate meeting all RCN/RCEM standards.

Investment for Option 2 in 2024/25 would require an uplift and reconfiguration of current ED Nursing workforce resulting in significant financial investment. It would enable 26 of the 27 RCEM nursing standards to be met.

ED Option 2 - Meet all RCEM standards		
	WTE	Cost
Band 8b	1.00	74,329
Band 7	6.30	423,796
Band 6	15.42	896,180
Band 5 registered nurses	76.46	3,605,014
Band 4	5.19	202,681
Band 3	9.00	361,936
Band 2	24.77	913,016
Total Cost	138.14	6,476,952
Increase to current	35.95	1,619,613

Bank usage based on 23/24 spend and agency reduction on external corridor cover	(831,341)
Contribution	788,272

Option 2 compared with the other two options requires substantial investment in the nursing workforce. It would deliver the key objectives outlined within this case previously. However, the option would not deliver a reduction in agency costs and would likely increase them as this level of investment is unrealistic from a recruitment perspective.

Option 3 Investment in a staffing model with selected staffing changes post CQC and Test of Change evaluation.

This option retains and funds some of the initiatives described in Section 3 – Drivers for change that were put in place after the input from the CQC, ECIST, NHSE and the Test of Change work in March 2024. Excluded from this option are the transfer team and the HCA support to the GP. This option allows for 24/7 Band 7 support, manager of the week and increased practice education, the benefits of which have been described earlier in the case.

The staffing for this option is detailed in the table below

RN	Band	Day shift 07.30 – 20.00 (unless otherwise specified)		Band	Night shift 19.30 – 08.00
	7	Nurse coordinator (supernumerary)		**7**	Nurse coordinator
	7	Practice educator 1 WTE (Monday to Friday core hours)			
	7	Manager of the week (8 hours per day/7 days per week)			
	6	Practice educator 0.8 WTE (Monday to Friday core hours)			
1	**6**	Navigator nurse (12.5 hours per day / 7 days per week)			
2	**6**	Pit stop streamer	1	**6**	Pit stop streamer
3	**6**	Majors NIC	2	**6**	Majors NIC
4	**5**	Pit stop nurse	3	**5**	Pit stop nurse
5	**5**	Majors nurse	4	**5**	Majors nurse
6	**5**	Majors nurse	5	**5**	Majors nurse
7	**5**	Resus	6	**5**	Resus
8	**5**	Resus	7	**5**	Resus
9	**5**	Internal corridor	8	**5**	Internal Corridor
10	**5**	RAA (majors 11-15)	9	**5**	RAA (majors 11-15)
11	**5**	(Fit2sit)	10.	**5**	(fit2sit)
12	**5**	SDEC	11.	**5**	Pit stop/triage nurse
13	**5**	SDEC	12.	**5**	(fit2sit)
14	**5**	Pit stop/triage nurse	13.	**5**	Waiting room nurse
15	**5**	ABC (fit2sit)			
16	**5**	Waiting room nurse			

HCA			
	Day shift x 6 HCA's All Band 3		**Night shift x 5 HCA's All Band 3**
1	SDEC	1	Pads
2	Majors	2	Majors
3	RAA majors 11-15)	3	RAA Majors 11-15
4	Pit stop	4	Pit stop
5	Fit2sit	5	Fit2sit
6	Waiting room		

This option requires the following uplift to staffing:

ED Option 3 -Preferred Option		
	WTE	**Annual Cost**
Band 7	8.09	423,796
Band 6	13.95	792,828
Band 5 registered nurses	62.34	2,962,514
Band 3	28.57	1,169,864
Total Cost	112.95	5,349,002
Increase to current	10.76	491,663
Bank usage based on 23/24 spend and agency reduction on external corridor cover		(831,341)
Contribution		(339,678)

Option 3 will require an investment of £491k to deliver and enable a minimum net reduction to bank overspend of £339k.

In terms of delivery against the critical success factors of this case, Option 3 would support the following:

- The option delivers a number of schemes set out in Section 3: Drivers for Change
- Reduced operational pressure and reduced the risk of compromising quality of care;
- Improved compliance with the RCEM National Nursing Standards;
- Improvement in ambulance handovers and increased compliance with the 30 minutes KPI.
- Continued use of B6 Nurse Navigator role to support the GP streaming pathway
- Improved performance metrics, CQIS, etc. ambulance offload times and improved triage times.
- Increased morale within the nursing team by enhancing senior leadership.
- Substantive Band 7 educational practice hours to support the Band 6 substantive Practice Development Nurse in post.
- Implement 24/7 Band 7 clinical support to the department improving the overall safety within the department.
- Band 7 manager of the week to ensure governance, staff support, patient experience, rota management and general management duties
- A reduction in the nurse vacancy rate, sickness and turnover rate due to the enhanced leadership over the 24/7 period and the increase of substantive nursing positions.

- This option reduces agency spend in line with the critical success factors.

Outcome:

It is assessed that **Option 3** delivers the essential elements to run a safe and efficient ED in the most cost-effective way and approval is sought to formalise those changes that are deemed essential following the various external visits and inspections. The current Band 7 workforce have been informally consulted regarding these changes with a view to implement 24/7 Band 7 support as soon as practicably possible. A full management of change process may be required for some or all of the B7 team which may delay the implementation of this element of the workforce model.

8. Financial Analysis

The financial analysis for the preferred option (3) is outlined below and contributes £339k to the minimum baseline agency /bank reduction programme assumption of £831k:

ED Option 3 -Preferred Option		
	WTE	Annual Cost
Band 7	8.09	423,796
Band 6	13.95	792,828
Band 5 registered nurses	62.34	2,962,514
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Total Cost	112.95	5,349,002
Increase to current	10.76	491,663
Bank usage based on 23/24 spend and agency reduction on external corridor cover		(831,341)
Contribution		(339,678)

Cost Type	**Cost Sub-Type** (Delete/Add rows as necessary)	**Description of Cost** (narrative not numbers)
Capital	Building/Estates	No additional costs
	Equipment	No additional costs
	Specialist instrumentation	No additional costs
	IT	Costs have been covered through approval of 200k at Capital Planning Committee in June 2024
Revenue	Workforce	As above
	Insourcing/Outsourcing	Not required
	Recruitment costs	As standard recruitment costs
	Consumables	No additional costs
	Training	No additional costs
	IT Licences	No additional costs
	Radiology	No additional costs
	Pathology	No additional costs
	Pharmacy	No additional costs
	Leases	N/A

Cost Type	Cost Sub-Type (Delete/Add rows as necessary)	Description of Cost (narrative not numbers)
	PFI costs	N/A

Finance Manager Recommendation:

In order to deliver the required improvements, Option 3 is recommended for approval. It provides the optimum balance of cost and quality. There will be requirement to create additional budgeted establishment of 10.76 WTE at a total cost of £491k.

Current Q1 nurse bank and agency expenditure is £595k and is forecast at existing run-rates to reach £2.38M by year end. This is an unsustainable financial position and conversion to sustainable budget baseline will avoid reliance on agency and bank.

Note the workforce model is based upon current capacity and demand and any material changes to demand may need step cost investments, however this will be managed through the annual business planning cycle.

Whilst the department will ensure bank and agency usage is reduced, there will be a requirement to continue if there are delays in recruitment and unforeseen flow demand.

The Trust are therefore requested to support the preferred option in full.

Other Potential Costs – to be determined / picked up by Division:

- IT/Office Space for Nurse Navigator.

Capital:

- Investment required in the longer term to re-configure the space in the department.

Activity:

- The ED is seeing additional activity. It is anticipated to deliver more timely and appropriate care for the new attendances in the department.

Income:

- No additional income is expected from this business case.

Financial Risks:

- The target for medical division for 24/25 is to reduce agency and bank costs by 35%. There is a risk that this may not be achieved if there is high sickness absence, turnover and recruitment is challenging.

9. Critical Assumptions and Risk Assessment

9.1 Critical Assumptions:

The proposal assumes that:

- Turnover and vacancy will reduce to support the reduction in agency spend and help to deliver a balanced budget;
- Substantive posts will be recruited to;
- The case will deliver 'value for money';
- The case will improve operational performance and support with the delivery of key performance indicators
- Enable the delivery of an improved quality of care and service.

9.2 Risk Assessment:

The following risks have been identified:

- The demands on the services, including the complexity of the patients increase beyond this uplift's ability to safely manage the service;
- Inability to achieve the target of 76% 4 Hour performance by December 2024;
- Inability to release staff to attend ED specific training and skills drills, therefore not achieving the 85% compliance target;
- Inability to reduce sickness to the desired level;
- Unable to reduce agency spend by 35% in 2024/25 due to inability to recruit into substantive posts;
- Cost pressures associated with staffing the external corridor in times of extremis;
- MOC process within the Band 7 workforce may result in an increased vacancy rate within the senior nursing team with a lack of suitable internal candidates to fill vacancies and impact on morale.
- Not funding the transfer team nurse will increase the time that the nursing workforce are away from the department. The handover and transfer process is being reviewed to streamline the process and maximise the use of porters
- Not funding the B2 to support the GP has been mitigated through support from surgical SDEC, this may represent a risk as surgical SDEC expands its service.

10. Impact Assessments

10.1 Equality Impact Assessment:

Equality Impact Assessment (EIA)

The EIA is at Appendix 2.

10.2 Quality Impact Assessment:

This proposal is solely focussed on matching capacity to demand and therefore is expected to positively impact the QIA domains of Patient Safety, Clinical Effectiveness, Patient Experience, Staff Experience, Inequalities and Targets & Performance.

10.3 Sustainability Impact Assessment:

The business case does not have an impact on environmental sustainability.

10.4 Data Protection Impact Assessment

Not completed as yet

11 Impact on other areas of the trust

Impact on other areas of the trust and outcome of discussions (select all that apply)			
Clinical Support - Radiology	☐	Admin / management	☐
Clinical Support - Pathology	☐	Estates	☐
Clinical Support - Pharmacy	☐	Other Specialties / Pathways	☒
Clinical Support - Outpatients	☐	Other	☐
ICT Support – Application and/or infrastructure support	☐	No material impact	☒

This business case represents appropriate funding and skill mix against a current workload, therefore for this specifically, impact on other services cannot be fully articulated

12 Implementation Timeline

Timelines and Key Milestone for Completion

Milestone Activity	Date
Design reconfigured Nursing roster	Completed
BC submission to TMB	16th August 2024
TMB Approve BC	16th August 2024
Trust Board approval	5th September 2024
Commence management of change process	September 2024
Advertise vacancies	September 2024
Review nursing workforce to support uplifted establishment	November 2024
Recruited into and commence in post	February 2025
Training and supernumerary period	March 2025

Recruitment and Training Timeline

Description	Estimated time start to finish	Variables	Risks
Recruitment Process - Upload to TRAC - Scrutiny Panel - Advert - Shortlist - Interview	Up to 4 months	Funding approval Scrutiny delays Variable notice periods	Numbers being recruited National recruitment challenges

- Notice Period - Start & Enrol			Lack of suitable applicants Non appointable applicant
Start in post & supernumerary period	3 – 4 weeks		Non starters
Competency document sign off	6 – 12 months	Some may achieve competencies sooner depending on background and progress/capability Some may take longer depending on background and progress/capability	Leaver Failure to achieve competencies
Average Total Timescales	6- 12 months		

13 Leadership and Project Management

Role	Name
Executive sponsor	Lucy Flanagan, Chief Nurse
Project Lead	Louise Weaver, UEC Matron
Other	Kate O'Shea, General Manager A&E

The proposal seeks to address a number of workforce issues, including senior leadership within the department. It also underpins the Trust in meeting its 2024/25 objectives. The increase in resource is well considered, evidence-based, and does not require organisational structural adjustments.

14 Workforce Plan

Recruitment

There will be a requirement to recruit 10.76 new staff members. ED has a high volume of vacancies that are being backfilled by bank and agency. There are plans to grow our own staff alongside new recruitment.

Additional workforce requirements				
	Position/Title	**Permanent/**	**Band**	**WTE**

Staff Group		Fixed Term		
Nursing	Senior Sister	Permanent	7	3.53
Nursing	Junior Sister	Permanent	6	- 0.5
Nursing	Staff nurse	Permanent	5	8.88
Nursing	Health care assistants	Permanent	3	- 1.15
			Total	**10.76**

15 Conclusions and Recommendations

Recommendation: It is assessed that **Option** 3 offers what is essential to the delivery of a safe and more efficient ED environment. Trust Board is asked to support this case outlining the use of additional investment for 2024/25 and future years.

Going forward demand and capacity plans will form part of the yearly business planning process to enable robust workforce planning to meet the needs of the department. This will ensure that the workforce requirements regularly reflect any changing demand as improvements are made to patient flow.

The department operate a 2 shift system, this is currently under review and shift patterns will be reviewed to see if these can be better aligned to peaks in demand. This will be completed by the end of September and may be subject to a further management of change or informal consultation, this should not impact the cost of this case negatively.

Approval of this investment case will allow the ED to have a robust plan to meet the current level of demand at the same time as meeting the necessary safety standards will enable the creation of a robust emergency nursing career pathway within WVT. This will allow the Trust to develop talent and retain the workforce.

Overcrowding in the department currently remains a significant issue and has led to nursing care being delivered in areas not intended for clinical use, unfortunately a now common practice in emergency departments, referred to as ‘corridor care’. As part of this business case the internal corridor has been included as part of the baseline nursing establishment. Whilst the Trust does not endorse or normalise corridor care it is a symptom of the demand and pressure on urgent and emergency care. Assuming that our strategies to improve urgent and emergency care demand help to improve patient flow and reduce the demand on

ED we anticipate being able to revise staffing and will review this on a quarterly basis. This may result in a requirement for less staff and could see a reduction as follows:

- Waiting room nurse B5 24/7
- Internal corridor nurse B5 24/7
- Waiting room HCA B2 days.

This would deliver a saving as outlined below:

	WTE	Annual Cost
Band 7	8.09	423,796
Band 6	13.95	792,828
Band 5 registered nurses	51.95	2,468,570
Band 3	24.13	988,017
Total Cost	98.12	4,673,211
Increase to current	-4.07	- 184,128
Bank usage based on 23/24 spend and agency reduction on external corridor cover		(831,341)
Contribution		(1,015,469)

16 Appendix 1 - National Nursing Workforce Standards RCN/RCEM

The table below details the level of compliance achieved with the national nursing workforce standards against the various options outlined in this case

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
1	The ED nursing workforce will be reviewed on at least an annual basis.	Yes	N/A	Yes		Yes	yes	yes
2	The ED nursing workforce will be determined by triangulation of professional judgement, nursing workload, calculated using appropriate ED nursing workload tool and benchmarked with appropriately selected and comparable peers	Yes	N/A			Yes	yes	Yes
3	Each ED will have a Lead Nurse Manager (Band 7/8a)	Yes		Yes		Yes	yes	Yes
4	Each ED will have a Matron / Senior Lead Nurse (Band 8a).	Yes		Yes		Yes	Yes	Yes
5	Each ED will have at least one Emergency Nurse Consultant (Band 8b / 8c).	No	Not funded	No		No	yes	No

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
6	Each ED will have a WTE dedicated Practice Development Lead (Band 7 / 8a)	No	Not funded	Yes		No	Yes	Yes
7	In EDs with > 75 individuals in the nursing workforce, Practice Educators (Band 6 / 7) will be required to support the Practice Development Lead.	No	Not funded	Yes		No	Yes	Yes
8	When calculating the nursing workforce WTE a minimum uplift of 27% will be applied to cover planned leave, unplanned leave, mandatory training and specialty specific training, without compromising patient safety.	No	No	Currently 21%		No	Yes	No
9	The nursing workforce will comprise a minimum of 80% Registered Nurses.	No	RN: 67% HCA::33%	No		No	Yes	Yes
10	A minimum of 50% of Registered Nurses will be in possession of an academic post registration award in emergency nursing.	No	Turnover of staff and current skill mix. Allocation of staff will be on the	Included on workforce plan, would be RAG rated as red if required	Trajectory of a number of years to achieve this standard	No	Yes - Long term plan	Yes Long Term Plan

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
			educational training plan to undertake a specific course in emergency nursing.					
11	All Nursing Associates and Clinical Support Workers will have training for their role to include competency assessment and a personal development plan according to local policy.	Yes	All staff should have an annual SDPR. Compliance figures are low but there is a trajectory in place to improve this.			No	yes	Yes
12	Individuals appointed to the nursing workforce will be allocated a supernumerary period.	Yes	N/A			Yes	Yes	Yes
13	The shift patterns for the nursing workforce will be determined by the predicted variation in clinical demand according to time of day and day of week.	Partial	Currently there are staggered shifts times for the health care assistant workforce but not currently applicable to registered staff	Yes		No	yes	No

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
14	Rostering patterns for the nursing workforce will take into account best practice on safe shift working, minimizing the use of long shifts where appropriate and in consultation with staff.	No	All nursing staff currently work a long day shift pattern	No		No	No	No
15	No greater than 20% of individuals on any given shift will be from bank or agency out with the substantive ED nursing workforce. When using Registered Nurses from bank or agency, the ED must be assured that they are competent to work in the role or clinical area to which they are allocated. All staff from bank / agency will be provided with ED orientation.	Partial	All agency staff must meet a certain skill set as determined by the departmental skills checklist	Yes		No	yes	Yes
16	There will be a nominated Emergency Charge Nurse / Emergency Nurse lead for each of the cross-cutting themes and clinical domains in the RCN ECA National Curriculum and	No			Expansion of the B7 team will allow this	No	Yes	Yes

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
	Competency Framework for Emergency Nursing							
17	There will be a nominated lead for nursing research.	No		No	Expansion of the B7 team will allow this	No	Yes	Yes
18	There will be a clinical coordinator (Emergency Charge Nurse Band 6 / 7) on duty 24/7 in addition to the nursing workforce required to deliver direct patient care.	Compliant				Yes	yes	Yes
19	An Emergency Charge Nurse or an Emergency Nurse with level 2 competencies will be the nominated shift lead for the resuscitation area.	Partial	Every effort is made to ensure that staff with Level 2 competencies are allocated to this area.			No	yes	Yes
20	There will be a minimum of 1 Registered Nurse to each patient in the resuscitation area.	Non-compliant				No	Yes	No

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
21	There will be a minimum of 1 Emergency Charge Nurse / Emergency Nurse to undertake initial assessment / triage 24/7.	Compliant				Yes	yes	Yes
22	There will be a minimum of 1 Registered Nurse to 3 cubicles where moderate and high dependency patients are nursed.	Non-compliant	1:4 ratio at the moment	No		No	Yes	No
23	Where EDs receive children there will be at least two Registered Children's Emergency Nurses on shift.	Non-compliant			Funding has been allocated to the surgical division to allow PAU/Paeds ED to be staffed 24/7.	No	Working towards Will be x 1 RSCN	Working towards Will be x 1 RSCN
24	The nursing workforce on shift will be sufficient to accommodate staff breaks without compromising patient safety and quality of care.	Non – compliant		The current review of the shift system will address this		No	yes	Yes when shift review concluded
25	Audio-visually separate areas of the ED will have a minimum of 2 members of staff present at all times, unless a reliable and effective method for	Compliant				Yes	Yes	Yes

	Standard	Currently Compliant? Yes/No/Partial	Reason for non-compliance	Compliant Post Business Case?	How Improvement will be achieved?	Option 1	Option 2	Opt 3
	summoning immediate support is in use.							
26	Where other registered healthcare professionals, such as paramedics, are used to complement the nursing workforce, they must be able to demonstrate the relevant competencies from the RCN ECA National Curriculum and Competency Framework for Emergency Nursing [3] for the role / clinical area to which they are allocated.	Compliant				Yes	Yes	Yes
27	The nursing workforce will be complemented by other staff such as receptionists, ward clerks, porters and housekeepers.	Partial	No dedicated ED porter				Yes	Partial

Table 2: WVT Nursing Workforce Standards for Type 1 Emergency Departments

17. Appendix 2 – Equality Impact Assessment

EQUALITY IMPACT ASSESSMENT (EIA) FORM

Please read EIA guidelines when completing this form

Section 1

Name of Lead for Activity:	**Louise Weaver**
Job Title:	Matron, Acute & Emergency Directorate

Details of individuals completing this assessment	**Name**	**Job Title**	**Email Contact**
	Louise Weaver	Matron, Acute & Emergency Directorate	**Louise.Weaver@wvt.nhs.uk**
Date assessment completed		**04 April 2024**	

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** WVT Emergency Department Nurse Staffing Business case			
What is the aim, purpose and/or intended outcomes of this Activity?	This Business Case seeks to create a self-sustaining ED nursing workforce and career structure that allows the ED to grow talent, support the development of the nursing workforce while allowing our team to work flexibility. -			
Who will be affected by the development & implementation of this activity?	X X X X	Service User Patient Carers Visitors	X ❑ ❑ ❑	Staff Communities Other _____
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)	Acute & Emergency Directorate personnel have utilised tools such as NHSE Capacity & Demand to calculate the impact of demand vs capacity at the weekends and also overall. This work has been complicated by national mandated changes to the JD and SD terms and conditions. However, new compliant rotas are now in place and			

	operating – this business case is asking for increased budgets to meet the demand taking into account the new terms and conditions.
Summary of engagement or consultation undertaken (e.g. who, and how, have you engaged with, or why do you believe this is not required)	All affected staff have been engaged with support / direction from HR. Most of the SDs are now on the new contract but to cater for those not wishing to change, the newly implemented rota is compliant for either contract ensuring the Trust meets its obligations.
Summary of relevant findings	This business case seeks an increase in budget for Emergency Nursing capacity following mandated changes that set better work / life balancing conditions – there are no changes to the service per se other than decreasing the gap to meet demand.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	√			This activity will improve care quality indicators – Time to be seen, ambulance offloads, 4 hour performance, and average time to clinically ready to proceed, so will improve the patient experience and the overall level of safety within the department.
Disability	√			This activity will improve care quality indicators – Time to be seen, ambulance offloads, 4 hour performance, and average time to clinically ready to proceed, so will improve the patient experience and the overall level of safety within the department.
Gender Reassignment		√		Improvement to existing services so neutral impact.
Marriage & Civil Partnerships		√		Improvement to existing services so neutral impact.
Pregnancy & Maternity		√		Improvement to existing services so neutral impact.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities	√			This activity will improve care quality indicators – Time to be seen, ambulance offloads, 4 hour performance, and average time to clinically ready to proceed, so will improve the patient experience and the overall level of safety within the department.
Religion & Belief		√		Improvement to existing services so neutral impact
Sex		√		Improvement to existing services so neutral impact.
Sexual Orientation		√		Improvement to existing services so neutral impact.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	√			This activity will improve care quality indicators – Time to be seen, ambulance offloads, 4 hour performance, and average time to clinically ready to proceed, so will improve the patient experience and the overall level of safety within the department.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		√		Improvement to existing services so neutral impact.

Section 4

What actions will you take to mitigate any potential negative impacts?			
Risk identified	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Time frame**
No risks have been identified.	**N/A**		

How will you monitor these actions?
• Demand and capacity analysis • Nursing Bank & Agency spend analysis • Financial analysis • Appraisals (annual) • Effective rota management via Nursing Rostering (monthly review) • Performance Management: Care Quality Indicators • Statutory & Mandatory Training: Equality, Diversity & Inclusion • Engagement with key stakeholder groups (already established veterans & neurodiversity contact groups) • Business case evaluation

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)
This EIA will be reviewed upon 'option' approval to understand if there are emerging implications based on budget allocation. However, current position remains extant – this is an increase in capacity to meet demand against rotas that are compliant regardless of contract held so no issues are expected.

Section 5

Please read and agree to the following Equality Statement

Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. WVT will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carers etc. and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics

Signature of person completing EIA:	

Date signed:	
Comments:	
Signature of Lead for this activity:	
Date signed:	
Comments:	

Report to:	**Private Board**
Date of Meeting:	**05/09/2024**
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]

The report provides an update on the work undertaken by the One Herefordshire partnership. Good progress is being made on integrating general practice and community services responding to urgent care with co-location of teams planned for October. This is a significant step towards the urgent care 'blueprint' designed last year.

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.

1.0 Integrated Care System Update

The ICB has commenced the process to re-procure the GP out of Hours service which has relevance to the integrated urgent care vision (blueprint) for Herefordshire.

2.0 One Herefordshire Partnership (One HP) Update

<u>One HP Strategy Forums.</u>

Each month One HP invites a broader membership (tailored to the subject) to an extended session to spend a little more time looking at some of the strategic priorities for Herefordshire.

Joint Strategic Needs Assessment

In August One HP received an update on the development or our local Joint Strategic Needs Assessment (JSNA). Health and wellbeing boards have a statutory duty to produce a JSNA for their area. The JSNA is essentially a continuous process of identifying local needs to inform commissioning decisions.

One HP has taken on a system wide role to support the Health and Wellbeing Board in the development of Herefordshire's JSNA and receives quarterly report at the Strategy Forums.

Integrated Urgent Emergency Care

One HP had agreed an Integrated Urgent Emergency Care vision (blueprint) at the start of 2023/24. The vision essentially focussed around a 'single point of access' for all 'on-the-day unplanned care' resources across Herefordshire with a clinical assessment being undertaken to determine need and the most appropriate service being deployed based on need rather than on the point of access. This 'vision' was agreed by all One H Partners and shared with the Integrated Care Board.

A year later, One HP is refreshing that vision to reflect learning over the last year as our collective teams begin to work more closely together e.g. Herefordshire General Practice now providing out of hours medical support to the Hospice. The refreshed 'vision' needs to also reflect the progress we have made, and are making, in structurally integrating our services more closely e.g. planned developments to the Community Response Hub and Virtual Wards.

A newly created One HP Urgent and emergency care forum has agreed the draft changes, and these will be presented to the One HP in September.

Strategy forums have also received updates from Partners regarding Technology Assisted Living and reviewed partner financial savings plans for this financial year.

<u>One HP main sessions</u>

Herefordshire Together

One HP received a first quarterly update on the work of the Herefordshire Together Collaborative where the focus is on prevention and inequalities. All actions are on track and good progress is being made. The key risk remains the ongoing funding for Talk Wellbeing. The work streams are outlined below:

1. Establish system steering group - Herefordshire Together Collaborative (Complete)
2. Establish a collaborative approach to coproduction & engagement (On Track)
3. Clarify and commission the requirements for VCSE infrastructure support (On Track)
4. Deliver the 2024-2025 work programme for Herefordshire Together (On Track)

5. Develop a prevention/inequalities programme building on the Talk Communities review and Talk Wellbeing evaluation (On Track)

6. Improve functioning of CAN meetings to ensure that intelligence feeds up and down (On Track)

7. Evaluate success of Talk Wellbeing and secure long-term funding (On Track)

Business Cases/justifications

One HP has recently approved/recommended two business cases

Same day bridging team (BCF funding)

In order to prevent avoidable admission to hospital for those frail patients who medically do not require an admission but do need some support at home, a same day Bridging Service has been proposed. The proposal extends the existing Hospital at Home workforce and provides a dedicate resource to support Frailty SDEC patients at home within 2 hours of a decision to discharge. The Better Care Funded proposal was supported by One HP and will be live in the autumn.

Community Response Hub - Single Point of Access (ICB funding)

This plan strengthens both volume and availability of the clinical resources with the Community Integrated Response Hub (to be renamed to Community Referral Hub in a planned September relaunch) and creates a greater capability to take referrals from health and care professionals across Herefordshire, including WMAS, General Practice, WVT (ED and SDEC) and Care homes. This is a significant element of the winter plan to reduce emergency demand for admission.

The increased capability will provide support for an additional circa 2000 patients per annum and lead to system savings of circa £700k with a cost of circa £350k

One HP supported the proposal and recommended the case to the ICBs Strategic Commissioning Committee which will review the case on the 4th September 2024.

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Trust Infection Prevention Annual Report 2023-24
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Laura Weston, Lead Infection Prevention Nurse
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To present the Trust Infection Prevention Annual Report.

2. Recommendation(s)

Following discussion and scrutiny at Quality Committee, Board is asked to approve the report.

3. Executive Director Opinion[1]

This report summarises the key infection prevention and control (IPC) initiatives and activities of Wye Valley NHS Trust (WVT) from the 1st April 2023 to 31st March 2024.

The report is written in line with suggested best practice and includes our performance against those key performance indicators as set out in the NHS Standard Contract.

The year has continued to be dominated by high prevalence of respiratory infections, and our annual report reflects this. Our focus on hand hygiene, cleanliness and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care.

The Trust remains on intensive support from NHSE England and they have overseen our improvement activities and continue to provide support to the infection prevention team and wider trust as we progress our improvement journey.

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

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

NHS
Wye Valley
NHS Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2023/24

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Executive Summary

This report summarises the key infection prevention and control (IPC) initiatives and activities of Wye Valley NHS Trust (WVT) from the 1st April 2023 to 31st March 2024.

The year has continued to be dominated by high prevalence of respiratory infections, and our annual report reflects this. Our focus on hand hygiene, cleanliness and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas. The Quality Committee continued to scrutinise our infection prevention performance at quarterly intervals on behalf of the Board throughout 2023-24.

Section 1: Key Outcomes of 2023/24

- The Trust reported one Trust attributed Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias during the year 2023/24 against a threshold of zero.
- Sixty six patients were identified with a Gram negative blood stream infection (GNBSI). This included 52 Escherichia coli (E. coli) GNBSI, 11 Klebsiella species (Klebsiella spp.) GNBSI and 3 patients with a Pseudomonas *aeruginosa* GNBSI.
- Six of the reported GNBSI were linked to the presence of an indwelling device. Areas of learning related to the completion of device documentation.
- The Trust reported 37 cases of hospital attributable *Clostridioides difficile* infection (CDI) against an NHS England set trajectory of no more than 43. Post infection reviews identified that 31 of these cases had learning opportunities
- There were 176 patients who were deemed to have probable or definite hospital onset COVID-19 infection.
- There were 35 infection outbreaks reported during the year. These all meet the national criteria set for declaring outbreaks. This included 24 outbreaks due to COVID-19, 8 due to norovirus infection, 2 outbreaks of Influenza and 1 due to MRSA colonisation.
- Hand hygiene and bare below the elbow (BBE) audits of compliance are completed monthly by the Infection Prevention nurse team and ward/ department based clinical staff. The mean compliance score for hand hygiene practice was recorded as 95% and 97% for BBE compliance.

Section 2: Introduction

This annual report covers the period 1st April 2023 to 31st March 2024 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider against the cleanliness and IPC requirements detailed in the legislation. It looks at all aspects of IPC, including monitoring and surveillance, environment, cleaning, staff, policies and laboratory provision.

Criterion Compliance	What the registered provider will need to demonstrate
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4	Provide suitable accurate information on infections to service users and their visitors & any person concerned with providing further support or nursing/medical care in a timely fashion.
Criterion 5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide secure adequate isolation facilities.
Criterion 8	Secure adequate laboratory support as appropriate.
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Ensure, as far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

NHS England (NHSE) National infection prevention and control board assurance framework was updated nationally in September 2023. This is set out using the Hygiene Code criterion, and this annual report also provides assurance of compliance with this framework.

The Trust supports the principles that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection must be in place within the Trust.

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2024-25 as we continue to manage and move beyond the challenge of the COVID-19 pandemic.

WVT provides both acute and community healthcare services, including neighbourhood teams, maternity and children's services for Herefordshire. Acute and general services are provided from the Hereford County Hospital Site with over 250 inpatient beds across 18 wards and departments. Community inpatient care is provided in three community hospitals Ross, Bromyard and Leominster.

The Hereford County Hospital site is a private finance initiative (PFI) site and the NHS Trust partners are Mercia Healthcare and Sodexo. Estates and facilities services are provided in house at the community sites.

The term Infection Prevention Service is a collective term used throughout the report and includes the Infection Control Doctor and the Infection Prevention nursing team.

A list of abbreviations used throughout this report can be found in Appendix 1.

Section 3: Compliance

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

Infection Prevention Service & structure

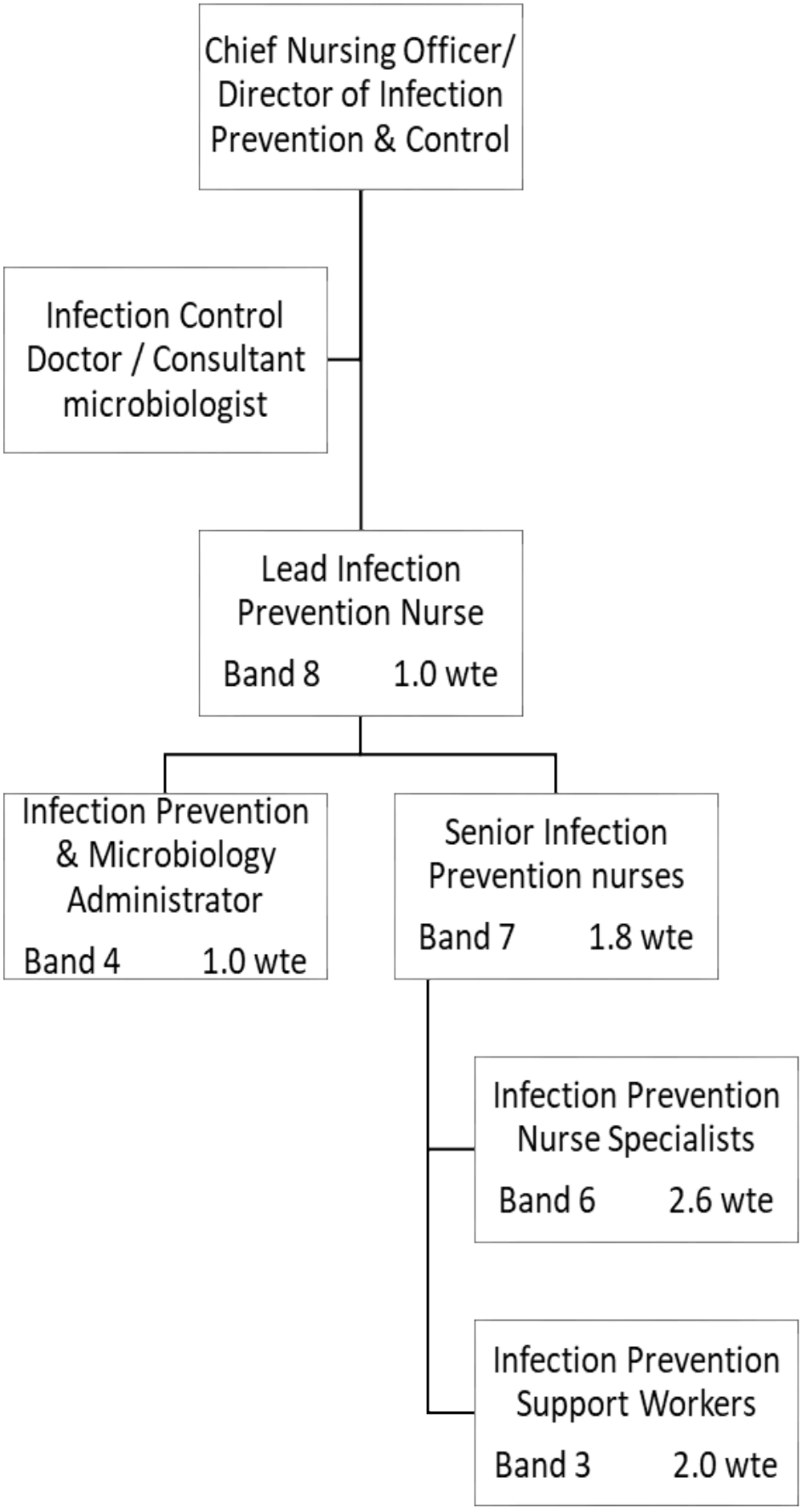
The Infection Prevention Service provide IPC advice and support to wards and departments. The Infection Prevention nursing service is provided seven days a week between 08:00-16:00. Out of hours microbiologist cover is provided by the on-call Consultant Microbiologists from Hereford and Worcester.

The Chief Nursing Officer also holds the role of Director of Infection Prevention & Control (DIPC) and has overall responsibility for the Infection Prevention team.

An Associate Specialist in Microbiology holds the role of Infection Control Doctor. This post is for 4 programmed activities. The role is supported by the Microbiologist team in their absence.

The Infection Prevention nursing team remain in the Corporate division directly line managed by the Chief Nursing Officer. Nursing team members have been allocated to each division to support infection prevention practice and governance within those divisions. To ensure that IPC is at the forefront of divisional governance, information is disseminated to the Board and Divisions via monthly infection prevention reports.

The team continued to support frontline staff and prioritise urgent IPC issues during the waves of respiratory illnesses including COVID-19 and during winter pressures. Any priorities that were



not completed throughout the year have been reviewed and added to the Infection Prevention 2024-25 schedule as appropriate,

Committee structures and assurance processes

Trust board

The Code of practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive has overall responsibility for the control of infection at the Trust, the Trust designated Director of Infection Prevention and Control (DIPC) role is undertaken by the Chief Nursing Officer. The DIPC attends Trust Board meetings with detailed updates on IPC matters. The Infection Control Doctor also attends Board meetings as required.

Quality committee

The Quality Committee is a sub- committee of the Trust Board and has overarching responsibility for managing organisational quality risks. This committee reviews high level infection prevention key performance data monthly and a detailed report is presented to the committee by the Lead Infection Prevention Nurse quarterly. This report outlines the Trust's compliance with statutory obligations and work streams, providing board assurance. The Chief Nursing Officer is a member of the Quality Committee.

Infection Prevention committee

The Infection Prevention Committee is chaired by the DIPC and in their absence, by the Infection Control Doctor. The sub-committees of the Infection Prevention Committee are:

- Decontamination Committee
- Cleanliness Committee
- Water Management Group
- Ventilation Committee
- Surgical Site infection surveillance group (new this year)
- Antimicrobial Stewardship Committee (new this year)

The Infection Prevention Committee then reports directly to the Quality Committee.

Other meetings and committees attended by members of the Infection Prevention Service are as follows:

- Post infection reviews with appropriate clinical staff and colleagues from the Herefordshire and Worcestershire Integrated Care System (H&W ICS)
- Capital planning and equipment committee (CPEC)
- Health and Safety committee
- Estates and Facilities performance meetings for acute and community
- Countywide healthcare associated infection forum chaired by H&W ICS
- Countywide *Clostridioides difficile infection* reduction forum chaired by H&W ICS
- New build and re-design meetings
- Incident meetings as they arise
- Infection Prevention service meetings
- Joint cleanliness monitoring with WVT and the private finance initiative partner.

- Patient Experience Forum & Committee
- Patient led assessment of the care environment (PLACE)
- Safety Sharps working group
- Food safety committee

Antimicrobial Management Group

The Trust has an Antibiotic Stewardship Team consisting of an Antimicrobial Pharmacist and the Antimicrobial Stewardship (AMS) lead / Associate Specialist in Microbiology. The group meets monthly and produce a quarterly report on antibiotic use and audit results which is presented at the Infection Prevention Committee.

External assurance reviews

The Trust remains at an Intensive Support level of support with NHS England for infection prevention and control following a multi-agency visit in October 2022. During 2023/24, the infection Prevention service has received onsite support and supervision from ICS and NHSE infection prevention specialist colleagues. This has included them leading on an IP nurse away days and also undertaking visits onsite working alongside the IP nurse team.

The H&W ICS Infection Prevention Nurse has also undertaken regular assurance reviews throughout 2023/24. Feedback is provided and reported to Department leads as appropriate.

The IP service continue to address the areas highlighted for improvement raised in 2022 and logged in the Infection Prevention Improvement Plan (Appendix 2). The adherence and completion with the plan has been monitored via the Infection Prevention Committee and the Quality Committee on a quarterly basis. All actions have been completed by March 2024.

The Infection Prevention Annual Plan for 2024/25 will continue to focus on these elements to ensure IP standards become embedded into Trust practices.

Board assurance Framework

NHSE issued a National Infection Prevention and Control Board Assurance Framework (BAF) in 2022, updated in September 2023. This BAF supports all healthcare providers to effectively self-assess their compliance with the National infection prevention and control manual (NIPCM) and other related infection prevention and control guidance. The framework helps identify risks associated with infectious agents and provides an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability.

Compliance against the 10 key lines of enquiries (KLOE) has been regularly reviewed by the Infection Prevention service with the support of the Quality & Safety team and reported quarterly to the infection Prevention Committee. By year end, 5 of the 10 KLOE are fully compliant; 5 KLOEs require additional evidence to ensure full assurance is achieved and 0 are non-complaint. Actions to support achieving compliance have been developed and included in the Trust's Infection Prevention Improvement plan.

Infection Surveillance

In May 2023, the NHS Standard Contract for 2023/24 was published. This stipulated that all Community Onset Healthcare Associated (CO-HA) and Hospital Onset Healthcare Associated (HO-HA) infections are to be included in Trust's data reporting.

Hospital onset healthcare associated: (>AD+1) - HO-HA	Cases that are detected in the hospital two or more days after admission (where day one is day of admission).
Community onset healthcare associated: (<AD+1) CO-HA	Cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (where day one is day of admission).

Healthcare Associated Infections Review Panel

All healthcare associated infections (HCAI) that occur within the organisation are appraised by the HCAI Review Panel. The review panel meets weekly with the primary objectives of providing a multidisciplinary review of all HCAI incidents, identifying areas of good practice/ improvement and ensuring that any HCAI which necessitate serious incident reporting are identified and escalated.

The panel consists of the Infection Control Doctor, Lead Infection Prevention Nurse, and Quality & Safety manager, H&W ICS Infection Prevention Nurse Specialist and Clinical Representatives.

All HCAIs are logged as incidents on the Trust incident reporting system.

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemias

Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult to treat infections in humans. The Department of Health continues to drive a Zero-tolerance approach to MRSA bacteraemia.

During 2023/24, one Trust appointed MRSA bacteraemia cases was reported. The case was reviewed at the HCAI Review Panel and the Trust Patient Safety Group to look for preventable causes and identify any future learning opportunities.

Outcome from the reviews have been shared with the Division.

Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemias

MSSA is the much commoner antibiotic sensitive version of *Staphylococcus aureus* and less likely to be hospital acquired. As a formal target for reduction of MSSA bacteraemia cases has not been defined in the NHS Standard Contract for 2023/24, the Infection Prevention Committee agreed to establish a local threshold for MSSA bacteraemias following the calculation used to set the GNB threshold in the NHS Standard Contract 2023/24. This supports local monitoring and enables effective benchmarking; this has been set at 12 cases for 2023/24.

Twenty one MSSA bacteraemia cases were apportioned to the Trust for the period 2023/24, in comparison to 15 in 2022/23.The 2023/24 cases included 4 CO-HA and 17 HO-HA cases. All cases were reviewed to look for preventable causes when the source of infection was unknown or device related. Eight cases were identified as being linked to the patients underlying health concerns. Seven cases were linked to the presence of an indwelling invasive device, specifically the documentation of ongoing care management.

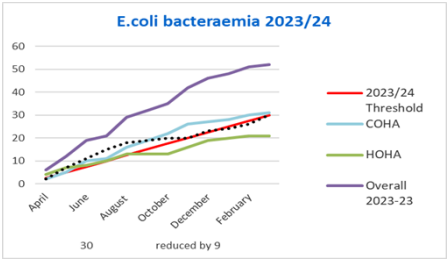
The Infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

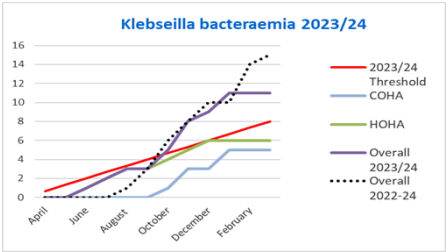
Gram negative blood stream infections

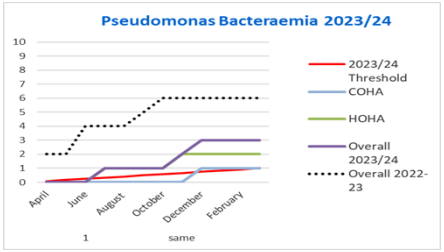
A healthcare associated Gram-negative blood stream infection (GNBSI) is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days. The top three GNBSI causative organisms which account for 72% of all Gram negative bacteraemias are: Escherichia coli (*E. coli)*, *Pseudomonas aeruginosa* (*Pseudomonas*) and *Klebsiella* species (*Klebsiella*).

The focus is on the reduction of the top three GNBSIs and includes all CO-HA and HO-HA reported cases. In 2023/24 the following cases of GNBSI were reported:

Bacteraemia	Standard Contract Threshold for WVT	End of year tally
E.coli	30	52 ↑
Klebsiella spp.	8	11 ↑
Pseudomonas	1	3 ↑







All cases were reviewed and root cause analysis carried out to look for preventable causes when the source of infection was unknown or device related.

Forty four of the cases were identified as being linked to the patients underlying health concerns. Six of the reported GNBSI were linked to the presence of an indwelling device. Areas for learning were related to the completion of device documentation.

The infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

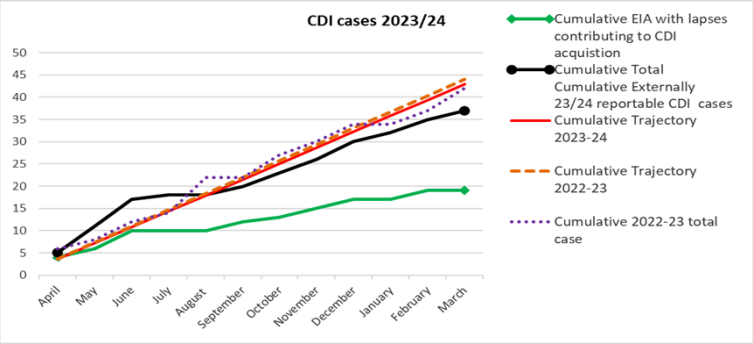
Clostridioides difficile infection (CDI)

Clostridioides difficile (C. difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. It forms resistant spores which require very effective cleaning and disinfection to remove them from the environment.

C. difficile Infection (CDI) is nearly always preceded by antibiotic treatment but antibiotics may have been stopped up to 6 weeks before the patient presents with symptoms. Although most antibiotics have been implicated, broad-spectrum agents such as cephalosporins, quinolones and carbapenems (e.g. meropenem) are most likely to cause it as they wipe out the "normal flora" of the gut which usually holds *C. difficile* in check.

The reportable cases of CDI are CO-HA and HO-HA CDI cases that are positive by two tests, polymerase chain reaction (PCR) and enzyme-linked immunosorbent assay (EIA).

WVT was given an externally set trajectory of 43 cases of CDI this year. This included CO-HA and HO-HA cases. The Trust reported 37 CDI cases by the end of March 2024. This included 8 CO-HA cases and 29 HO-HA cases.



All reportable cases of CDI are investigated by the Health Care Associated Infection review panel. Learning opportunities were identified in 31 cases. Learning opportunities noted included:

- Hand Hygiene & BBE practices
- Clinical equipment cleaning
- Prescribing and/ or administrating antibiotics outside of guidelines
- Environmental cleanliness
- Stool sampling processes

The Trusts CDI mortality rate at year end was 19%. This is 6% above the national benchmark. A mortality structured judgement review is being undertaken on the 7 patient cases to identify any areas for learning and improvement.

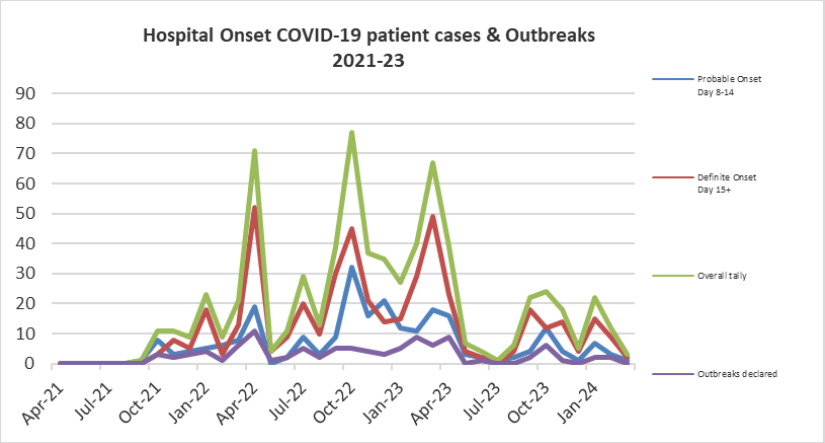
The Trust remain an outlier for CDI rates compared to other Trusts in the region and nationally. Some of the high rate but not all of it is explained by the fact that the denominator for the rate is taken from the NHSE quarterly KH03 occupied overnight bed data and does not include the community hospital beds.

COVID-19

The infection prevention year of 2023/24 continued to be dominated by the response to the COVID-19 pandemic.

In total, 176 patients were deemed to have probable or definite hospital onset COVID-19 infection (See Appendix 3 for COVID-19 onset definition); this is a reduction from 463 reported patient cases in 2022/23.

Twenty four outbreaks were declared due to COVID-19 linked transmission. 60 COVID-19 outbreaks had been recorded in 2022/23.



The prevalence of COVID -19 infection both internally and within the Herefordshire community was regularly discussed in the Herefordshire & Worcestershire ICS led meetings to ensure a unified system approach to the peaks in reported cases.

National recommendations for COVID-19 management have been implemented by the Trust following approval at the Infection Prevention Committee and or Trust Management Board. Outbreak meetings were held as required and were attended by key stakeholders including NHS England and UKHSA. The Infection Prevention Service continued to be heavily involved in planning and supporting patient pathways and providing staff education. The communications team issued a daily bulletin with key messages and updates for staff.

Carbapenemase-producing *Enterobacteriaceae* (CPE)

Carbapenemase – producing *Enterobacteriaceae* are bacteria that are very resistant to the last line of defence antibiotics, the carbapenems. They present a significant risk to healthcare. When isolated from a microbiological specimen, infection control measures are instigated to reduce the risk to other patients. The Trust has a CPE policy in place which reflects screening guidance recommended by UKHSA.

Seven healthcare acquired cases of CPE where reported in 2023/24. All infection prevention measures were actioned. In 2 of the cases there was evidence of person to person spread.

A full review of the cases has been undertaken and actions are in place to support timely identification and effective patient management. This includes:

1. Review of screening questions undertaken in the Emergency department
2. Review of screening reviews in ward settings
3. Tracking cases by the IP team
4. Environmental screening for future cases

Measles

UKHSA alerted all healthcare providers in the autumn of 2023 that measles was circulating in England and that the World Health Organisation (WHO) warned that Europe is likely to see an increase of infections. All recommendations issued by UKHSA were actioned by the Trust.

- Check staff immunity
- Promote MMR vaccination to patients
- Awareness of measles symptoms to enable swift patients isolation on arrival to healthcare setting
- Undertake contact tracing for measles exposures in setting
- Notify UKHSA of any suspected / confirmed cases

No cases of Measles were reported in Wye Valley NHS Trust.

M-POX

Mpox (previously known as monkeypox) is a rare infection most commonly found in west or central Africa. There was an increase in cases in the UK throughout 2022/23 with most cases arising in the United Kingdom, especially London. UKHSA issued guidance on health promotion and infection management & control. All measures were adopted by Wye Valley Trust and the Infection Prevention Service worked collaboratively with the ICS and local providers to ensure all measures were in place.

No cases of Mpox were reported in Wye Valley NHS Trust.

Tuberculosis (TB)

There were no healthcare associated TB incidents reported in 2023/24.

MRSA colonisation

An outbreak of MRSA colonisation was reported in September 2023. Three patients linked to time and place were identified through routine screening. Ribotyping of the patient's samples identified the same strain confirming cross contamination. To identify cause, environmental swabs of the associated Bay were taken; three sites were identified as being contaminated with MRSA.

All affected patients were treated as per Trust MRSA policy. Enhanced cleaning was undertaken in the affected bay. Repeat screening of the environment recorded zero MRSA contamination.

No further linked cases have been reported.

This incident was reported to UKHSA.

Seasonal infections

- Norovirus

All stool samples submitted to the laboratories are tested for Norovirus as routine. 205 patients were identified as having norovirus whilst inpatients in Wye Valley NHS Trust.

Eight norovirus outbreaks were declared between November 2023 and February 2024; in total 77 patients and 48 staff were affected, all incidents were managed as per Trust policy. Patient flow restrictions were applied in four of the outbreaks to contain the spread of infection.

See Appendix 3 for details on Norovirus associated outbreaks.

Outbreak meetings were held as required and were attended by key stakeholders including NHSE and UKHSA.

- Influenza

127 patients were identified as having influenza during 2023/24; the majority of these cases were identified November 2023 - March 2024. This was reflective of the national picture and also of enhanced testing.

Two outbreaks due to Influenza were declared as per national and regional guidance. Both outbreaks occurred in February 2024. The wards remained open as infection spread was contained.

See Appendix 3 for details on Influenza associated outbreaks.

Hand Hygiene & Bare below the elbow (BBE) compliance

The Trust expected compliance for hand hygiene and BBE practices for staff working within clinical settings has been set locally as 100%. Compliance with this objective is monitored monthly by clinical areas. The Infection Prevention nursing team undertake validation audits of compliance monthly throughout the Trust. 6509 observations were completed in 2023/24. The overall annual scores:

Hand hygiene	95%
BBE	97%

Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Decontamination

There has not seen a significant incident linked to Decontamination practices during this financial year. Incidents, if they occur, are discussed at the Decontamination Committee.

Endoscopes continue to be processed at the County Hospital in Hereford and at Ross Community Hospital in their respective endoscopy departments. Ear, nose and throat scopes are also processed in the Endoscopy Decontamination suite, bringing a centralised process to the clinics within the trust.

A Joint Advisory Group (JAG) audit on all endoscopy services was completed in 2024 and most actions are currently being worked through. This audit process provides assurance in the safety and quality of endoscopy decontamination activities and ensures the processes are appropriate. Site wide reviews by the Trust appointed Authorising Engineer and the company Tristel with no serious concerns identified.

All surgical instruments continue to be re-processed in the sterile services department at the Hereford County Hospital which is run by our PFI partner. Protein detection has been implemented and it is effective in assisting Central Sterilising Services Department (CSSD) in managing their decontamination processes. Furthermore CSSD services have increased capacity to cope with surgical robot instruments and increased turnover of standard instruments due to the opening of the new theatres.

Local decontamination of dental instruments is undertaken in most of the dental access centres. The washer disinfectors at all sites were on a loan contract. However, these assets now belong to the trust. The Trust has extended the service contract with the current service provider. Competitive quotes have been obtained for new decontamination equipment (autoclaves and washer disinfectors) in 2024 and this currently sits with procurement.

A Laundry assurance visit did not occur in 2023/24 but is scheduled for the coming year. The visit will be to gain assurance of the laundry providers processes. The laundry provider Elis provide a microbiology report to the Trust every month, which is reviewed, monitored and discussed at the Decontamination Committee.

A review of the Decontamination committee is planned in 2024/25. This will consider attendance and agenda. This will coincided with the potential restructuring of Decontamination Lead and Decontamination authorised person roles.

Cleanliness Monitoring

The Trust has now completed two full years of input to deliver the requirements set out under National Standards for Healthcare Cleanliness 2021 (NCS21). The standards are embedded into our Cleanliness culture whereby the monthly Cleanliness Committee meetings are generally well

attended by all areas of the Trust and NCS21 compliance is the main focus of the meeting. Clinical leads are aware of their expectations and the standards to be met.

Some important considerations to note for 2023/4 include the change of over (mid-year) of the Monitoring tool, from using 'Formic' to the now established 'Ambinet' bespoke auditing system (created specifically for NCS21 monitoring). Although initially there was a notable difference in the audit scores, the bespoke system is generating consistency of results and we are witnessing similar trends across the Trust and each of the Functional Risk categories (FR1 to FR6). Secondly, the Trust now undertakes joint monitoring with Sodexo, members of the Infection Prevention team and a local Clinical representative when possible. These audits provide a much greater level of assurance and management input than previously known. The speed of defect rectification has subsequently improved greatly due to this level of input at the time of audit.

High Risk (FR1) areas such as ED, Theatres, SCBU, ITU and Delivery Suite continue to receive significant focus with local action plans receiving input from Clinical and Estates management. Audit score improved over the latter part of 2023/4. General Ward areas (FR2) which receive audits on a monthly basis have remained more consistent and very few action plans are required for Audits that receive a 3 star rating or below.

The below table indicates the last three years scores for both Domestic and Clinical cleaning, and shows individual Star rating for each of the elements plus the Combined (displayed) Star rating which also includes the relevant 'Estates' scores.

Year	**FR1 Domestic Cleans**	**FR1 Clinical Cleans**	**Star Rating**	**Combined Star Rating (Displayed)**
2021/22	95.8%	94.3%	4* & 3*	N/A
2022/23	96.3%	94.25%	4* & 3*	4*
2023/24	98.2%	94.16	5* & 3*	5*
Year	**FR2 Domestic Cleans**	**FR2 Clinical Cleans**	**Star Rating**	**Combined Star Rating (Displayed)**
2021/22	93.7%	95.1%	4* & 5*	N/A
2022/23	93.9%	93.75%	4* & 4*	4*
2023/24	97.9*	92.4*	5* & 4*	5*

These scores show a continued improvement in Domestic Cleans and a continuing albeit small reduction in Clinical Clean scores from the previous year, across both FR1 and FR2 risk areas.

#WyeClean Quality Improvement campaign

#WyeClean has continued throughout 2023/24. Themed IPC roadshows have been held throughout the year focusing on key clinical cleaning responsibility's such as specific equipment cleaning, cleaning products to promote and embed standardization of practice.

#WyeClean will continue into 2024/25 to embed training.

Patient Led Assessments of the Care Environment (PLACE)

The PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

The aim of PLACE assessments is to provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. Clinical facilities across all four Wye Valley Hospitals were inspected by PLACE assessors between September and October 2023.

The results were published March 2024. Action plans addressing all issues highlighted by the assessment have been developed. This is being overseen via the Patient Experience Committee.

Individual sites	Cleanliness Score %	Food Score %	Organisational Food Score %	Ward Food %	Privacy, dignity & wellbeing Score %	Condition, appearance & maintenance Score %	Dementia Score %	Disability Score %	2023 Average score %
National Average	98.4%	92.0%	91.2%	92.9%	89.2%	95.9%	85.6%	85.6%	91.3%
Weighted Organisation average	98.4%	90.5%	93.8%	89.4%	81.0%	97.1%	75.3%	77.4%	87.9%
COUNTY HOSPITAL	98.2%	90.0%	94.6%	88.0%	81.1%	97.9%	74.9%	77.2%	87.7%
BROMYARD HOSPITAL	99.6%	90.3%	87.3%	94.3%	81.0%	95.4%	71.6%	71.6%	86.4%
ROSS HOSPITAL	98.3%	93.8%	92.0%	96.1%	82.3%	94.8%	80.7%	82.6%	90.1%
LEOMINSTER HOSPITAL	99.5%	93.0%	92.0%	94.3%	77.8%	91.8%	74.5%	77.6%	87.6%

Key

- On or Greater than National Average
- Under national Average – within 5%
- Under national Average – greater than 6% below national average

The 2023 audit tool included some changes from previous PLACE assessments. However, they were kept to a minimal, allowing comparison with the 2022 results possible.

PLACE LITE inspections are planned to commence in 2024/25.

Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship for 2023/24

This is a programme of activities which aims to ensure that antibiotics are used carefully and in ways which minimise side effects and the development of antibiotic resistance. This is very important as increasing antibiotic resistance threatens the delivery of healthcare now and in the future.

The Trust has an antimicrobial stewardship team consisting of consultant microbiologists / Infectious diseases specialist, a 0.6 Whole Time Equivalent (WTE) antimicrobial pharmacist, and 0.5WTE pharmacy technician.

Key achievements in 2023/24 include:

- Launch of the Intravenous to oral switch campaign
- Taking part and completing the national Point prevalence Survey for antibiotic use and hospital associated infections
- Relaunching the Trust AMS group
- Expanding OPAT and successfully submitting a business case to pilot the use of antibiotics given via a Folfusor elastomeric pump.
- Completing baseline audits for antibiotic use across the Trust
- Completing “deep dive audits” for non-adherence to guidelines, ward audits as part of Enhanced review periods following C difficile cases, and vancomycin prescribing
- Setting up a weekly antibiotic ward round with the respiratory team
- Maintaining national targets for reduced antibiotic consumption and reducing antibiotic use from the WHO “watch” and “reserve” categories
- Reporting quarterly to the IPC

There are a number of work streams in progress including a general review of antibiotic guidelines, update and relaunch of vancomycin prescribing guidelines, launch of a *S.Aureous* bacteraemia pathway, and launch a penicillin de- labelling protocol

Criterion 4:

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Patient leaflets

The infection prevention related leaflets are available in hard copy or through the Trust intranet and public facing web sites. All leaflets are reviewed by the Trust reading group prior to publication.

Communication Team

Establishing a clear communication programme is a key requirement in the improvement of patient care, the instigation of IPC initiatives, public information and visitor safety, as the way we all worked had to change, often at short notice.

The Infection Prevention Service has worked closely with the Communications Team throughout 2023/24. They have been instrumental in assisting with in ensuring the correct media information has been developed in a timely and clear manner.

The Communications Team attend incident and outbreak meetings to ensure that appropriate messages are delivered both to Trust staff and to the public. They have issued frequent Trust bulletins throughout 2023/24 with regular contributions from the Infection Prevention Service team members. Wider dissemination of current issues is also achieved by global emails and through the Trust weekly Team Brief newsletter.

The Trust website also promotes the IPC information page for general IPC issues and guidance including link nurse information, information on MRSA, *Clostridioides difficile* and other organisms. This is also the media area to review a range of information leaflets on various organisms and access the regularly updated policies and guidance.

Criterion 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Notification of infections in a timely fashion is facilitated by laboratory reports directly to the Infection Prevention nurse team from the laboratory staff. These are also available electronically via the MAXIMS laboratory system. The ward area is then either telephoned or visited by their appointed Infection Prevention nurse to ensure that the correct information is available for treatment and care of that patient.

If patients have been identified as having CDI or MRSA and they have been discharged, a letter is sent to their general practitioner.

The Infection Prevention nurses advise the Clinical Site Management team and ward staff regarding isolation and management of patients with known or suspected infections. The electronic patient record system, MAXIMS, has a notification flag on it so that patients with a history of alert organisms such as MRSA can be brought to the attention of nursing and medical staff when accessing the electronic patient record. The Infection Prevention nurse team also attend the daily bed meetings to advice on patients with known or suspected infections and on bay and ward closures.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

Compliance with screening for COVID-19, MRSA colonisation and CPE is also monitored. This information is reported to the Infection Prevention committee monthly.

Mandatory surgical site infection surveillance (SSI)

During the financial year April 2023 – March 2024, 260 hips operations and a total of 333 knee operations took place in WVT.

WVT has received the UKHSA reports back for 3 of the 4 data collection periods during this financial year. Jan – Mar 2024 data was submitted and reconciled in June 2024 and the UKHSA report will be available by Sep 2024.

The Trust has undertaken continuous data collection and has participated in all data collection periods. WVT will continue to participate in each of the quarterly data collection periods going forward.

The inpatient data and the post discharge data collection has been undertaken by designated clinical members of staff on Teme Ward where the patients were cared for post-surgery & data collection has been inputted onto the UKHSA database by the Admin staff in the Surgical Directorate. The Infection Prevention Team reviews the data prior to submission and reconciliation.

In the period of Jul – Sep 2023: 2 externally reportable SSI's were identified.

WVT received a notification from UKHSA regarding the Jul – Sep 23 data collection period to highlight the Trust was an outlier for hip SSI and WVT has responded with the improvement plan and no further externally reportable hip SSI's have been identified.

Archive externally reportable SSI data:

Type of surgery	**April - June 2015**	**April– June 2016**	**April - June 2017**	**April - June 2018**	**April 2019 - March 2020**	**April 2020 - March 2021**	**April 2021 – March 2022**	**April 2022 – March 2023**
Knee replacement	0.9%	0%	1.2%	0%	1.6%	No Data submitted	0%	0%
National rate	2.1%	1.9%	1.7%	1.6%	1.2%		1.2%	1.2%
Hip replacement	0%	0%	0%	0%	0.4%	No data submitted	0%	1.6%
National rate	1.3%	1.2%	1.1%	1.0%	0.9%		0.8%	0.8%

2023 – 2024 data:

Type of surgery	April- June 2023	Jul– Sep 2023	Oct– Dec 2023	Jan– Mar 2024
Knee replacement	0%	1.6%	0%	0%
National rate	1.0%	1.0%	1.0%	pending
Hip replacement	0%	2.0%	0%	0%
National rate	0.8%	0.7%	0.8%	pending

Outbreak and incident management

The Infection Prevention Service is involved in the management of outbreaks, periods of increased incidence and incidents.

The Infection Prevention nurse team monitor all alert organisms to identify trends and potential links between cases based on their location. If links are identified a meeting is convened to discuss potential cases. This is a manual process and completed without the aid of an automatic surveillance system.

All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC and lessons learnt are shared with the Trust and disseminated through communications such as Safety Bites bulletin.

Attendees at outbreak and incident meetings include the DIPC, Infection Control Doctor, Infection Prevention nurses, Leads of the affected areas and Estates and Facilities colleagues'. Colleagues in the H&W ICS, UKHSA and NHS England are informed and dial in to participate in the meeting if necessary.

A list of all outbreaks declared in 2023/24 can be found in Appendix 3,

Criterion 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Each member of WVT staff has their responsibility for infection prevention within their job description. All staff are required to attend induction training before they work clinically and an annual refresher training session. This process is then monitored via the electronic staff record and is key to pay progression and revalidation. The block booked agency staff, have their in-house training as well as a local induction delivered by the area that they are working in. All contractors have IPC training which has been prepared by the Infection Prevention nurse team but is delivered by our estates team and our PFI partner.

Education resources on Personal protective equipment (PPE), Standard infection control precautions and hand hygiene have been developed to educate and support the Trust's Infection Prevention Champions.

Infection Prevention Team/Team Development

The Infection Prevention Service found this a challenging year due to the ongoing surges of the respiratory infections and the re-emergence of new infections such as Measles, staff shortages and clinical demands. Staff have attended regional & national infection prevention conferences held by the Infection Prevention Society.

Additional team training has included: Leadership and development and the Infection Prevention Society Marion Reed Education programme.

One Infection Prevention Nurse has commenced a Royal College of Nursing led Infection Prevention Degree module.

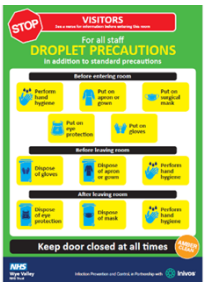
Criterion 7

Provide or secure adequate isolation facilities.

All wards have side rooms available to them. There are a total of 82 side rooms across the County Hospital site, 12 of these are specially ventilated rooms. Three of these are positive pressure rooms and nine are negative pressure rooms. The Infection Prevention nurse team monitor and prioritise the usage of side rooms for patients with known or suspected infections.

The Trusts Prioritisation Reference Guide has been updated in Line with the National Infection Prevention and Control Manual for England (NIPCM, NHS 2022). This was developed for the Clinical Site Management team to follow out of hours. The team are also receive regular updates on the priority side rooms for environmental decontamination using the ultra violet and hydrogen peroxide environmental decontamination equipment.

Isolation room door signs have also been reviewed and redesigned in line with the NIPCM. The Infection Prevention nurse team have held education and awareness sessions on the new tools promoting best practices in patient isolation.



Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for WVT are located in the purpose built Pathology Laboratory on-site at the County Hospital site. The Microbiology Laboratory has full UKAS accreditation. The Trust has declared microbiology as a fragile service due to limited substantive consultant cover. A grow our own workforce strategy is in place with specialty doctors being supported by an experienced consultant microbiologist. The Trust is fully staffed although some of this is by the use of locum staff. The department also has a trainee Consultant Clinical Scientist in post.

Despite this, the Microbiology department were heavily involved in both the laboratory side of developing testing systems, providing IPC and antimicrobial stewardship advice and assisting with HCAI outbreak management.

The Infection Prevention nurse team work closely with the Microbiologists and laboratory staff to ensure prompt handover of alert organism data and management response.

Criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Policies are available for staff to view on the Trust intranet.

The Infection Prevention Service has a rolling programme of policies which require updating each year. In addition, policies are updated prior to review date if national guidance changes. In 2023/24 the team updated the following IPC polices & Standard operation procedures.

- Blood Culture
- Ventilation
- Respiratory policy

All information regarding emerging organisms, infection management guidelines, protocols, pathways and practices have been available to Trust staff via a dedicated page on the Trust Intranet. This was updated regularly throughout the year in line with changes to national and regional guidelines. Information has also been cascaded to staff via the email, Trust Talk and are available on the Trust staff myWVT app.

An Infection Prevention & Control A-Z of Common Infections is available on the trust's intranet. This significantly enhances the quick location of key infection prevention guidance by our front line staff in regards to common infections. Staff also have a direct link from the intranet to the Royal Marsden polices on nursing procedures.

Infection Prevention team audit program

The Trust have an IPC programme of audits in place, in order to demonstrate compliance with the Health and Social Care Act: Hygiene Code. The audits are undertaken by both clinical areas and the Infection Prevention nurse team, to ensure that areas are consistently complying with evidence based practice and policies.

This year's programme of audit continued to concentrate on gaining assurance that standard infection control standards were being upheld across the Trust. This has primarily focused on clinical and environmental cleaning and monitoring the implementation of the NSC21. Any deferred audits have been marked against the 2023/24 Audit plan (Appendix 4).

All audit results are reported into the post infection reviews and reported to Divisions. Any issues identified were fed back to the divisions for action at the time of auditing. The audits provided a balanced picture of the wards involved.

In response to the audits undertaken, Divisions develop local action plans in response to the audit findings. These are reported by Division to the Infection Prevention Committee.

Saving Lives: High Impact Intervention audits

Saving Lives: High Impact Intervention (HII) are audits that monitor compliance with best practice for a number of clinical interventions that will reduce the risk of healthcare associated infections in specific aspects of nursing care. The original audits were amended by NHS Improvement & the Infection Prevention Society in 2017. From April 2018, Wye Valley Trust has implemented modified audits which have been adapted by the Infection Prevention team to incorporate the stipulated care bundles and additional information that will support local initiatives.

The following audits are undertaken quarterly by each clinical area by point prevalence: and the results are collated by the infection prevention team.

- Preventing infection associated with peripheral vascular access devices
- Preventing infection associated with central venous access devices
- Preventing catheter associated urinary tract infection
- Preventing ventilator associated pneumonia

The HII audit data is shared with clinical leads for action and learning. The results per division are displayed in the clinical settings on eth IPC notice boards.

Three HII are not completed as a separate audit by the Infection Prevention nurse team as they duplicate work already undertaken within the organisation. These are:

- Preventing infection in chronic wounds
- Preventing surgical site infection
- Stewardship in antimicrobial prescribing

Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Personal Protective Equipment including FFP3 mask fit testing

All clinical staff working within the organisation have been offered personal protective equipment (PPE) training & Filtering Face Piece protection level 3 (FFP3) Fit mask testing.

The Trust Mask fit testing has been managed by the Lead Infection Prevention Nurse (LIPN) from November 2022; with the infection prevention team taking over the daily running of the service from April 2023. The service runs Monday – Friday 08:00-16:00. However, additional sessions can be rostered based on clinical needs.

All training and testing records are stored centrally on the Trust electronic staff record system.

Training and fit testing will continue throughout the coming year and compliance with national recommendations for fit mask testing will be reported via the Infection Prevention Committee.

Safety Sharps Working Group

The Trust has a Safe Sharp Working Group which is a sub-group of the Health & Safety Committee and is co- chaired by the Trusts Health & Safety Officer and Lead Infection Prevention Nurse. It meets quarterly to evaluate Trust compliance with relevant Health & Safety Legislation and the European Safety Sharps Devices Directive. The occupational health exposure incidents and monitoring reports are discussed and trends in incidents investigated. Safety products are reviewed and any items considered by the Safety Sharps Working Group must be reported to Foundation Group Procurement Group for review/ comment and final approval.

To strengthen the groups governance structure a review of the group's Terms of reference including membership is planned for 2024/25.

Staff mandatory infection prevention training

All staff must attend Trust induction before commencing work within WVT. Infection prevention constitutes part of formal teaching on the clinical staff induction and annual refresher sessions. If there are any emerging infection threats or increased incidents of infection, extra targeted training sessions are undertaken. Training has also been provided for specific staff groups as requested. The Trust threshold for mandatory compliance is 85%. In 2023/24 Trust compliance with IPC mandatory refreshing training:

Level 1 (Non clinical staff): 91.50%

Level 2 (Clinical staff): 81.82%

Infection Prevention Champions

The WVT Infection Prevention Service is supported by over 80 Infection Prevention Champions across all divisions and professional groups. The Champions receive regular information which provides education on incidents that have occurred within the Trust with lessons learnt.

Infection Prevention Champions are expected to cascade information received to their teams.

Section 4: IPC Focus for 2024/25

Infection prevention & control is a priority for Wye Valley NHS Trust. Our focus for 2024/25 will be:

- Reducing the incidence of HCAI infections
- Aligning the IPC review of HCAI infections/ incidents with the PSIRF principles
- Proactive planning for further waves of respiratory and seasonal infections and the surges in endemic infections such as measles and pertussis (whooping cough)
- Advising on the decontamination of the environment and clinical equipment
- Working with Estates and Facilities colleagues to review outstanding estates maintenance work across the Trust
- Reviewing insertion and ongoing care of invasive devices
- Supporting Antimicrobial Stewardship
- Reviewing mandatory training with EDC colleagues to ensure staff receive annual contemporaneous training on infection prevention & control measures.

Section 5: Conclusion

Eliminating avoidable healthcare associated infection has remained a priority for the trust to ensure our patients, staff and the public are kept safe. Infection Prevention and Control is the responsibility of all the Trust employees and the IPC team do not work in isolation. None of this would be possible without the enthusiasm and commitment of Trust and Sodexo staff.

Nonetheless, this year has remained a challenge for the infection prevention service at WVT. The work of the IPC team continues to be unpredictable due to the emergence of new infections and incidences of infection outbreaks. There have been staffing shortages in the team, incidents of infection outbreaks and the Trust did not achieve the externally set objectives of zero MRSA bacteraemias and reductions in Gram negative bacteraemia infections.

However, there have also been achievements. Highlights include a reduction in CDI and completion of the tasks set in the Infection Prevention Improvement Plan.

The successes over the last year have been possible due to the commitment for infection prevention and control of all Wye Valley NHS Trust staff ensuring IPC is high on everyone's agenda. The Infection Prevention Improvement Plan for 2023/24 reflects a continuation of support and promotion of IPC.

Going forward into 2024/25 the IP team will continue to build on and strengthen the improvement work commenced in 2023/24, including the close working relationships with the IPC Integrated care system. There is much planned for the coming year including staff education resources, Quality Improvement initiatives on clinical cleaning and also continuing with interventions to reduce C. difficile and Gram negative bacteraemias.

The IPC service remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Section 6: References

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-onthe-prevention-and-control-of-infections-and-related-guidance

NHS (2022) Infection prevention and control board assurance framework. Updated 13/09/24 Available online 30/04/24: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2022) National infection prevention and control manual (NIPCM) for England Version 2.10 Updated 15/02/24 Available online 30/04/24https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2021) National Standards of Healthcare Cleanliness 2021 Publication approval reference PAR271. Available online 30/04/24: https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdfhttps://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf

Appendix 1: List of Abbreviations

BAF	Board Assurance Framework
BBE	Bare below the elbow
CDI	Clostridioides difficile infection
CO-HA	Community Onset- healthcare associated
CPE	Carbapenemase-producing Enterobacteriaceae
CPEC	Capital planning & equipment committee
CSSD	Central Sterile Services Department
DIPC	Director of infection prevention and control
EIA	Enzyme-linked immunosorbent assay
E. coli	*Escherichia coli*
FFP3	Filtering face piece – protection level 3
FR	Function Risk
GNBSI	Gram negative blood stream infection
HCAI	Health care associated infection
H&W ICS	Herefordshire & Worcestershire Integrated Care system
HO-HA	Hospital Onset- healthcare Acquired
HII	High Impact Intervention
IPC	Infection prevention and control
JAG	Joint Advisory Group in GI Endoscopy
Klebsiella	*Klebsiella* species
KLOE	Key lines of enquiry
LFD	Lateral Flow Device
LIPN	Lead Infection Prevention Nurse
MRSA	Meticillin-resistant *Staphylococcus aureus*
MSSA	Meticillin sensitive *Staphylococcus aureus*

NHS	National Health Service
NHSE	National Health Service for England
NIPCM	National Infection Prevention & Control Manual for England
NSC21	National Standards for Cleanliness in Healthcare 2021
PCR	Polymerase chain reaction
PFI	Private Finance Initiative
PPE	Personal protective equipment
Pseudomonas	Pseudomonas aeruginosa
PSIRF	Patient safety incident review framework
QSIR	Quality service improvement and redesign
UKAS	United Kingdom Accreditation Service
UKHSA	United Kingdom Health Security Agency
PLACE	Patient led assessments in the Clinical environment
PFI	Private finance initiative
SSI	Surgical site infection
TB	Tuberculosis
WHO	World Health Organisation
WTE	Whole time equivalent
WVT	Wye Valley NHS Trust

Appendix 2: Infection Prevention Improvement plan 2022-2024

Theme	Link to H&S care Act 2012	Programme of work	Rationale (Why)	Measurement (How)	Internal Lead	RAG
CDI	Criterion 5	Audit clinical staff compliance with collecting Type 5-7 stool for sampling in line with Trust and national policy.	Benchmarking against policy. Early identification of infection	IP Committee (IPC)	ICD & LIPN	Complete
CDI	Criterion 1	Undertake a GAP analysis against the "how to deal with the problem" guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/340851/Clostridium_difficile_infection_how_to_deal_with_the_problem.pdf	Benchmarking against national standards	IPC	ICD	Complete
Cleaning	Criterion 2	Establish Cleanliness Scrutiny Meetings	Address/resolve deficits in cleaning standards/requirements Address issues reported in areas scoring 3 stars and below in line with National Cleaning Standards	Cleanliness Committee	LIPN/ Trust Estates	Complete
Cleaning	Criterion 2	Commence Cleanliness efficacy audits in line with National Cleaning Standards requirements	National cleaning standard requirement Benchmarking against national standards	Cleanliness Committee	LIPN/ Trust Estates	Complete
Cleaning	Criterion 2	Implement the NHSE Cleaning for confidence e- learning programme to all clinical staff and appropriate estates staff Trust wide.	Improve staff knowledge and awareness around cleaning	Cleanliness Committee	LIPN/ Education team	Complete
Cleaning	Criterion 2	By 01/07/23 85% of identified staff will have completed the cleaning for confidence e-learning training	Improve staff knowledge and awareness around cleaning	Cleanliness Committee/ IPC	LIPN/ Education team	Complete
Cleaning	Criterion 6	IPT to deliver Commode & toileting aid Train the trainer practical sessions to 100% of wards and department with toileting aids by 28/02/23	Recurring lapse theme in the HCAI Post Infection Review process. Also identified on assurance walk rounds. Improvement required	IPC Via Divisional KPIs	LIPN/ DCNO	Complete
Cleaning	Criterion 6	IP Champions to cascade commode and toileting aid cleanliness training in their clinical settings to a minimum of 50% of their clinical staff * by 31/03/23 and 85% of available staff by 30/06/23 * staff who have responsibility for commode & toileting aid	Recurring lapse theme in the HCAI Post Infection Review process. Also identified on assurance walk rounds. Improvement required Cascade training to wider team	IPC Via Divisional KPIs	Ward level ownership	Complete

Cleaning	Criterion 6	All wards where commodes & toileting aids are used are audited a minimum of monthly by clinical areas and post HCAI or quarterly assurance by IPT	Benchmarking against National Cleanliness standards	IPC Via Divisional KPIs	LIPN/ DCNO	Complete
Cleaning	Criterion 1	Undertake a spot check mattress and cushion review to ensure all items in use or in storage are fit for purpose, are clean and have no fluid ingress. Replace any that are not deemed fit for purpose. Provide assurance report to IPC	To establish baseline of current needs Deficit in standard identified on assurance walk rounds. Improvement required	Cleanliness Committee	LIPN/ DCNO	Complete
Cleaning	Criterion 2	All clinical areas with mattresses, trolleys and chair toppers will audit their cleanliness and damage a minimum of monthly by clinical areas and via quarterly assurance by IPT	Deficit in standard identified on assurance walk rounds. Improvement required	Cleanliness Committee IPC Via Divisional KPIs	LIPN	Complete
Cleaning	Criterion 1	All patient beds frames, couches and trolleys are audited for cleanliness and damage a minimum of monthly by clinical areas and via quarterly assurance by IPT.	Deficit in standard identified on assurance walk rounds. Improvement required Benchmarking against National Cleanliness standards	Cleanliness Committee	LIPN/ Trust Estates	Complete
Cleaning	Criterion 6	Develop screensavers and additional resources to refresh & inform clinical staff knowledge on cleaning type terminology - Red, Violet, Amber & Green	Ensure the correct clean is requested/ undertaken post patient transfer/ discharge Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	Cleanliness Committee	LIPN	Complete
Cleaning	Criterion 2	Implement PLACE lite programme of audits for 2023-24	Strengthen governance on clinical cleanliness To support the Trusts prompt identification of cleanliness & estates concerns in the clinical environment	Cleanliness Committee	LIPN/ Trust Estates	Complete
Cleaning	Criterion 2	Produce a Clinical Cleaning policy	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC	LIPN	Complete
Cleaning	Criterion 2	Gain assurance from Domestic services that cleaning methods and products are used in accordance with National guidance	Variation in standards noted on assurance walk rounds. To gain assurance of standardised practice	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Complete
Cleaning	Criterion 9	Develop a cleaning product formulary agreed by all parties for use across the Wye Valley sites	To gain assurance of standardised practice To ensure products effective for task and used correctly	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Complete

Cleaning	Criterion 2	Undertake an evidence based review of existing cleaning products/ processes used across the Trust	To ensure products effective for task and used correctly	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Complete
Cleaning	Criterion 2	Escalate concerns raised from NHSE inspection October 2022 regarding the Domestic trollies being suitable for task	To ensure equipment effective for task	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Complete
Cleaning	Criterion 2	Explore opportunities (? Task & finish group with domestics) for reviewing available Domestic trollies with a long term replacement plan	To ensure equipment effective for task	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Complete
Cleaning	Criterion 2	Seek monthly assurance from Domestic service providers that a robust process is in place that ensures the Domestic trollies are clean, intact and used appropriately by their staff	Deficit in standard identified on assurance walk rounds. Improvement required. Improve clinical cleaning standards	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Complete
Cleaning	Criterion 2	Develop a process for escalation of ongoing/ long standing Soft FM cleaning concerns (including Domestic trollies) to ensure discussion in appropriate forums for resolution	Deficit in standard identified on assurance walk rounds. Improvement required. Improve cleaning standards	Estates and Facilities committee/ Cleanliness committee	Estates team	Complete
SICP	Criterion 6	Analyse results of Hand hygiene audits to allow training to target specific staff groups and / or key moments & tasks	HCAI reduction Compliance with policy	IPC Via Divisional KPIs	LIPN	Complete
SICP	Criterion 6	All isolation rooms will have the appropriate PPE available outside for staff use	Deficit in standard identified on assurance walk rounds. Improvement required. HCAI reduction	IPC	LIPN	Complete
SICP	Criterion 6	Review department use of lubricant gel. Ensure trust is compliant with recommendations set out in https://www.gov.uk/government/publications/ultrasound-gel-good-infection-prevention-practice	Comply with national guidance.	IPC Via Divisional KPIs	LIPN	Complete
SICP	Criterion 10	Roll out of Regional Gloves off campaign planned in line with regional comms campaign.	Direct staff to correct/best practice	IPC Via Divisional KPIs	LIPN	Complete
SICP	Criterion 10	Update PPE posters in line with National guidance and disseminate Trust wide	Direct staff and visitors to correct/best practice Compliance with national guidance	IPC	LIPN/ Comms team	Complete

SICP	Criterion 7	Review Isolation door signs in line with national IPC manual routes of transmission/ PPE guidance	Streamline current signage and promote best practice and compliance Comply with national guidance. Direct staff and visitors to correct/best practice Reduction in cross contamination	IPC	LIPN/ Comms team	Complete
Estates	Criterion 1	Establish an Estates Scrutiny Team	To review backlog maintenance issues to address and prioritise outstanding works Deficit in standards identified on assurance walk rounds.	Estates & facilities Committee	LIPN/ Trust Estates/ Sodexo Hard FM Estates	Complete
Estates	Criterion 1	Standardise the use of Dirty Utilities including storage.	Standardisation of practices Improve clinical cleaning standards & reduce cross contamination	IPC	LIPN/ Trust Estates	Complete
Estates	Criterion 1	Roll out agreed standardised Dirty Utility layout/ plan trust wide; Share expected standard photographs with all areas as gold standard	Improve clinical cleaning standards & reduce cross contamination	IPC	LIPN/ Trust Estates	Complete
Water management	Criterion 1	Undertake a review of all swan neck taps outlets across Trust sites to ensure compliance with HTM 04-01 Safe water in healthcare premises and HTM 07-04 Water management & water efficiency and consider long term future plans/ replacements	Benchmarking against National HTM standards	Water management committee	Sodexo Hard FM Estates	Complete
Water management	Criterion 1	Review sinks and waste pipe drainage position across Trust sites to ensure compliance with HTM 04-01 Safe water in healthcare premises and HTM 07-04 Water management & water efficiency and consider long term future plans/ replacements	Benchmarking against National HTM standards	Water management committee	Sodexo Hard FM Estates	Complete
Quality	Criterion 1	Develop template action plan for Lapses identified in HCAI panel	Strengthen governance around HCAI reduction/ management	HCAI panel	LIPN	Complete
Quality	Criterion 1	Complete Health Act compliance review to ascertain areas requiring additional action	Benchmarking against National standards	IPC	LIPN/ ICD	Complete
Quality	Criterion 1	Develop a proposal to streamline the IPS annual IPC audit plan for 2023-24	Streamline current process to provide timely rectification to issues raised and ensure key themes are recognised and acted upon	IPC	LIPN	Complete
Quality	Criterion 1	Review IP committee structure and develop proposal and framework for reporting to Trust Board	Streamline current process for reporting	IPC/ Quality Committee	DIPC/ LIPN	Complete

Quality	Criterion 6	Facilitate an IP team away day	To support team development and enhance knowledge and skills	LIPN	LIPN/ NHSE	Complete
Quality	Criterion 1	Establish Infection Prevention assurance checks with the ICS	To provide assurance to ICS & external agencies and strengthen Trust governance	IPC	LIPN	Complete
Quality	Criterion 6	Facilitate NHSE training to Board on Infection Prevention & control Responsibilities	Strengthen governance and clarify role responsibility for clinical staff.	IPC/ Quality Committee	LIPN/DIPC/ NHSE	Complete
Quality	Criterion 6	Facilitate NHSE training to Matrons & Lead nurses on infection prevention & control to include responsibilities & how to complete a IP Quality ward walkabout	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC/ Quality Committee	LIPN/DIPC/ NHSE	Complete
Quality	Criterion 1	Plan a peer review with Shrewsbury and Telford NHS Trust or other key Trust to share good practice	To share learning with peers To provide assurance to ICS & external agencies and strengthen Trust governance	IPC	LIPN	On hold-under review
Quality	Criterion 6	Establish baseline numbers of IP Champions across Trust	Strengthen governance and clarify role responsibility for clinical staff.	IPC	LIPN/ Matrons	Complete
Quality	Criterion 6	Undertake a TNA for IP Champions learning needs	To identify training needs	IPC	LIPN	Complete
Quality	Criterion 6	Plan and deliver an educational conference for IP Champions with a focus on IPC standards based on TNA outcomes * deliver by end of September 23	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC	LIPN	Complete
Quality	Criterion 2	IP team to undertake quarterly Quality IP Ward Walkabouts trust wide with Matrons/ Lead nurses across divisions to strengthen IPC governance.	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	Divisional Governance meetings	LIPN	Complete
Quality	Criterion 1	Establish an audit process for IPC quality data to ensure reliable data is obtained. Audit to be annual as a minimum	Strengthen governance	IPC	LIPN	Complete

Appendix 3: Hospital declared Infection outbreaks

COVID-19 infection onset definition

Community onset:	<= 2 days after admission to trust	Day 0= Day of admission
Hospital onset **indeterminate** healthcare associated	First positive specimen date 3- 7 days after admission to Trust .	
Hospital onset **PROBABLE** healthcare associated	First positive specimen date 8- 14 days after admission to Trust .	
Hospital onset **DEFINITE** healthcare associated	First positive specimen date 15 or more days after admission to Trust .	

COVID-19 Outbreaks – 24 Outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed * 14 days from last positive case	No. of affected patients	No. of affected staff
Gilwern	01/04/2023	18/04/2023	4	0
Arrow	03/04/2023	19/04/2023	5	0
Ashgrove	11/04/2023	30/04/2023	4	0
CCU	15/04/2023	29/04/2023	3	1
Peregrin	17/04/2023	03/05/2023	5	0
Wye	22/04/2023	04/05/2023	2	0
Garway	25/04/2023	11/05/2023	6	0
Gilwern	26/04/2023	10/05/2023	2	0
Merlin	30/04/2023	13/05/2023	3	0
Lugg	16/06/2023	05/07/2023	3	0
Lugg	29/08/2023	10/09/2023	3	3
Ross- Peregrin	22/09/2023	14/10/2023	10	1
Dinmore	25/09/2023	09/10/2023	2	0
Bromyard	01/10/2023	17/10/2023	5	2
Ashgrove	11/10/2023	25/10/2023	6	2
Leominster	13/10/2023	15/11/2023	3	0
Wye	26/10/2023	22/11/2023	3	0
Lugg	29/10/2023	p 26/11/2023	3	0
Arrow	30/10/2023	p 27/11/2023	2	0
Bromyard	16/11/2023	12/12/2023	3	0
Ross	17/01/2024	01/02/2024	5	2
Gilwern	24/01/2024	14/02/2024	10	0
Leominster	01/02/2024	13/03/2024	8	3
Lugg	29/02/2024	27/03/2024	2	0

Norovirus Outbreaks- 8 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed * 3 days from last positive case	No. of affected patients	No. of affected staff
Gilwern	24/11/2023	06/12/2023	6	1
Bromyard	26/11/2023	13/12/2023	26	4
Ross	17/01/2024	24/01/2024	7	7
Ashgrove	18/01/2024	01/02/2024	14	7
Garway	20/01/2024	26/01/2024	3	0
Frome	22/01/2024	29/01/2024	3	12
Arrow	24/01/2024	01/02/2024	8	5
Bromyard	18/02/2024	29/02/2024	10	12

Influenza outbreaks- 2 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed * 14 days from last positive case	No. of affected patients	No. of affected staff
Leominster	06/02/2024	12/02/2024	3	2
Lugg	29/02/2024	06/03/2024	2	0

Appendix 4: Infection Prevention team audit plan 2023/24

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Progress
Post infection Spot Check Clinical Environment (Including hand hygiene, & BBE compliance)	Not applicable	Completed post HCAI acquistion	Locally developed tool focusing on the cleanliness of the clinical environment and equipment	HCAI Review panel	Completed
Hand hygiene & bare below the elbow (BBE) compliance	Monthly in all inpatient & outpatient clinical areas Bi annual in neighbourhood team	Completed post HCAI acquistion	Based on the Infection Prevention Society's hand hygiene observation tool	Infection Prevention Committee	Completed
Commode & toileting aid cleanliness compliance	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquistion	Locally developed tool focusing on the equipment's cleanliness	Infection Prevention Committee	Completed
MRSA Screening compliance	Not applicable	Monthly in High Risk areas Monthly review of 28 day screening Monthly monitoring of patients with known alert	Surveillance data	Infection Prevention Committee	Completed
Infection Prevention Matrons Checklist	Monthly in all inpatient & outpatient clinical areas by Matrons	Monthly, supporting Matrons as per plan	Locally developed tool focusing on environmental cleanliness and clinical practices	Division Governance meetings	In place
Audit of Diarrhoea & C. difficile infection prevalence, isolation and management documentation	Not applicable	Planned annual review	Locally developed tool reviewing the prevalence of patients with diarrhoea and their subsequent management	Infection Prevention Committee	Completed
Audit use and completion of transfer documentation when patients are discharged to community hospitals and into district nurse care	Not applicable	Planned annual review	Locally developed tool monitoring communication between providers regarding a patients infectious status & management	Infection Prevention Committee	Audit not completed - rolled over to 2024/25
High Impact Interventions - Urinary indwelling catheter - Peripheral venous cannula - Central Venous Access Device - Ventilated patient	Quarterly	Following lapses in care being identified following HCAI - Completed as planned	Based on the Infection Prevention Society's High Impact Intervention care Bundles	Infection Prevention Committee	completed
Audit of isolation management; incl. time to isolation	Not applicable	Planned annual review	Locally developed tool monitoring compliance with the Trust isolation policy	Infection Prevention Committee	Management element completed. Time to isolation rolled over to 2024/25
Infection Prevention Society Annual Audits	Not applicable	Annual programme developedto ensure all clinical areas are audited	Infection Prevention Societys Process Improvement Tools (2019)	Infection Prevention Committee	Completed
National Standards for healthcare Cleanliness 2021: Efficacy audits:	Not applicable	Planned annual review of all patients facicing FR1,2,3 and 4 areas	National tool	Cleanliness committee	Completed
Mattress cleanliness and intergity audit	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquistion & manage annual review	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Completed

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Perinatal Services Quality 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:	Dashboard

1. Purpose of the report

To provide Board with a quarterly update in line with Trust, local and national reporting requirements.

2. Recommendation(s)

Board is asked to receive the quarterly exception report in addition to the monthly dashboard.

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

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 report features the monthly reporting requirement data for July 2024 and the quarterly elements will cover Q1 (Apr-Jun 24). This report will be shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board.

2. PERFORMANCE

2.1 Activity

2.1.1 There were 154 births in the month of July. These are stable rates in keeping with our annual trends.

Midwife to birth ratio (<1:24)	1:22

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 July are recorded as:

	July
Delay in Induction >2hrs	0
Delay in Catagory 1 C-Section >30mins	0
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	1
Any movement of midwifery staff from any area to provide midwifery cover	1
Delayed recognition of and action on abnormal vital signs	0
DSC lost - supernumerary status	0
Full clinical examination not carried out when presenting in labour	0
Delay of more than 30 minutes in providing pain relief	0

There were two red flag incidents reported for the month of July, which on review were related to the same incident. This was an appropriate reallocation of midwifery staff, and utilisation of community on-call to accommodate high acuity. The event was unpredictable with a high number of women in labour at the same time; the woman received 1:1 care and the events were well managed.

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 July 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	0	N/A	
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	1	100%	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	1	100%	

There were 2 instances in the month of July where a Consultant was required to attend and was in attendance on both occasions.

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. A summary of this is provided to private board through the chair's exception reporting.

3.1.2 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
July	2	0	2	0	0	0	0

3.1.3 **Cluster Review**

The service previously reported a higher than average number of Postpartum Haemorrhage over 1500mls. The governance team devised an audit tool to review incidents of PPH which enables identification of any care issues in a themed approach. A Task & Finish Group has been put together to work on this, and includes a wide MDT presence. This is being undertaken as a QI project which is being monitored through Perinatal QI Forum.

Key themes identified include:

THEME / ISSUE	ACTION	LEAD	DATE	MONITORED
Early recognition: • Not always identifying blood loss >500mls until much further on • Not always live weighing / cumulative calculations	• Scales in every room with Practice Facilitators doing weekly demonstrations and drills. • Further work to be undertaken with theatre team for weighing in theatres • Introduction of OBSUK pathway	T&F Group	01.12.24	QI Forum
Escalation: • Not activating emergency bell for support when abnormal blood loss, rather waiting for 1500mls and emergency call • Leaving the room to communicate concerns rather than call bell.	• Weekly drills and immediate debriefs after real events. • MoC attends all Obstetric Emergencies during working hours • Enhanced focus in PROMPT	Manager On Call / Practice Facilitators	Commenced and in progress	QI Forum
Documentation: • Not using the algorithm or PROMPT scribe sheets • Medical documentation limited post emergency • Limited midwifery documentation for PPH in theatre • Management plans not always reflective of needs • EMC pathway not always commenced	• Policy needs a full review – can be undertaken in line with introduction of OBSUK pathway • Theme of the Month has been used to enhance learning opportunities. • The thematic review findings were shared in the staff 'Over to You' sessions and have been shared on staff forums.	T&F Group	31.01.24	QI Forum
Communication: • Not always standing down blood products from blood bank	• Policy update and review of calls being made as MOH being used when blood products not required.	T&F Group	01.12.24	QI Forum

The Task & Finish group will continue to review clusters and determine progress based on outcomes and performance. A further thematic review will be undertaken in March once change is fully imbedded to measure for improvement. Progress has been reported to Patient Safety Panel.

3.2 PMRT compliance

CNST requires the service to provide a quarterly PMRT report. The below cases are a summary of the reportable cases, specified by MBRRACE criteria (late fetal loss (between 22+0 and 23+6 weeks), stillbirths, early neonatal death (from 20 weeks gestation), late neonatal deaths or cases joint with another hospital). In line with CNST Safety Action 1, the report includes details of the deaths reviewed, highlights themes identified and the consequent action plans.

Internal

Category of loss	Date of MDT review	Grading of care	Date report published	CNST compliant?	Actions plan
Stillbirth	12/04/2024	A, A	01/05/2024	Yes	None
Stillbirth	14/06/2024	D, B	Pending	Yes	Thematic review is required to identify issues in preterm pathway. Review WVT policies for documenting on paper notes for women out of area Review GROW process for generating Out of Area
Stillbirth	05/05/2024	B,B	Pending	Yes	Care Outside of Guidance Policy requires review. There is some ongoing National work around this, however this has been requested to be undertaken as a system process across the LMNS
NND	Pending	Pending	Pending	Yes	Pending
Late Miscarriage	09/08/2024	C,A	Pending	Yes	Thematic review is required to identify issues in preterm pathway. Local learning to be shared across the Obstetric Team as policies in place and accurate

External

Category of loss	Date of MDT review	Grading of care	Date report published	Actions plan
Stillbirth	Pending	Pending	By Glangwilli Hospital	Pending
NND	Pending	Pending	By Heartlands	Pending

For Reference, MBRRACE categories used to grade aspects of care for each death:

A. No issues with care identified
B. Care issues that would have made no difference to the outcome
C. Care issues which may have made a difference to the outcome
D. Care issues which were likely to have made a difference to the outcome

The Bereavement Midwife is in communication with organisations where the external cases have happened and we are expecting to be invited to participate in the joint reviews.

3.2.1 **PMRT thematic review and action**

Reduced Fetal Movements

In the last quarterly report we reported similarities in 3 cases; patients received midwifery care out of county and attended WVT reporting reduced fetal movements and in all 3 cases the babies were found to have died in utero. The cases have been subject to full review and lessons learned. The LMNS have funded a system wide #MovementsMatter campaign which has been shared across all women accessing care in Herefordshire and materials have been shared with Powys Teaching Health Board.

Preterm Birth Prevention

Over Q1 the PMRT reviews have identified issues where women should have been referred for the Preterm Pathway. The service is now undertaking a thematic review of preterm births. This will include babies with poor outcomes, but also cases of pre-term birth for babies under our care whether they delivered in our Trust or were transferred out and delivered. This will allow identification of key themes for improvement. The service will complete this by the end of September, and the newly appointed Consultant Midwife will become the named lead for the QI project when she commences in post in October. Full findings and action plan will be shared in the November quarterly report.

3.3 **Claims Scorecard**

There is a CNST requirement to share the Trust Claims Scorecard, and for this to be reviewed by the Maternity Safety Champions, and for this data to be reviewed and presented to Trust Board on a quarterly basis, alongside themes from Incidents and Complaints. The Associate Director of Midwifery and the Perinatal Quality and Safety Matron have met with the Claims and Inquest officer and collated the detail in line with the CNST recommended guidance. This has been included in section 5; Triangulation.

4. PATIENT EXPERIENCE / SERVICE USER FEEDBACK

4.1 The data presented within the section of the report relates to maternity services only.

4.1.1 Concerns and Complaints

	Concerns	Complaints
July	3	1

The service currently has four open complaints; two were due for completion in July, one has required multi-disciplinary input which has contributed to the delay but is nearing completion, and the other is awaiting the outcome of a surgical procedure before the letter is finalised. The remaining two are within timeframe for completion. Themed analysis is included under section 5; Triangulation.

4.1.2 Friends and Family Test

The service uses Friends and Family Text messaging to gather service user feedback. This information is collated through Envoy and is presented as:

	July
Delivery Suite	
Maternity Ward	
Outpatients	

The learning from patient feedback is covered within the Triangulation section (5) of this report.

4.1.3 SCORE Survey

The Perinatal Quad (Associate Director of Midwifery, Clinical Lead for Obstetrics, Clinical Lead for Neonates and the General Manager for Women's and Children's) have participated in the NHSE Perinatal Culture Club. This saw the roll out of the SCORE survey across maternity service staff. The findings from the report were published earlier this year and the team have been working with external facilitators to identify an action plan.

Findings from the report identified 105 Respondents equating to a 50% response rate, carried out over 7 work settings. The summary of findings are:

	Trust Percent Positive		Trust Benchmark Percentile†
CULTURE			
Improvement Readiness	**52%**	18% ↑	**53rd**
Local Leadership	**35%**	10% ↑	**50th**
Burnout Climate‡	**25%**	8% ↑	**64th**
Personal Burnout‡	**48%**	17% ↑	**66th**
Emotional Thriving	**39%**	3% ↑	**36th**
Emotional Recovery	**34%**	6% ↓	**19th**
Teamwork	**30%**	7% ↑	**45th**
Safety Climate	**50%**	25% ↑	**68th**
Work / Life Balance	**57%**	12% ↑	**55th**
ENGAGEMENT			
Growth Opportunities	**44%**	7% ↑	**43rd**
Job Certainty	**67%**	5% ↑	**43rd**
Intentions to Leave	**82%**	5% ↑	**55th**
Decision Making	**37%**	13% ↑	**64th**
Workload Strain	**43%**	4% ↓	**39th**

Largely positive, the results show only two areas which demonstrate a negative change including emotional recovery and workload strain. That said, although an improved position there is still much room for further improvement and as such the Quad have been supported to generate an action plan.

The action plan has been shared with Quality Committee and progress against the action will be reported on a 6 monthly basis, next due in the February report.

4.1.4 **Maternity and neonatal voices partnership (MNVP)**

The current focus of the MNVP work is on health inequalities, and joint work is on-going with the LMNS. The team are working together to ensure the voice of service users are heard from areas of deprivation and ethnic minorities. The CQC maternity survey is being shared with the MNVP at the next meeting in August, where an action plan will co-produced to ensure the maternity team focus on what is important to the service user. We have recently appointed a new Co-Chair which will enhance the co-production progress.

The service user voice demonstrated a desire for face to face antenatal education. The service sourced antenatal education through external NHS approved facilitator, The Real Birth Company. This method was sought to support those who face greater challenge in accessing face to face education, such as those who face travel and financial challenges, those who do not speak English as a first language and teenage mothers. This online, interactive package is offered to all pregnant women across Herefordshire and uptake has been positive with evidence of high uptake. In order to offer all women face to face education, the 34 week antenatal appointment is booked for 1 hour face to face with the midwife and women are supported to make birth choices whilst receiving education individualised to their needs. This practice has since been strongly supported by the Birth Trauma Report published earlier this year.

We have recently received confirmation that the Local Authority has funded face to face education through the Real Birth Company for women who meet an eligibility criteria to tackle health inequalities. The funding is in place for 6 months and may be extended if found to contribute to better outcomes and experiences.

5. TRIANGULATION

5.1 The service uses all of its knowledge from safety information and service user feedback to determine key learning and actions. This informs the improvement initiatives taken across the service. All immediate actions reported in the previous report have been completed. The NHS CNST Year 6 document requires Trusts to review the data from the Claims Scorecard, alongside the Complaints / Incidents / PMRT to determine themes and identify relevant learning and subsequent actions. Below is the recommended National template and will be reported quarterly. This covers Q1 (Apr-June).

Claims Scorecard April 13 – March 23

Top injuries by volume:	**Top injuries by value:**
• Fatality (4) • Stillborn (4) • Psychiatric/Psychological Dmge (3) • Bladder Damage (2) • Unnecessary Pain (2)	• Brain damage (1) • Psychiatric/Psychological Dmge (3) • Stillborn (4) • Fatality (4) • Bladder Damage (2)
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (9) • Inadequate Nursing Care (2) • Fail/delay in Diagnosis (2) • Fail to Recog. Complication (2) • Inapprop. Use Forceps/Ventouse (1)	• Fail/delay in Treatment (9) • Fail to Recog. Complication (2) • Inadequate Nursing Care (2) • Fail to Monitor 1st Stage Labour (1) • Fail/Delay to Avail Op Theatre (1)

Complaints Q1 24-25 (N=5)

Communication (5)
Clinical Treatment (5)
Bladder issue (1)
Retained Placenta / pain (1)
Medication (1)
Partner staying overnight (1)

Incidents/PMRT Q1 24-25

PPH > 1.5litres (25)
Missed OOA discharges from Gloucester (9)
Missed Pre-term Pathway Referral (3)
Issues with Grow charts for OOA women (2)
Urine Retention Issues (2)
Incorrect referral for Fetal Growth monitoring (1)

Themes Q1 24-25

- Prevention of Preterm Birth
- PPH management
- Discharge management / OOA practice
- GROW review for OOA women
- Fetal Movement Campaign

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS Wye Valley NHS Trust

Learning Q1 24-25

There are issues with referrals in to Preterm birth clinic
There are concerns with the management of PPH – this is improving but further work ongoing
Some Out of Area practices need improving including communication around discharges and GROW monitoring
The Fetal Movements campaign is ingoing and needs to be shared widely.

Action Plan Q1 23-24 Not started | In progress | Completed

Work with clinical leads to improve ward round attendance	By 30.09.24 (EH)	
PPH thematic review and subsequent action plan	By 30.09.24 (AS)	
Devise a comms strategy with LMNS re: partners staying	By 30.09.24 (CL)	
Book FREE Coms for Personalised Care Training all staff	By 30.09.24 (CL/EH)	
Preterm birth thematic review and action plan	By 31.10.24 (CL/MC)	
Review issues / improve process GROW charts OOA	By 30.09.24 (AM)	
Share Movements Matter Campaign local and with Powys	By 31.08.24 (AS)	
Review Bladder Policy specific to maternity / Urology input	By 30.09.24 (CL)	
Review Discharge process with Gloucester	By 31.09.24 (AS)	
Review / improve internal discharge process	By 14.09.24 (AM/MC)	

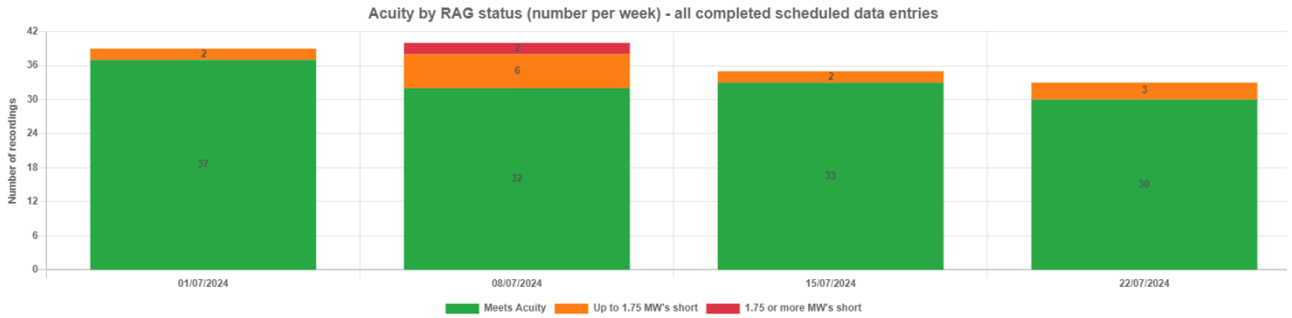
6. WORKFORCE

6.1 **Safe Staffing - Midwifery**

A monthly submission to Board outlining how safe staffing in maternity is monitored will provide assurance. Safe staffing is monitored by the following:

- Completion of Birthrate plus acuity tool
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags, also monitored for CNST compliance
- Shift fill data
- Daily SitRep reporting
- Sickness absence, vacancy and turnover rate

6.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 87.5% of the expected intervals, which is a very good reliability factor. A review of the data demonstrates when staffing met or did not meet acuity. This demonstrates that acuity has been met 90% of the time. For 9% of the time the service has been short by up to 1.75 midwives and for 1% of the time the service has been more than 1.75 midwives short. This is an improved picture on June but overall safe and reassuring.



6.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 23 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 2 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 have supported clinical acuity and this is a positive practice in that they all participate in a standby rota which supports them to retain clinical skill whilst meeting the needs of the service. There are 10 specialist midwives (8.9wte) and 2wte operational managers participating on this rota. There were 5 occasions where acuity was escalated to the manager on call for support.

Number & % of Management Actions Taken

From 01/07/2024 to 31/07/2024

MA1	Redeploy staff internally	23	72%
MA2	Redeploy from community	2	6%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	3%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	1	3%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	5	16%
MA11	Maternity Unit on Divert	0	0%
	Total	32	

6.1.3 The Antenatal and Postnatal ward Birthrate plus acuity tool is currently under maintenance and therefore data is currently not available. However, it is noted that 2 midwives are retained for minimum safe staffing on the maternity ward at all times.

6.1.4 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 contracted	MSW extra hrs	MSW bank only
AN clinic/DAU	75%	1.09%	0 hrs	63.04%	17.39%	0%
Community	85.36%	4.29%	0hrs	86.49%	4.05%	0%
Delivery Suite	88.64%	5.3%	1.01%	89.52%	1.61%	3.23%
Maternity Ward	85.48%	7.26%	0.81%	8.47%	0.81%	6.85%
Triage	73.39%	13.31%	0.4%	48.69%	6.45%	29.03%
DS Co-ordinators	100%	0 hrs	0 hrs	0 hrs	0 hrs	0 hrs

Maternity workforce sickness:

Unit	Grade Type Category	Contracted Hours	Episodes	Sickness Days	Sickness Hours	
Maternity - Ward/Delivery Suite - W01000355	Estates and Ancillary	538.07	1	6	6	1.12%
	Registered Midwives	8,627.96	13	129	693.5	8.04%
	Unregistered Nurses	2,698.00	4	11	69	2.56%
	Total:	**11,864.03**	**18**	**146**	**768.50**	**6.48 %**
Total:		**11,864.03**	**18**	**146**	**768.50**	**6.48 %**

Unit	Grade Type Category	Contracted Hours	Episodes	Sickness Days	Sickness Hours	
Maternity - Clinics - W01000353	Registered Midwives	647.68	-	-	-	-
	Support	166.07	-	-	-	-
	Unregistered Nurses	487.14	2	43	202.5	41.57%
	Total:	**1,300.89**	**2**	**43**	**202.50**	**15.57 %**
Total:		**1,300.89**	**2**	**43**	**202.50**	**15.57 %**

Unit	Grade Type Category	Contracted Hours	Episodes	Sickness Days	Sickness Hours	
Maternity - Community - W01000350	Registered Midwives	2,659.36	4	13	65	2.44%
	Unregistered Nurses	584.57	-	-	-	-
	Total:	**3,243.93**	**4**	**13**	**65.00**	**2.00 %**
Total:		**3,243.93**	**4**	**13**	**65.00**	**2.00 %**

Maternity clinics has the highest rate of sickness in both midwives and support staff. This area has a small workforce and therefore % rates can often appear inflated. Staff in the clinic area are supported by managers, HR colleagues and occupational health where indicated.

Community midwifery has improved whilst Delivery Suite and Maternity Ward have deteriorated slightly, but all staff continue to be managed and supported in line with best practice and Trust policy.

6.2 **Obstetric workforce**

The obstetric rotas have been covered throughout July, however due to staffing issues within the directorate, it has not been possible to include the July data. This will be reported in the next report.

During July, one of our substantive Consultants returned from long term sick leave on a phased return and is now back to normal duties. We continue with one vacancy until the newly appointed Consultant commences in September, and all work is covered by the existing workforce.

6.3 **Anaesthetic workforce**

The anaesthetic rotas have been covered throughout July as outlined below. The rota gaps were filled by existing members of staff with cover provided 100% of the time. There is a notable deterioration in the contracted hours fill rates and the need for use of extra hours. This is due to long term sickness of a member of the team on the Obstetric rota.

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	22	71%	21	68%
Anaesthetist extra hours	9	29%	10	32%

6.4 **MDT ward rounds**

MDT ward rounds take place at 08:30 and 20:30 daily. Medical staff attendance is expected 100% of the time, however due to high acuity for example, this may not always be possible. Previous poor attendance was escalated to the CD and CL for Obstetrics, and also to the CL for anaesthetics. Following shared learning, improvement has been noted in the July data.

	08:30	20:30
Anaesthetist	100%	90%
Obstetric Consultant	100%	97%
Ward round completed	100%	100%

6.5 **Neonatal Nursing**

The Neonatal Nursing workforce is outlined as:

Nursing position	Budgeted WTE	Contracted WTE	Maternity leave	Long term sickness
Band 7 WM	1	1	0	0
Band 7 Practice Education Lead	1	1	0	0
Band 6	5.2	5.05	0	0
Outreach	1.30	1.21	0	0
Band 5	10.5	8.14	0.92	0

Date	Qualified in Specialty workforce (expected standard 70%)	Qualified in Specialty on shift
April 2024	**49.8%**	**40%**

Mitigation to reduce the issues with QIS – 3 staff to commence QIS course from September 2024. There were no unit closures during July 2024 and bed occupancy was stable.

7. COMPLIANCE

7.1 **TRAINING**

CNST standards (Year 6) require compliance with training to be at 90% in all staff groups by 1st December 2024. Compliance is on track for all staff groups and there is no concern that the targets will not be met.

Maternity Support Workers were not initially required to be a part of the CNST Standards, therefore the speciality has been added to the training agenda from 2023 onwards. A staggered approach has been taken to ensure safe staffing in the clinical environment, and this group is on trajectory to meet the target of 90% by December 2024.

Training compliance in PROMPT: Midwives	93%
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	65%
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	93%
Annual NLS update compliance: Neonatal Nurses	100%
Fetal Wellbeing update day: Obstetrics	89%
Fetal Wellbeing update day: Midwives	94%
Midwifery update day (Core Competency): Midwives	98%
Midwifery update day (Core Competency): Support Staff	79%

7.2 **Saving Babies Lives**

Saving Babies Lives v3. was launched in March 2023 with an update to the previous 5 elements and introduction of a 6th element to cover maternal diabetes. Under CNST standards, Trusts are required to demonstrate compliance with the use of the nationally approved toolkit, which WVT are fully compliant with. The trust progress is also quality assurance checked by the LMNS on a quarterly basis. The latest quarterly review for Q1 took place in August, but we are awaiting the final findings and therefore this will be reported in the August report.

CNST year 6 requires full implementation by March 2024, however where this has not been met compliance can still be achieved if the ICB confirms it is assured best endeavours and sufficient progress has been made. The LMNS have confirmed that they are satisfied with efforts and progress to date.

7.3 **CNST MIS Year 6**

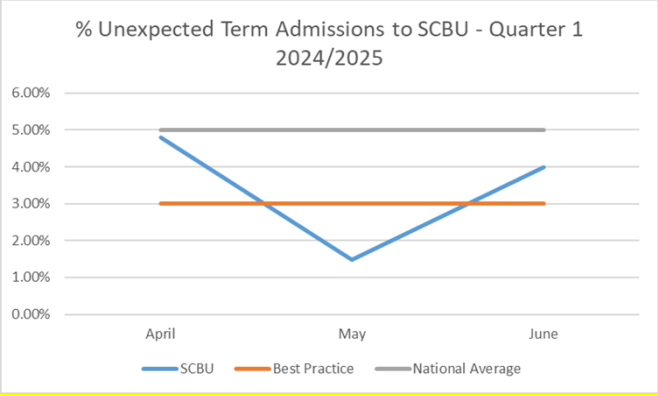
CNST launched Year 6 on the 2nd April. The maternity leadership have reviewed each of the 10 safety actions to ensure that compliance can be achieved again this year.

Whilst the service starts to pull evidence for each of the relevant sections it is not possible to share progress in a visual format as almost all actions are 'in progress' status. The NHS Futures Platform offers a tracking tool this year and the team are currently working to embed this into their governance, and this will enable sharing of the progress in future reports.

7.4 **ATTAIN**

The Term admission rate had, for some time been consistently below the National average rate of 5%, and the Best Practice rate is 3%. Q1 performance is:

Month	Unexpected term admission to SCBU	Total Live Births	Number of Exclusions	Included in ATAIN data	Unexpected term admissions to SCBU as % of all total live births.
April 24	7	125	1	6	4.8%
May 24	2	135	0	2	1.48%
June 24	9	150	3	6	4%



The full findings and report is available and reported to the Network.

7.5 **SINGLE DELIVERY PLAN**

The Single Delivery Plan, published in March 2023, is a three year plan which aims to make care safer, more personalised and more equitable embedding actions across 4 key themes. The perinatal team are working closely with the LMNS to deliver against the themes and there are no areas for current escalation and this work remains on track and in progress.

Theme	RAG Progress
Theme 1; Listening to women and families	
Theme 2; Growing, retaining and supporting workforce	
Theme 3; Culture of safety and learning	
Theme 4; Safer, more personalised care	

7.5 **SAFETY CHAMPIONS**

Maternity Safety Champions work at every level – trust, regional and national – and across regional and organisational boundaries. They develop strong partnerships, can promote the professional cultures needed to deliver better care, and play a key role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

CNST Safety Action 9 requires all Trusts to have visible Maternity and Neonatal Board Safety Champions who are able to support the perinatal leadership team in their work to better understand and craft local cultures.

A safety walk round took place on the 31st July and the areas visited this time included Delivery Suite and Antenatal Clinic. Safety Champions gave good advice about the regular rotation of grab boxes to support a reduction in the potential of waste medication that expires. The recent pharmacy audit was also reviewed and discussed.

The Safety Champions responded positively to the new vaccination area that has been created and a reconfiguration of seating and items in the waiting area give the impression of more space. Positive feedback was proved from staff in clinic and Day Assessment Unit.

Overall the areas were noted to be clean and some changes have been made to the corridor and the leaflets available and on display. The governance team are currently working with the communications team to develop the Safety Champions Board into something more meaningful and aesthetically pleasing for staff, women and their families.

No safety concerns were raised on this visit.

APPENDIX 1 – PQSM Dashboard

Indicator Description	April	May	June	July
Total bookings	143	132	139	154
Women who were booked before 12 + 6 weeks	135	124	126	147
%Women who were booked before 12 + 6 weeks (target 90%)	94.4%	93.9%	90.6%	95.5%
Women who were booked after 12 + 6 weeks	8	8	13	7
%Women who were booked after 12 + 6 weeks	5.6%	6.1%	9.4%	4.5%
Midwife led care at booking	18	19	16	27
%Midwife led care at booking	12.6%	14.4%	11.5%	17.5%
Women with BMI of 30 and over at booking	39	41	39	40
%Women with BMI of 30 and over at booking	27.3%	31.1%	28.1%	26.0%
%Antenatal Personalised Care Plan completed	99.2%	97.6%	95.9%	97.1%
%Intrapartum Personalised Care Plan completed	50.7%	63.2%	61.5%	61.0%
%Portal Access Consent	100.0%	99.2%	100.0%	100.0%
%Portal Access - Women who registered and logged in	80.4%	88.5%	83.5%	82.5%
%Contacts were place of birth suitability was recorded	14.9%	13.7%	65.3%	65.4%
%High risk women assigned a named Consultant - within 7 days	35.0%	50.7%	56.6%	62.7%
%High risk women assigned a named Consultant - at any time	74.4%	79.7%	83.5%	86.0%
%Antenatal contacts with a reviewed / authorised risk assessment	29.6%	30.7%	56.3%	77.1%
%Antenatal contacts with a risk assessment form completed	96.2%	92.9%	94.3%	91.1%
Recorded Smoking Status at Booking - Yes	16	7	14	10
Recorded Smoking Status at Booking - No	127	125	125	144
Recorded Smoking Status at Booking - Unknown	0	0	0	0
%of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%	100.0%
Women who were current smokers at booking	16	7	14	10
%Women who were current smokers at booking	11.2%	5.3%	10.1%	6.5%
Smokers who were referred to smoking cessation services	14	7	14	9
%Smokers who were referred to smoking cessation services	87.5%	100.0%	100.0%	90.0%
Smokers who accepted CO screening at booking	16	7	14	10
%Smokers who accepted CO screening at booking	100.0%	100.0%	100.0%	100.0%
Women who were screened for CO at booking	141	126	133	149
%Women who were screened for CO at booking (of total bookings)	98.6%	95.5%	95.7%	91.4%
Women with CO reading of 4 ppm or more at booking	12	9	14	6
%Women with CO reading of 4 ppm or more at booking (of total bookings)	8.4%	6.8%	10.1%	3.9%
Indicator Description	**April**	**May**	**June**	**July**
Total births (deliveries)	124	135	148	128
Home Births	0	2	3	0
BBA's	2	0	1	0
Vaginal births (deliveries)	45	62	68	47
%Vaginal births (deliveries)	36.3%	45.9%	45.9%	36.7%
Ventouse & forceps births (deliveries)	18	22	16	17
%Ventouse & forceps births (deliveries)	14.5%	16.3%	10.8%	13.3%
RG*1 having a caesarean section with no previous births	2	3	5	2
RG*1 Deliveries	13	26	22	17
RG*1 %C-section deliveries	15.4%	11.5%	22.7%	11.8%
RG*2 having a caesarean section with no previous births	20	15	16	20
RG*2 Deliveries	35	36	30	36
RG*2 %C-section deliveries	57.1%	41.7%	53.3%	55.6%
RG*5 having a caesarean section with at least one previous birth	20	19	17	18
RG*5 Deliveries	25	20	21	19
RG*5 %C-section deliveries	80.0%	95.0%	81.0%	94.7%
Total Elective C-Sections	30	23	19	27
Total Emergency C-Sections	31	28	45	36
Total Caesarean births (deliveries)	61	51	64	63
%Total Caesarean births (deliveries)	49.2%	37.8%	43.2%	49.2%
%Grade 1 C-Sections within 30 minutes	77.8%	71.4%	62.5%	75.0%
%Grade 2 C-Sections within 75 minutes	90.5%	80.9%	84.8%	84.6%
Midwife led (low risk care) births	24	33	31	29
%Midwife led (low risk care) births	19.4%	24.4%	20.9%	22.7%
Home births (deliveries) - midwife led only	0	0	2	0
%Home births (deliveries)	0.0%	0.0%	1.4%	0.0%
Total number of babies born	125	136	150	131

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Babies born preterm (singletons born 36+6 or less)	11	9	10	17
% Babies born preterm (singletons born 36+6 or less)	8.94%	6.62%	6.67%	13.0%
Singleton babies born 26+6 or less	0	1	0	0
% Singleton babies born 26+6 or less	0%	1%	0%	0.00%
Babies (multiples) born 27+6 or less	0	0	0	0
% Babies (multiples) born 27+6 or less	0%	0%	0%	0.00%
Stillbirths	0	1	0	2
% Stillbirths	0.0%	0.7%	0.0%	1.5%
Stillbirths rate per 1,000	0	0.136	0	0.3
Live births where breastfeeding initiated (first feed = breastmilk)	100	114	119	102
% Live births where breastfeeding initiated (first feed = breastmilk)	80.6%	85.7%	80.4%	81.0%
Women who were current smokers at booking (delivered mothers)	6	9	16	7
% Women who were current smokers at booking (delivered mothers)	4.8%	6.7%	10.8%	5.5%
Women who were current smokers at birth (delivery)	9	7	13	8
% Women who were current smokers at birth (delivery)	7.3%	5.2%	8.8%	6.4%
% Women with CO measured at 36 weeks	100.0%	98.4%	99.3%	100.0%
% CO >= 4ppm at booking and below 4 ppm at 36 weeks	60.0%	7.3%	10.4%	2.7%
Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0	0
% (as a % of all singleton births)	0.00%	0.00%	0.00%	0.00%
% Detection rate for FGR (below 3rd centile)	13%	15%	13%	10%
Women who had a PPH of 1,500ml or more	6	11	8	6
% Women who had a PPH of 1,500ml or more	4.8%	8.1%	5.4%	4.7%
Women who sustained a 3rd or 4th degree tear	1	1	2	1
% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.6%	1.2%	2.4%	1.5%
% Induction of labour rate (of all births)	33.9%	34.8%	36.5%	34.4%
Routine Enquiry Domestic Violence - Asked	90	87	92	84
Routine Enquiry Domestic Violence - Unable to ask	33	45	54	43
Routine Enquiry Domestic Violence - Unknown	1	3	2	1
% routine enquiry domestic violence	99.2%	97.8%	98.6%	99.2%
Midwife to birth ratio	1:23	1:25	1:26	1:22
Delay in Induction >2hrs	0	0	8	0
Delay in Catagory 1 C-Section >30mins	0	1	3	0
Delay in administering medication	1	0	0	0
Delay in starting syntocinon/ARM >30mins	0	0	2	0
Delay in Suturing >60mins	0	0	0	0
Unable to provide 1:1 care in labour	0	0	0	0
Delay in Triage >30mins	0	0	0	0
Community midwives on call covering maternity unit	0	0	8	0
Any movement of midwifery staff from any area to provide midwifery cover	2	0	2	1
Delayed recognition of and action on abnormal vital signs	0	0	1	0
DSC lost - supernumerary status	0	0	0	0
Full clinical examination not carried out when presenting in labour	*	*	*	0
Delay of more than 30 minutes in providing pain relief	*	*	*	0
Number of women presenting to service with reduced fetal movements	158	174	199	220
Number of women presenting with RFM who are recorded as having a CTG	158	172	197	218
% of women presenting with RFM who received CTG	100.0%	98.9%	99.0%	99.1%
Indicator Description	**April**	**May**	**June**	**July**
Total admissions to neonatal care	17	5	13	12
Unexpected admissions of full-term babies to neonatal care	7	1	7	3
% Unexpected admissions of full-term babies to neonatal care	6.1%	0.8%	5.0%	2.7%
Eligible Babies	2	2	3	1
% taken within hour	50.0%	50.0%	100.0%	100.0%
Adm temp <36.5 degrees	0	0	0	0
Eligible Babies	19	9	17	22
% taken within hour	89.5%	89.0%	82.3%	86.3%
Adm temp <36.5 degrees	1	0	0	3
Babies born with an APGAR score between 0 and 6 (at 5 minutes)	0	3	3	3
Neonatal deaths	0	0	0	0
% Neonatal deaths	n/a	n/a	n/a	0.0%
Neonatal mortality per 1,000 births	0	0	0	0
Neonatal transfers for therapeutic hypothermia	0	0	0	0
% Neonatal transfers for therapeutic hypothermia	0%	n/a	n/a	n/a
Neonatal brain injuries	0	0	0	0
% Neonatal brain injuries	n/a	n/a	n/a	n/a
Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	2	2	3	1
Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	2	3	3	2
% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	100.0%	66.7%	100.0%	50.0%
Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0
Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0	0
% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a	n/a

Indicator Description	April	May	June	July
Obstetrics admissions to ITU	0	0	0	1
Maternal deaths	0	0	0	0
%Postnatal Personalised Care Plan completed	95.7%	97.0%	97.7%	98.4%
Postnatal readmissions within 28 days (mothers)	16	16	16	16
Postnatal readmissions within 28 days (babies)	7	6	7	5
Number of times Maternity Services Suspended per month	0	0	1	0
Number of hrs Maternity Services suspended	0	0	8	0
Number of times Home Birth services suspended per month	0	0	0	0
Number of hrs Home Birth services suspended	0	0	0	0
Number of times SCBU suspended per month	0	0	0	0
Number of hrs SCBU suspended per month	0	0	0	0
Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0	0	0
New HSIB SI referrals accepted	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0
Coroner Reg 28 made directly to Trust	0		0	0
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	160	0	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	4	150	4.5	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	4	0	0
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	6	0	4	3
Vacancy rate for midwives (black = over establishment, red = under establishment	6.2	4.8	0.06wte	0.06
Inphase related to workforce (service provision/staffing)	3	0	11	0
MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%	100.00%
Service User feedback: Number of Compliments (formal)	13	*	4	5
Service User feedback: Number of Complaints (formal)	1	0	4	1
Staff feedback from frontline champions and walk-abouts (number of themes)	1	2	0	0
Progress in achievement of CNST /10	10	On Track	On Track	On Track
Training compliance in PROMPT: Midwives	95%	96%	98%	93%
Training compliance in PROMPT: Obstetric Consultants	100%	100%	100%	100%
Training compliance in PROMPT: Obstetric Middle Grades	81%	93%	87%	93%
Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%	100%	100%
Training compliance PROMPT: Maternity Support Workers	60%	67%	67%	65%
Annual NLS update compliance: Paediatric Consultants	100%	100%	100%	100%
Annual NLS update compliance: Paediatric Middle Grades	100%	100%	100%	100%
Annual NLS update compliance: Paediatric Juniors	*	*	90%	91%
Annual NLS update compliance: Midwives	95%	96%	98%	93%
Annual NLS update compliance: Neonatal Nurses	90%	94%	98%	100%
Fetal Wellbeing update day: Obstetrics	100%	100%	89%	89%
Fetal Wellbeing update day: Midwives	99%	98%	98%	94%
Midwifery update day (Core Competency): Midwives	93%	97%	97%	98%
Midwifery update day (Core Competency): Support Staff	76%	88%	88%	79%

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 August 2024 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present:

Russell Hardy	(RH)	Group Chair
Chizo Agwu	(CAg)	Chief Medical Officer WVT
Charles Ashton	(CAs)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(AC)	Managing Director SWFT
Stephen Collman	(SC)	Managing Director WAHT
Neil Cook	(NC)	Chief Finance Officer WAHT
Catherine Free	(CF)	Managing Director GEH
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Natalie Green	(NG)	Chief Nursing Officer GEH
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WAHT
Jane Ives	(JI)	Managing Director WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Helen Lancaster	(HL)	Chief Operating Officer WAHT
Vikki Lewis	(VL)	Group Strategic Chief Digital Data and Technology Officer
Kim Li	(KLi)	Chief Finance Officer SWFT
Anil Majithia	(AMa)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Julie Moore	(JM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Simon Page	(SP)	NED and Vice Chair SWFT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
David Spraggett	(JR)	NED WVT
Nicola Twigg	(DS)	NED SWFT
Sue Whelan Tracy	(NT)	NED WVT
Robert White	(SWT)	NED SWFT
Umar Zamman	(RW)	NED SWFT
	(UZ)	NED GEH

In attendance:

Jon Barnes	(JB)	Chief Transformation and Delivery Officer WVT
Julian Berlet	(JBe)	Interim Chief Medical Officer WAHT
Rebecca Bourne	(RB)	Head of Communications WAHT

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 August 2024 at 1.30pm via Microsoft Teams

In attendance continued:

Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
John Burnett	(JBu)	Head of Communications WVT
Paul Capener	(PC)	ANED GEH
Oliver Cofler	(OC)	ANED SWFT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Catherine Driscoll	(CD)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Fiona Gurney	(FG)	Communications Officer WVT (present from minute 24.063)
Erica Hermon	(EH)	Associate Director of Corporate Governance WVT and Company Secretary WVT/WAHT
Oli Hiscoe	(OH)	ANED SWFT
Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KLa)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Sara MacLeod	(SMa)	Interim Chief People Officer GEH/SWFT
Alex Moran	(AMo)	ANED WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Bharti Patel	(BP)	ANED SWFT
Lisa Peaty	(LP)	Deputy Director of Strategy and Planning WAHT (deputising for Chief Strategy Officer WAHT)
Mary Powell	(MP)	Head of Strategic Communications SWFT
Jackie Richards	(JR)	ANED GEH
Alison Robinson	(AR)	Deputy Chief Nursing Officer WAHT (deputising for Chief Nursing Officer WAHT)
Jo Rouse	(JR)	ANED WVT
Sue Sinclair	(SSi)	ANED WAHT
Robin Snead	(RS)	Chief Operating Officer GEH
Vidhya Sumesh	(VS)	Group Business Information Specialist

There were four SWFT Governors and two members of the pubic also in attendance.

MINUTE		**ACTION**
24.057	**APOLOGIES FOR ABSENCE** Apologies for absence were received from: Phil Gilbert, NED SWFT; Paramjit Gill, Nominated NED SWFT, Richard Haynes, Director of Communications WAHT; Julie Houlder, NED and Vice Chair GEH; Ian James, NED WVT; Simone Jordan, NED GEH; Rosie Kneafsey, ANED GEH; Zoe Mayhew, Chief Commissioning Officer (Health and Care) SWFT; David Moon, Group Strategic Financial Advisor; Jo Newton, Chief Strategy Officer WAHT; Sarah Shingler, Chief Nursing Officer WAHT; and Jules Walton, Interim Chief Medical Officer WAHT. **Resolved – that the position be noted.**	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
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24.058	**DECLARATIONS OF INTEREST** Anil Majithia, NED GEH, declared that he had completed his term with Canal and River Trust and had been appointed as NED for Health Inequalities and Communities at Leicester, Leicestershire and Rutland Integrated Care Board (ICB). Sarah Raistrick, NED GEH, declared that she was a practicing General Practitioner (GP) in the Coventry and Warwickshire ICB. This was not a new declaration but was reiterated due to the nature of the discussions taking place on the agenda. Robert White, NED SWFT, declared that there had been accountancy advice provided to SWFT from RSM UK, where his son was an accountant. He assured the Foundation Group Boards that his son did not work for the public sector of the organisation. **Resolved – that the position be noted.**	
24.059	**PUBLIC MINUTES OF THE MEETING HELD ON 2 MAY 2024** **Resolved – that the public Minutes of the meeting held on 7 February 2024 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
24.060	**CHAIR'S REMARKS** The Group Chair welcomed the new ANEDs of WAHT, Alex Moran and Catherine Driscoll, and the new NED of SWFT, Robert White, to the Foundation Group. The Group Chair acknowledged and thanked the Chief Transformation and Delivery Officer of WVT and the Group Strategic Chief Digital Data and Technology Officer for their contributions to the Foundation Group Boards and wished them well in their future endeavours. The Group Chair took the time to thank the volunteers across the Foundation Group for their work, contribution and fundraising efforts. The Group Chair informed the Foundation Group Boards that he and the Group Chief Executive had reached out to the Chairs of the Black, Asian and Minority Ethnic (BAME) Network to confirm their unwavering support to all colleagues feeling anxious following the distressing events taking place across the country. He added that communications had also been sent around to all staff reiterating each Trust's support and values. A copy of the messages were available upon request. **Resolved – that the Chair's Remarks be received and noted**.	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 August 2024 at 1.30pm via Microsoft Teams

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24.061	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.061.01	Foundation Group Performance Report (Minutes 23.058, 23.080.01, 24.007.02 and 24.034.01 refers) The Managing Director for GEH confirmed that the cancer diagnosis following Emergency Department (ED) attendance data had been received. She shared this with the Foundation Group Boards and explained that GEH was an outlier. The next piece of work was to understand why GEH was an outlier and where any adjustments needed to be made. This work was taking place in August 2024 and an update would be provided at the November 2024 Foundation Group Boards meeting. **Resolved – that the GEH cancer diagnosis from ED attendance update be provided at the Foundation Group Boards meeting in November 2024.**	**CF**
24.061.02	Group Informatics Proposal (Minute 24.042 refers) The Group Strategic Chief Digital Data and Technology Officer informed the Foundation Group Boards that the Informatics and Business Analytics leadership would sit with the WAHT team. The digital data and technology portfolio would be worked through alongside the Group Chief Executive to determine what that should look like in the future. **Resolved – that the position be noted.**	
24.062	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the Foundation Group Boards Workshop held earlier that day, which focused particularly on prevention and the work each Trust was doing within their communities. Julian Kelly, Chief Financial Officer and Deputy Chief Executive of NHS England (NHSE) attended the meeting and spoke about the challenges faced across the NHS. The Group Chief Executive added that he was pleased to see the level of activity that had gone into the prevention agenda across the Foundation Group and reiterated the importance of prevention continuing to be embedded in improvement work. **Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.**	
24.063	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director for WVT presented an overview of the WVT performance to the Foundation Group Boards. She explained that she was quite worried regarding the continued congestion in the ED and hospital. She	

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added that the hospital was averaging around 30 extra patients to the standard bed base which had continued through the summer period. This was the highest risk on the WVT's risk register and therefore the Trust's top priority. The Managing Director for WVT informed the Foundation Group Boards that pressured faced within the hospital would continue and become more challenged between September 2024 and October 2024. This was due to needing to decant the Accident and Emergency (A&E) Department to enable refurbishment work to be completed. The Managing Director for WVT explained that WVT had done a lot of work to understand the drivers to cause the position the hospital was in. She continued that over the last two years demand had increased significantly, however length of stay had remained the same. The Managing Director for WVT confirmed that focus on demand reduction, internal processes and discharge were taking place. She explained that two key pieces of work were taking place to try and help the hospital congestion. One was around increasing the capacity of community services as well as simplifying the model with a Community Referral Hub from September 2024. The other was challenging integrated neighbourhood teams such as Primary Care Networks (PCNs), General Practitioners (GPs), and community services to reduce patients attending the hospital.

The Managing Director for WVT informed the Foundation Group Boards that she was proud of the Trust's mortality indicators decreasing despite demand and were under 100. She emphasised that mortality was an important indicator therefore to see that decreasing despite the congestion was worth celebrating, as it showed staff were continuously working on improving pathway management and mitigating potential problems.

The Managing Director for WVT concluded by explaining that she had a rising concern with the Trust's waiting list size, going up 9% in twelve months. Work was taking place regarding reducing the list especially long waiters and understanding referral patterns.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chief Executive explained that the Elective Recovery Plan Version Two would be published nationally in due course. One of the concerns that people had currently was that within waiting lists there were patients who needed diagnostic tests. With more diagnostic capacity in place with the Community Diagnostic Centres (CDC), there could be the option to provide Primary Care with direct access to those diagnostic tests which would in turn speed up waiting lists.

The Managing Director for SWFT provided the Foundation Group Boards with SWFT's key performance data. He explained that ED and flow remained a focus area with sustained increase in ED demand which was starting to feel like the new normal in terms of level of demand, particularly around type one attendances (more unwell patients). A lot of the demand was driven by out of

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	area, however there had also been significant changes in the Coventry and Warwickshire (C&W) system resulting in taking on more activity then previous which had impacted performance. The Managing Director for SWFT highlighted the work from Outpatient Services particularly the work they had led with Outpatient redesign. SWFT's Did Not Attend (DNA) rates remained in the top quartile nationally, however it was felt there was more possibility for improvement. He explained that work alongside Deep Medical, regarding using Artificial Intelligence (AI) to analyse potential DNAs. This would then be piloted to be coupled with volunteers through Helpforce for direct contact with those potential DNA patients. Work had also taken place regarding analysing potential DNA rates and health inequalities, and whether there was more that could be done to address that. He continued by informing the Foundation Group Boards that Patient Initiated Follow Up (PIFU) remained in a positive place, it needed to be rolled out to more services, however a further increase in PIFU rates was expected over coming months. The Managing Director for SWFT highlighted that his area of concern was Cancer Services. SWFT continued to see a sustained high referral rate that was increasing year on year, however there had been some improvement in the faster diagnosis standard. The 62 day standard remained a challenge for SWFT, particularly in Breast Services and Dermatology Services. SWFT's waiting lists were still higher than ideal, with Orthodontics playing a key part in that. Orthodontics was a National and Regional issue, which SWFT had been working closely with the ICB and NHSE to establish a solution for the backlog. As a result, there had been a reduction in both 78 week waits, and 65 week waits. The Managing Director for SWFT concluded by highlighting the reduction in waiting times for Diagnostic Services, which had been driven mainly by the reduction in non-Obstetric ultrasound waits. The demand in CT and X-Ray demand had been watched as growth levels had increased to 14%. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive noted that SWFT's 52 week wait position looked slightly concerning in comparison to the position of the other Trusts in the Foundation Group. The Managing Director for SWFT agreed, he explained that focus had been on long waiters, however he assured the Foundation Group Boards that he would investigate SWFT's 52 week wait position. The Managing Director for GEH presented the GEH performance data to the Foundation Group Boards. She highlighted GEH's A&E performance and that it was now best in the Foundation Group, however there were still areas to focus on to achieve the 95% performance. GEH continued to see delays within ED, with 51 patients waiting over twelve hours from decision to admitting to then finding a bed in the Trust. There had been improvement from previous months, however remained a focus area. The Managing Director for GEH provided details to why GEH's A&E performance may have improved during June 2024, and it was clear that the work that had taken place around Medically	**AC**

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Fit For Discharge (MFFD) had supported this. This work included holding calls twice a day to follow up on patients and discuss who could leave the Trust's care and ensure community plans were in place to prevent delay. This had let to a reduction from around sixty patients in the Trust MFFD to forty patients. The MFFD number had increased in July 2024 but had improved again by the beginning of August 2024. The Managing Director for GEH noted SWFT's success with keeping ambulance handover delays to a minimum and explained that GEH would continue to focus on these as an area for improvement.

The Managing Director for GEH informed the Foundation Group Boards that she was most proud of was GEH's sickness levels. She explained that when the first Foundation Group Boards met GEH had the highest rate of sickness across all Trust's within the Foundation Group. However, sickness rates were now down to 4.6%, which was still higher than the Trust's target but a significant improvement. This showed the work that had taken place focusing on vacancy reduction, feedback from the Staff Survey and listening to staff was working. Appraisal rates were also at 87% which was the highest they had been.

The Managing Director for GEH explained that Cancer Services 62-day standard remained a challenge, however similarly to SWFT, there had been sustained improvement in the faster diagnostic standard. She concluded by informing the Foundation Group Boards that GEH had seen a slight reduction in the 52-week breaches for Elective Care, and there were meetings in place to try and clear long waiters by the end of September 2024.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chief Executive agreed with the Managing Director for GEH that the 62-day cancer indicator needed to be a focus area. He reassured members of the public that the indicator was triggered when a patient was treated. Therefore, some of the long wait patients included in the figures were being treated, but this would lead to a slight deterioration of the performance. The Group Chief Executive expressed that there was confident the figures would start to improve as patients were treated through the system.

The Managing Director for WAHT provided the Foundation Group Boards with an overview of WAHT's performance data. He started by presenting the Urgent Care performance, and in particular the role that occupancy was playing. The Trust had done a detailed analysis which had been shared at WAHT Board around contributions and impact. WAHT had been working with HealthCare Trust Partners regarding different service offers especially for general medicine patients which had been contributing significantly to the occupancy challenges. Two areas of capacity had also not been used, one area was due to lack of funding, and one was due to site works taking place. However, work to resolve these issues was underway and would continue later into 2024.

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	The Managing Director for WAHT informed the Foundation Group Boards that work was being completed with Public Health to undertake analysis of emergency admissions, capturing around 300-400 households. The work had allowed WAHT to look at the top ten areas that were contributing to their emergency admissions. There was a programme of work following this with Public Health and Integrated Care System (ICS) colleagues around what could be done differently. He hoped to hold a WAHT Board Development Session around the work. The Managing Director for WAHT explained that productivity was a focus area for WAHT, and improvements were starting to be seen. There was focus on how productivity linked to Elective Care, Cancer Performance and the overall financial performance of the Trust. WAHT continued to drive down high-cost agency spend, as well as providing focus to the Elective Plan. This was being reflected in the number of patients being seen, particularly when looking at the previously most challenged specialties which were Urology and Dermatology, where more recently WAHT had been in the top fifteen Trusts in terms of numbers treated for Urology. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive highlighted the improvements seen at WAHT, especially around the Cancer Performance which WAHT had managed to improve to no longer need national monitoring. He noted that sickness levels across the organisation remained challenged, however assured the Foundation Group Boards that reviewing of the staff support functions and analysing underlying trends was being worked through. The Group Chair thanked the WAHT Board and all WAHT colleagues for their continued work and celebrated the Trust's strong and steady progress. **Resolved – that** **A) the Managing Director for SWFT look into the SWFT's 52 week wait position and report back to the SWFT Board of Directors meeting, and** **B) the Foundation Group Performance Report be received and noted.**	**AC**
24.064	**GROUP FINANCE UPDATE INCLUDING PRODUCTIVITY** The Chief Finance Officer for GEH presented the overall financial position across the Foundation Group. He informed the Foundation Group Boards that all four Trusts had very challenging financial targets, which was reflective of the national picture. All four organisations were reporting deficits at the end of the first quarter, however full year plans for SWFT and GEH were planning and delivering small surplus by the end of the year. WVT and WAHT were planning on delivering deficits of £31m and £57m respectively. Challenges such as	

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Urgent and Emergency Care (UEC) increased capacity would impact cost but also inflationary pressures above funded levels. There had been impacts seen from Industrial Action, Elective Recovery, performance and high Cost and Productivity Improvement Plans (CPIP) targets. WVT had particularly been impacted by some of the challenges faced.

The Chief Finance Officer for GEH presented the CPIP data to the Foundation Group Boards. He explained that delivering a financial plan was very dependent on delivering CPIP targets including percentage of turnover. The Foundation Group had very high CPIP targets, however looking at the historic data all Trusts had done well to identify projects for the vast majority of the target. However, the proportion of developed projects varied quite considerably across all four organisations, showing more work was needed in terms of developing the relevant plans into delivery mode. The Chief Finance Officer for GEH assured the Foundation Group Boards that work was also taking place in each Trust to support and oversee the delivery of CPIP targets whilst also connecting other pieces of work such as improvement programmes. There was also work taking place to share best practice and ensuring efforts were not being duplicated across the Foundation Group.

The Chief Finance Officer for GEH provided the Foundation Group Boards with detail on some of the key elements within the financial plan. He started by presenting the temporary staffing costs, which had increased as a proportion of the total pay bill. However more importantly over the last year, particularly recent months, there had been reductions in temporary staffing spend with GEH reducing it significantly. This showed the actions being taken across the Foundation Group to focus on reducing that cost had been having an impact. There was still work that needed to take place to improve agency spend further following NHSE set targets, particularly around price compliance. Procurement colleagues across the Foundation Group were working to reduce agency rates. The Chief Finance Officer for GEH also explained that there were wide variations against the agency ceiling across the Foundation Group, with SWFT and GEH very close to their ceiling and WVT and WAHT some distance away from theirs. WVT and WAHT agreed plans would not get them below their agency ceiling, so there was more to work on in the financial year. The Chief Finance Officer took the time to celebrate good performance at GEH and WAHT in particular, with GEH below their agency ceiling compared to twelve months ago when they were double their ceiling limit. WAHT was also £1m ahead of their plan.

The Chief Finance Officer for GEH presented the other key element to the financial plan, which was Productivity and Elective Recovery. All four Trusts had set Elective Recovery targets above the national requirement which demonstrated a degree of ambition for the Foundation Group to improve productivity. The targets varied between Trusts due to the variation in baseline productivity levels. The year-to-date performance across the Foundation Group in terms of financial value was good and was higher then pre-Covid-19 levels. Work was still taking place to improve the Elective Recovery Fund (ERF)

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performance further, WVT was expecting performance to improve with the opening of the Elective Surgical Hub and GEH had set an internal stretch target to get to the 143% pre-Covid-19 levels of activity in an attempt to mitigate some of the risks faced.

The Chief Finance Officer for WVT presented the data on productivity to the Foundation Group Boards. She explained that more activity needed to be delivered, without relying on more cost to deliver it and this could only be achieved by being even more productive. The focus needed to be on how to improve performance through productivity, but also how Trusts assessed that they were being productive and whether they were improving or not. There was a range of tools available to look at metrics and trends to support this work. Nationally there were new tools being developed to support Trust's understanding their productivity challenge and both the Chief Operating Officers and Chief Finance Officers were engaged in those discussions. The Chief Finance Officer for WVT presented the Foundation Group Boards with a couple of example metrics alongside national benchmarking using the Model Health System which had some nuances but what it did show was that the NHS had seen a productivity reduction compared to pre-Covid-19 and significant workforce growth. The data also showed that there were some positive areas of performance from some of the Trusts in the Foundation Group, and it also demonstrated some clear areas of opportunity. The Chief Finance Officer for WVT went through some of the different tools such as the Cost per Weight Activity Unit (WAU) which attempted to standardise activity and unit cost so that there was a comparable measure that could be used. For example, as the Foundation Group continued to increase ERF performance and reduce temporary staffing costs, the cost per WAU figure would be expected to decrease and would demonstrate whether a Trust was delivering better value.

The Chief Finance Officer for WVT explained that alongside national tools each Trust had also developed local measures due to national tools not being refreshed as might be needed to support operational delivery. Each Trust had developed their own cost per WAU tool, which included a range of other metrics being linked to it to support the deep dives into performance. Following each Trust developing the tool, it showed each Trust had an increased cost per WAU. This spiked during Covid-19 and was slowly reduced during recovery, however cost per WAU remained higher than pre-Covid-19 which could imply activity deterioration. The National Cost Collection Index (NCCI) was another tool that could be used to look at productivity and it also compared provider's costs of carrying out activity and put it into an index to measure the relative cost and adjusted for case-mix. This showed SWFT and GEH below the national average, therefore performing strongly, WAHT was just about at the average and WVT was above average. WVT however was largely affected by its rurality and the excess costs incurred.

The Chief Finance Officer for WVT explained that there was costing intelligence across the Foundation Group and alignment of consistency with financial returns. This provided opportunity to share learning and best practice across

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	services. One example of this was in theatres cost per minute, and how to work with the Chief Operating Officers to use the theatre cost per minute to understand what was driving variance. The Chief Finance Officer for WVT concluded by explaining that financial positions remained challenged, however there were various tools available to support productivity improvement and areas to focus on to mitigate increased cost. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive highlighted the positive progress on reducing agency spend across the Foundation Group. However, he explained there was still a significant opportunity to improve the reduction further with an approximate £68m being spent across the Foundation Group each year based on month three figures. The Group Chief Executive also noted the £44m worth of schemes being worked up across the Foundation Group and highlighted that the challenge would be how to turn that into delivered schemes. The Chief Finance Officer for GEH explained that discussions were taking place internally with regards to the schemes, which included targeted areas that would provide the biggest values. He added that there was also a need to link in with the improvement programme to ensure efforts were not being duplicated. The Group Chair expressed that he felt CPIPs and income allocations across the Foundation Group were not where they should be so far into the financial year. However, he celebrated the level of performance that was being delivered across the Foundation Group in relation to Elective Recovery despite the ongoing pressures faced in each Trust. The Managing Director for GEH took the time to thank the analytics teams for pulling the data together in a way that enabled comparisons across the Foundation Group. The Group Chief Executive informed the Foundation Group Boards that there would be Learning and Improvement Networks launched across the NHS in due course. These would focus specifically on acute productivity and the Foundation Group would be in a West Midlands Network. **Resolved – that the Group Finance Update including Productivity be received and noted.**	
24.065	**DEEP DIVE INTO ELECTIVE PRODUCTIVITY** The Chief Operating Officer for WVT presented the Deep Dive into Elective Productivity. He introduced the presentation by providing the Foundation Group Boards with the key priorities across the Foundation Group to deliver improved productivity. They focused around working smarter in a more efficient way and continuously sharing learning and best practice. The Chief Operating Officer for WVT added that all four Trusts were part of the Getting it Right First Time	

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(GiRFT) Group B Cohort, where Trusts shared performance and learning. This enabled the Foundation Group to learn from other Trusts as well. The GiRFT Group B also enabled the utilisation and adoption of bed practice from the GiRFT handbooks to ensure transformation, improvement and getting the transactional delivery correct. The Foundation Group was also focused on maintaining a clear divide between Urgent Care and Elective Care pathways.

The Chief Operating Officer for WVT presented the Capped Theatre Utilisation Data to the Foundation Group Boards and explained that it was pleasing to see across the work that had taken place to build and stabilise theatre utilisation. Whilst there was a lot more work to go, all four Trusts were moving in the right direction. When you looked at theatre utilisation by speciality, all Trusts were benchmarking well against General Surgery, however work continued to take place to identify the variation in performance against other specialities such as Urology. The Chief Operating Officer for WVT continued by informing the Foundation Group Boards of the initiatives taking place to improve theatre utilisation across the Foundation Group. Key focus areas moving forward included High Volume, Low Complexity lists and Ear, Nose and Throat (ENT), as well as trying to reduce cancellations by looking at pre-operative planning. The Chief Operating Officer for WVT highlighted the average number of cases per list which showed similar numbers amongst a lot of services, however also areas of shared learning that could still place particularly with Trauma and Orthopaedics for GEH and SWFT. Initiatives had been developed in relation to improving numbers of cases per list, with a common theme for all four Trusts being High Volume Low Complexity cases.

The Chief Operating Officer for WVT provided an overview of the outpatient productivity with ongoing focus on clinic lists and how to maximise productivity. This included job planning and activity reviews around both medical and non-medical staff that delivered outpatient clinics. Work was also taking place in relation to DNA challenges and rolling out PIFU to more services. WAHT had the lowest DNA rate across the Foundation Group and good work was also taking place in SWFT, so there was more work to be done to share learnings to help bring DNA rates down.

The Chief Operating Officer for SWFT presented each Trust's key drivers and improvement areas. GEH had challenges around accuracy of reporting and useable data, ENT capacity which then impacted SWFT, and their theatre planning was a manual process currently due to their planning tool being under development. GEH developing their theatre planning tool would have a significant positive impact and should not be underestimated regarding the benefit it would have. Increased cancer referrals was one of the key drivers across the Foundation Group which caused issues, however there had been improvements shared across the Group including increased volume of cases per list. The Chief Operating Officer for SWFT presented SWFT's key challenges which focused on Orthodontic long waits, Acute Surgical Admission, and Cataracts. SWFT had improved and maintain their theatre metrics for utilisation and productivity which remained a focus area, Endoscopy utilisation

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	was strong and the waiting list back log was reducing. WAHT's focus areas included pre-operative capacity and follow-up waiting lists. Their drivers included limited capacity within pre-operative assessment, contributing to late cancellations and services and case mix across sites was not enabling the most efficient through put. The key issues for WVT were the ability to meet the 65-week and 52-week targets and their reliance on premium cost agency. Their drivers were the long waiting patients in Orthopaedics, Opthalmology and ENT as well as maximising ERF and reducing unnecessary follow-up appointments. WVT had started using Allocate Job Planning software to maximise clinical output which would continue to have a positive impact. The Chief Operating Officer for SWFT concluded the presentation by explaining the next steps, which included using Group-level analytics to look further at outpatient metrics, continuing shared learning and understanding productivity further. She took the time to thank the Group Informatics Lead for producing the level of data in the operational deep dives, as well as the operational teams from across the Foundation Group for continuously working together for improvements. The Group Chair invited questions and perspectives and of particular note was the following point. The Group Chief Executive thanked the Chief Operating Officers for an informative presentation. He continued that despite good performance, there was still opportunities for improvements, and therefore encouraged the Chief Operating Officers to continue the work they were doing. **Resolved – that the Deep Dive into Elective Productivity be received and noted.**	
24.066	**FOUNDATION GROUP OBJECTIVES UPDATE** The Group Chief Executive presented the Foundation Group Objectives Update report to the Foundation Group Boards. He explained that the report was to mainly ensure all four Trusts within the Foundation Group had sight of each other's objectives. The report also identified potential objectives in common and encouraged lead Chief Officers to share learning and identify common areas. **Resolved – that the Foundation Group Objectives Update report be received and noted.**	
24.067	**EQUALITY UPDATE REPORT** The Chief People Officer for WAHT provided the Foundation Group Boards with detail of the measures put in place to support staff considering recent events within the media. She explained that all four Trusts had a very clear stance against racism and riots, and messages had been sent to all colleagues	

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expressing the position. Additional conversations with security teams had taken place as well as putting in supportive measures with Trade Unions, Freedom to Speak Up (FTSU) Guardians, Chaplains and Multi-Faith teams.

The Interim Chief People Officer for SWFT/GEH informed the Foundation Group Boards that GEH's Equality, Diversity and Inclusion (EDI) agenda and priorities were driven by their staff networks. GEH had six active staff networks who worked in collaboration with the EDI and Engagement team to identify priorities and create an inclusive workplace. The Chief People Officer for SWFT/GEH took most of the presentation as read, however highlighted the Armed Forces Community Network, which had achieved the Silver Award for Defence Employer Recognition Scheme. She explained the network did a lot of work alongside veteran organisations to support veterans and their families. Also the EmbRACE Network the Faith, Spirituality and Belief Network had been working together to improve staff experience, inclusive recruitment, as well as arrange of celebratory events for diversity throughout the year. GEH hosted Pride Month on behalf of the ICS in June 2024 which had great engagement. Moving forward GEH would be focusing on improving inclusive recruitment and would be launching campaigns such as the 'Say My Name' campaign.

The Interim Chief People Officer for SWFT/GEH presented an overview of SWFT's EDI work and highlighted that SWFT had seen an increase in staff engagement and as a result of that had launched the antidiscrimination helpdesk. SWFT was proud of the Workforce Disability Network who had achieved the Midlands Inclusivity and Diversity Award Scheme award for Network of the year in the Midlands region. Moving forward SWFT would be focusing on launching the Neurodiversity Network as well as running Neurodiversity Awareness Sessions to ensure those staff members felt supported and that they belonged at SWFT. SWFT would also be hosting the Disability History Month in November/December 2024 on behalf of the ICS.

The Chief People Officer for WAHT provided WAHT's EDI work and highlighted that WAHT had just launched new Values and the Networks would be supporting that work moving forward. She continued that WAHT's Rainbow Badge initiative was very positively received and supported training and inclusivity. WAHT had recently launched speak up training to encourage staff to speak up against discriminatory behaviour or concern. The Chief People Officer for WAHT highlighted the Trust's Supported Internships Program which data showed needed to be an area of focus moving forward to support people with various different needs into employment. She informed the Foundation Group Boards that four interns that were on the program had successfully gained employment as a result, three within the Trust. Next steps would also include inclusive recruitment, embedding the new Trust Value's and further enhance the EDI agenda, and continue with charities including the creation of the new Multifaith Hub.

The Chief People Officer for WVT presented WVT's EDI highlights. He expressed that EDI was about winning hearts and minds, and not just about

MINUTE		ACTION
	statutory obligations. He explained that all four Trusts were going above and beyond statutory obligations to try and change culture and set the direction by promoting compassionate and inclusive leadership. WVT had been encouraging all managers to sign up to NHS Inclusive Leadership training, to act as role models within their respective departments and ensue a zero-tolerance approach to any discrimination, bullying, harassment or victimisation. Three Staff Networks had been refreshed and sponsored by Executive Colleagues, they also had Union representation and staff side involvement to encourage good working relationships across the organisation. Through Education, Training, Recruitment and Health and Wellbeing programs, steps were being taken to enhance working environments for staff. He continued that in the previous twelve months WVT had been working with Jobcentre Plus and the Department of Work and Pensions (DWP) and had now been recognised as an exemplar organisation to work for, through that work WVT had also employed fifteen individuals. Moving forward, WVT would continue focusing on EDI and was proud that the Trust had its most diverse workforce it had ever seen. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chair highlighted the importance of keeping EDI at the top of the Foundation Groups agenda despite the other challenges faced. The Group Chief Executive expressed that it was a worrying time for the country, however it was encouraging to see the Foundation Group leading impressive EDI agendas. The Managing Director for GEH took the time to remind members of the public and the rest of the Foundation Group Boards that work on EDI was not in response to recent events taking place in the country, but because it was the right thing to do. However, how the Foundation Group responded to such events was important. She highlighted that a diverse team, was a strong team and the Foundation Group prided themselves on treating everyone equally. **Resolved – that Equality Update Report be received and noted.**	
24.068	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON 16 JULY 2024 (INCLUDING THE FOUNDATION GROUP STRATEGY COMMITTEE ANNUAL REPORT FOR 2023/24 AND ANNUAL REVIEW OF SELF-ASSESSMENT OF EFFECTIVENSS FOR 2023/24)** The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting held on 16 July 2024 which included the self-assessment of effectiveness and Annual Report for 2023/24.	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 August 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	The Chief Strategy Officer for SWFT noted that the attendance record within the Foundation Group Strategy Committee Annual Report needed updating to reflect the Deputy Chief Strategy Officer of SWFT as a member on her behalf. The Foundation Group EA agreed that this would be amended accordingly.	CI
	Resolved – that **A) the Foundation Group EA amend the attendance record within the Foundation Group Strategy Committee Annual Report to reflect the Deputy Chief Strategy Officer for SWFT's membership, and** **B) the Foundation Group Strategy Committee report from the meeting held on 16 July 2024 including the Foundation Group Strategy Committee Annual Report for 2023/24 and Annual Review of Self-Assessment of Effectiveness for 2023/24, be received and noted.**	CI
24.069	**ANY OTHER BUSINESS**	
	There was no further business discussed.	
	Resolved – that the position be noted.	
24.070	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
	There were no questions from members of the public or SWFT governors.	
	Resolved – that the position be noted.	
24.071	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
24.072	**CONFIDENTIAL APOLOGIES FOR ABSENCE**	
24.073	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
24.074	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 MAY 2024**	
24.075	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.076	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 16 APRIL 2024**	
24.077	**ANY OTHER CONFIDENTIAL BUSINESS**	
24.078	**DATE AND TIME OF NEXT MEETING**	
	The next Foundation Group Boards meeting would be held on 6 November 2024 at 1.30pm via Microsoft Teams.	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 August 2024 at 1.30pm via Microsoft Teams

Signed _____ (Group Chair) Date: 6 November 2024
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 6 NOVEMBER 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
24.068 (07.08.2024) Foundation Group Strategy Committee Report from the Meeting held on 16 July 2024 (including the Foundation Group Strategy Committee Annual Report and Self-Assessment of Effectiveness for 2023/24)	The Foundation Group EA amend the attendance record within the Foundation Group Strategy Committee Annual Report to reflect the Deputy Chief Strategy Officer's membership.	C Ireland	
ACTIONS IN PROGRESS			
23.080.01 (01.11.2023), 23.058 (02.08.2023), 24.007.02 (07.02.2024), 24.035.01 (02.05.2024) and 24.061.01 (07.08.2024) Foundation Group Performance Report	The Managing Director of GEH provide an update on why GEH were an outlier for cancer diagnosis from Emergency Department (ED) attendance at the next Foundation Group Boards meeting.	C Free	An audit will be undertaken in with the Urgent and Emergency Care (UEC) team to prospectively understand the reasons that are driving the number of patients being referred to Cancer pathways from ED. This has been delayed and will take part in August 2024.
24.064 (07.08.2024) Foundation Group Performance Report	The Managing Director for SWFT look into the SWFT's 52 week wait position and report back to the SWFT Board of Directors meeting.	A Carson	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

AGENDA ITEM	ACTION	LEAD	COMMENT

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Update from the Integrated Care Executive (ICE)
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	ICE, Trust Board
Lead Executive Director:	
Author:	Erica Hermon (Company Secretary), on behalf of Frances Martin (NED)
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the WVT Board on the ICE meetings.

2. Recommendation(s)

The WVT Board is invited to note the continuing development of ICE in providing oversight and assurance in relation to agreed areas of responsibility, including delegated services. There were no issues escalated to the One Herefordshire Partnership (OHP).

3. Executive Director Opinion[1]

ENHANCED CARE IN CARE HOMES

The report was presented was based on the General Practice report and an EHCH stocktake. The following points were highlighted:

- There has been an increase in collaboration between care homes and practices and an improvement in processes and pathways. Included has been a newsletter introduced to provide care homes with information and contact details for the practice teams.
- Most networks have Care Home Nurses to support. North and West Primary Care Network (PCN) have also been able to provide dieticians through WVT.
- The Care Home Steering Group has been well received by the care home manager representatives. There have been some recommendations for shared learning work and feedback.
- Work continues (with input from WVT and the local authority) to develop joint learning reporting. This will enable homes to escalate where the outcome for residents might have been different with a different intervention or information.
- The following issues have been flagged to ICB:
    - The Care Home Steering Group has highlighted a gap in discharge planning where patients are perhaps being discharged too quickly and then have to be re-admitted. The data to support this had been obtained through a new template, together with re-admission data. That said, the template is still under review to ensure that pertinent questions are being asked and the correct information is being captured to quantify any gap in planning. For example, access to CSU and other WVT data could be beneficial. Engagement with the ICB by ICE representatives will ensure a coordinated approach.
    - There have been some day to day issues and availability of staff to attend MDT meetings.

The meeting considered that it would be helpful to be able to see where funds are being spent and an assessment of the benefits realisation/return on investment. A meeting was pending on this matter with a view to starting audits in mid-September to allow feedback in October.

[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.

DISCHARGE TO ASSESS (D2A)

Despite advising Board previously of a plan to reintroduce the D2A board in July, unfortunately it did not go ahead and had been postponed to August 2024. That said, it was clear that there have been a number of improvements in D2A, not limited to:

- A review of the activity of the flow and discharge co-ordinators had confirmed that discharges using D2A pathways are effective in avoiding delays and, in turn, reducing the number of bed days lost. Specifically, delays to patients waiting for discharge in pathway 1 had reduced by 2 days. Pathways 2 and 3 are under review.
- Progress continues to ensure that the D2A dashboard is able to provide analysis and understanding of the length of stay (LoS), together with the number of patients in the pathway. The second phase, now in progress, focusses on demand and capacity analysis.
- There has been an overall reduction in LoS in community hospitals and, where concerns remain, a meeting has been scheduled with a view to improving occupancy. ICE acknowledged that pathways 1 and 3 still had long LoS but that One Herefordshire had approved the recruitment to the bridging team of 3 WTEs to support patients awaiting pathway 1 between frailty SDEC and home.

BETTER CARE FUND

Further to the previous report to WVT Board which had stated that there was less money available in 2024/25, since there have been some small changes made to the plan and the Council are apportioning savings targets to specific budgets and moving out to cost centres/services. YTD there is an underspend against the revised plan of £208K, primarily due to staffing vacancies in Home First and social work teams.

The impact of the restructure of community wellbeing staff will be reflected in the plan once the exercise is complete.

The current plan, total amount of funding and any risks to change of that total will be presented to ICE in September, including a breakdown of cost for care per day for different pathway solutions. Once approval is given by NHSE for the plan, revisions can be submitted at any point via region.

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

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Quality Committee 30 May 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 May 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

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

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***

☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***

☒ ***Work with partners to deliver the improvement plan for Children's services***

Digital

☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***

☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***

☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***

Productivity

☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***

☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***

☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***

Sustainability

☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***

☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***

☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***

Workforce

☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***

☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***

☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***

Research

☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***

☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Matters for Noting

1. **Infection Prevention and Control Quarterly Report** – Committee noted positively that the Trust had met its C-Diff annual trajectory for 2 consecutive years. However, there was concern that we had exceeded the national mortality rate for both C-Diff and E-Coli and further audits and case reviews are being carried out. Committee welcomed improvements in antimicrobial stewardship and focussed on hand hygiene and clinical cleaning where there improvements to be made.

2. **Mortality Report -** Committee noted that SHMI continues to be around the national average and welcomed the new Learning from Deaths Committee which met for the first time in May. A Public Health workshop in Herefordshire had noted some areas for mortality where the county is showing as an outlier in contrast to the patient mortality outcomes for the Trust. The Trust is working with Public Health to understand the background better.

3. **Improving Patient Experience** – This first quarterly report under the revised quality priorities focussed on complaints with the year-end seeing a 49% increase in complaints received. Committee questioned the increase and particularly comparisons with some of our Foundation Group partners where we benchmark higher. Response times remain a key challenge and the report explained key pressure points in the process particularly where the Investigating Officer needs to change and where issues cross divisional boundaries. Additionally the Trust is focussed on agreeing timeframes with complainants. The level of focus on this area was acknowledged and Committee urged continued focus on governance of the response process including escalation to executives.

4. **Boarding Report –** Quality Committee continues to scrutinise and challenge the number and experience of boarded patients and the consequences for quality and safety of all patients impacted. Additional patients on our wards impacts on the care environment for all patients and Committee was assured that balancing the need for boarded patients with the need to protect the environment on key wards is continuously reviewed to minimise and balance risks. Positively, Committee noted the improvements in discharge processes.

5. **Medical Division Quarterly Report** – Committee welcomed the report from the Medical Division that had a good focus on key quality and safety areas. In particular, Committee noted:

    - The focus on nutrition improvements following an HSSIB report on a previous incident;
    - Work to reduce time in ED for fractured neck of femur patients where we are an outlier for mortality rates;
    - Improvements in triage times and NEWS scores following the CQC ED inspection.

6. **Maternity Quarterly Report** – Committee welcomed the new format bringing together PQSM data with a full range of safety information. The format will be finalised as a common approach across the Foundation Group, strengthening cross-group scrutiny. Committee noted in particular the latest quarterly assessment by the regional LMNS which had confirmed satisfaction with progress against CNST standards for this year and the Safety Champions visit in April which had found no safety concerns.

7. **Clinical Effectiveness and Audit Committee Summary Report** – It was reported that this key sub-committee has been struggling to ensure quoracy and attendance due to diary pressures. Committee timing is being reviewed to remedy this.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 30 May 2024 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Ellie Bulmer	EB	Associate Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Mehmood Akhtar	MA	Associate Chief Medical Officer, Surgical Division
Chris Beaumont	CB	Directorate Manager – For Item 5
Jo Clutterbuck	JC	Acting Associate Chief Operating Officer – Medical Division
Rachael Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Leah Hughes	LH	Advanced Practitioner Radiographer – Arrived during Item 4.1
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Sarah Sharp	SS	Matron, Head, Neck & Orthopaedic Directorate
Rachael Skinner	RS	Integrated Care Boards Representative
Amanda Spooner	AS	WVT South West Locality Manager- Nursing, Integrated Care Division
Emma Wales	EW	Associate Chief Medical Officer, Medical Division
Laura Wathen	LW	Lead IPC Nurse – For Item 4

QC001/05.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Chizo Agwu, Chief Medical Officer, Jonathan Boulter, Associate Chief Operating Officer, Surgical Division, Dan Harding, Associate Director Diagnostic Programmes, Hamza Katali, Associate Chief Medical Officer, Clinical Support Division, Emma Smith, Associate Chief Nursing Officer, Surgery Division and Amie Symes, Associate Director of Midwifery.	
QC002/05.24	**QUORUM**	
	The meeting was quorate.	
QC003/05.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/05.24	**MINUTES OF THE MEETING HELD ON 25 APRIL 2024**	
	Resolved – that the minutes of the meeting held on 25 April 2024 be received and approved.	

QC005/05.24	**ACTION LOG**	
	(a) QC006/04.24 – (C) – Safeguarding Quarterly Reports - The Integrated Care Boards Representative advised that following the meeting with the ICB, work is continuing with the teams. The Dentist is advising on follow up for the children. (b) QC018/03.24 – (B) – Divisional Quarterly Report – Clinical Support Division – The plan is to use I-Passports further around the Trust but usage is based on licence purchase. Further update at the next Quality Committee meeting when a representative from the Clinical Support Division is present.	**CC**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The Associate Chief Operating Officer, Clinical Support Division to provide an update on the progress of the use of I-Passports across the Trust at the next Quality Committee meeting.**	**CC**
	BUSINESS SECTION	
QC006/05.24	**INFECTION PREVENTION AND CONTROL COMMITTEE QUARTERLY REPORT**	
	The Lead IPC Nurse (LIN) presented the Infection Prevention and Control Committee Quarterly Report, which was taken as read, and the following key points were noted: • We are below the threshold for our end of year C-Diff figures. We had 37 cases against a threshold of 43. This is the second year that we have been below our threshold. The threshold had been extended during Covid. We are reviewing cases and looking at any lessons learnt. Clinical cleaning, hand hygiene and antibiotic prescribing are areas picked up. We are using the Patient Safety Incident Response Framework to review all cases. • Overall, we exceeded our gram negative bacteraemia threshold. We also exceeded our locally set MSSA as well. We are reviewing these to see if there are any further lessons to learn. Similar themes to C-Diff were found and additionally documentation was found to be poor in some cases. Nationally, there has been a reported increase seen in the number of cases. It has been suggested that we review the patients on our long waiting lists due to Covid and delays for surgery due to the infection possibly occurring due to other reasons occurring in the background. • We exceeded our national mortality rate for E-Coli and C-Diff cases. A meeting has been held with the Directorate Manager with a plan agreed including further audits and case reviews.	

	• We had a drop in Covid cases with 11 outbreaks (including Norovirus). Areas were kept open during the outbreaks with measures in place to ensure patients were kept safe and patient flow continued in these areas with no increase in infection numbers due to this. • The Chief Nursing Officer (CNO) advised that regarding the mortality outliers, each case will be reviewed. • The Managing Director noted that the antibiotic stewardship issue around C-Diff numbers has largely been resolved but the cleanliness issues still remain. However, Quarter 4 has improved – is this a one off or are numbers now on the decline. The LIN advised that there has been an increase in patients which can effect these numbers. There have been a number of changes occurring over the last few years and it is difficult to know how much of this has improved the infection numbers. • Mrs Twigg (NED) noted that the national cleanliness standards performance is over 90% with PLACE averages under the national average regarding our cleaning standards which is a mixed message. Which one are we measuring? Secondly, there are a large number of hand hygiene failures being monitored, do we keep monitoring repeat offenders and is this the same people every time? The LIN advised on how hand hygiene data is collected which means repeat offenders are not identified however if this is observed in practice the IPC Team have conversations with repeat offenders and offer additional advice and training. Regarding cleaning, these are measured at a local and national level. Therefore we go by the final results. Mrs Twigg (NED) advised that there is a difference between the Sodexo and Estates measurements in a number of Reports. • The CNO advised that Sodexo and estates measurements are audits of different elements ie estate performance (paintwork, doors, flooring etc), whereas Sodexo relates to cleaning performance therefore the results will differ. The CNO also confirmed that we have joint monitoring which includes trust, estate, clinical and Sodexo representatives and that a consensus of the performance and score is obtained. Regarding PLACE, we cannot compare this to performance monitoring as the PLACE results are an impression that the public feel when they walk into an area rather than an audit. • The CNO still felt there were improvements to be made around C-Diff numbers with infection rates increasing a national trend. We are part of the Regional Collaborative looking at this.	

	• The CNO was concerned around our mortality status for E-Coli and C-Diff as this has not been an issue previously, hence work being carried out to review the background to this. Regarding antimicrobial stewardship, there was a quarterly update presented to the Infection Prevention Committee last week which shows good compliance with the formulary, our overall consumption of antibiotics is within national expectations yet we do use a higher amount of intravenous antibiotics and need to get better at review and hard stop dates. Antimicrobial stewardship is being presented to a number of forums by the Antimicrobial Pharmacist. • The Managing Director queried our C-Diff target for this year. The CNO advised that this has not yet been set. ICB guidance is to follow last year's figures. • Mr James (Chair of the Quality Committee and NED) questioned if there was a link between clinical cleaning and low mandatory training amongst clinical staff. The LIN agreed there was a link with face to face and E-learning available. Discussions have been held with the Education and Development Centre around more face to face training to show staff how to clean areas. We are also looking at being able to join the Health Care Support Worker training. • The CNO has asked, through the Cleanliness Committee, for more detailed analysis of the clinical clean failures particularly for those areas not meeting the standard The Chair of Cleanliness Committee is looking at how we can present this in a meaningful way.	
	<u>Resolved</u> – that the Infection Prevention and Control Committee Quarterly Report be received and noted.	
QC006.1/05.24	**<u>INFECTION PREVENTION TERMS OF REFERENCE AND FORWARD PLANNER</u>**	
	The CNO presented the Terms Of Reference and Forward Planner and the following key points were noted: • These were approved at the last meeting of the Infection Prevention Committee. Minor amends were made only. • They are being presented today for approval.	
	<u>Resolved</u> – that the Infection Prevention Terms Of Reference and Forward Planner were received and approved.	
QC006.2/05.24	**<u>INFECTION PREVENTION SUMMARY REPORT</u>**	
	The CNO presented the Infection Prevention Summary Report and the following key points were noted: • Surgery presented an excellent Divisional Report to the Infection Prevention Committee last month. It was agreed to use this as a template for the other Divisions going forward.	

	• The CNO thanked the teams for the Infection Prevention BAF – this is a huge document to evaluate and assess compliance against. There were no areas of non-compliance and a small number with partial compliance – with actions to progress. There were no risks associated with the areas of partial compliance. • It was agreed to review this biannually at the Infection Prevention Committee. • Discussion was held around Covid testing arrangements for discharges to Community Hospitals and Hospices which was approved and communicated.	
	<u>Resolved</u> – that the Infection Prevention Summary Report be received and noted.	
QC007/05.24	**<u>MORTALITY REPORT</u>**	
	The Directorate Manager presented the Mortality Report, which was taken as read, and the following key points were noted: • Our SHMI is just above the national average of 100 at 101.7. Our HED data shows that we are below the national average. • Heart Failure – There has been a stark drop in these figures. We lost a couple of months with large numbers in the reporting period. Pneumonia also saw a large drop, which is now well below 100 which is positive. • The first Learning from Deaths Committee was held this month with good clinical engagement. Presentations were received from a number of areas. • The Mortality Review Panel is starting this month. This includes Clinical Leads, key stakeholders and nursing leads. There will be an MDT Review of any cases of concern. • Public Health Workshop May – This is a deep dive into mortality in Herefordshire. There are differences in how mortality is measured. We have a good level of patient outcomes for patients in the Trust, but Public Health have us as a national outlier. Females aged over 75 years appear to be our issue. We are linking in with the Public Health Lead to try to understand the background to this. • The Medical Examiner roll out has been postponed until September. We are working through a large number of community deaths and working with GPs to ensure that processes are in place. • Mr James (Chair and NED) questioned where the new Learning from Deaths Committee reports into. The Directorate Manager advised that this will feed into the Quality Committee as part of the Mortality Report.	

	• The Managing Director noted that it would be very positive to be under 100 for our SHMI if we can achieve that. This is around the diligence of picking up on outliers quickly and understanding the drivers to change. She was keen to discuss stroke in Safety In Sync to drive this in a System way forward. • Mrs Martin (NED) queried why some of the GP practices had pulled out the Medical Examiner roll out. The Directorate Manager advised that the process is not ideal, we are working through issues to get access for everyone. Some of the GPs have pulled out due to capacity and want to wait until the September commencement date. The Hereford Medical Group is on board which is a huge test of the system. We will try again at the end of July to get everyone on board before the September start date.	
	Resolved – that the Mortality Report be received and noted.	
QC008/05.24	**QUALITY PRIORITY – USING LOCAL AND NATIONAL INTELLIGENCE TO IMPROVE PATIENT EXPERIENCE**	
	The Associate Director of Quality Governance (ADQG) presented the Quality Priority – Using Local and National Intelligence to Improve Patient Experience and the following comments were noted: • This is the first Report in relation to the amended Quality Priorities. Suggested measures for this are included in the Report to enable improvements being made to be seen throughout the year. • The Report focuses on complaints. We ended the year with a 49% increase in complaints. We have however seen a reduction in comebacks and reopened complaints which shows that the quality is improving. Overall, there has been a 40% increase on last year. • There has been a concerted effort to reduce overdue responses. Quarter 4 response times on average were 67 days. The focus is on those open the longest – 109 days. Although we are not always meeting the 30 day target, we have improved on agreeing timeframes with the complainant. The Quality and Safety Matron spent time over the last few weeks discussing with Divisions showing them how complaints are managed. Common themes with delays were only 1 IO Lead or this being changed partway through the complaint. Also cross Divisional complaints causing significant delays due to collating the information and agreeing who develops the final response. • A Working Group has been established around the PHSO Guidance regarding complaints and concerns. This was discussed at the Patient Experience Committee and it was agreed to adopt these principles. This talks about everyday conversations and not everything being documented as a concern but discussing this with the individual. There is appetite to look at this and change our processes.	

	• Mrs Twigg (NED) noted the change in culture which is positive but queried the governance around escalating to the Executives. The ADQG advised that we try to resolve issues before this occurs. The Managing Director reiterated that the Executives are happy to be the point of escalation. • The Managing Director was concerned with the increase in numbers as we benchmark higher than George Eliot and South Warwickshire NHS Foundation Trust. We need to understand why this is and was aware that this is being reviewed. She was also concerned regarding the single point of failure in the Surgical Division who is due to retire advising that we need to review how this will be covered once they leave. • Mrs Twigg (NED) questioned what the governance is around the agreed individual response times. The ADQG advised that everything is documented on InPhase. The timeline is led by the complainant not determined by ourselves. • The Associate Chief Medical Officer, Medical Division noted that agreeing a timescale with the complainant implies interaction which is beneficial to the outcome. • Mr James (Chair and NED) questioned if we can improve on the Patient Experience Committee being able to push back on areas. The ADQG agreed that further improvements can be made. • The Associate Chief Nurse, Medical Division confirmed that the Medical Division Survey Update will be presented to the next Quality Committee meeting.	
	<u>Resolved</u> – that the Quality Priority – Using Local and National Intelligence to Improve Patient Experience be received and noted.	
QC009/05.24	**<u>QUALITY ACCOUNT</u>**	
	The ADQG presented the Quality Account and the following key points were noted: • Comments and feedback were asked for on the Quality Account. • This is being presented in a new format this year which is more user friendly. The plan is to have a Patient Facing Executive Summary to sit alongside this. • The Chief Executive and the ICB sections will be added at a later date. • The CNO noted the tight turnaround of this document with any amendments needed by tomorrow to allow the papers to be sent out for the Board of Directors meeting. This will be subject to the ICB Statement of Assurance which will not be received until after the Board of Directors meeting but prior to publication.	

	• Mrs Martin (NED) highlighted the amount and complexity of information still included in the Quality Account and how accessible this was for the public to read and understand. The ADQG agreed advising that over the years this has been made a more reader friendly document but the amount of information we have to include is prescribed. A 1 or 2 page briefing might help with this. • Mr James (Chair and NED) agreed with the Patient Experience Committee suggestion of having a summary of each section which could be reviewed for implementation next year. • The Integrated Care Boards Representative felt that this was a longer document than last year. She appreciated the difficult balance between putting information in plain English and being sufficiently succinct to be readable and agreed having a briefing would idea. She also noted that the Core Indicators, the Trust's Plans around Dentists in training and Readmissions within 28 days core indicators were on the Contents Page but did not appear in the Report which would be ideal to include if possible. • Mrs Martin (NED) noted that the National Audit of Care at the End of Life is a really powerful document. These are stark figures which show that we could be doing better. It would be good to discuss this in more detail around where we are capturing this and what improvements can be made. The CNO advised that the Audit was presented to the Clinical Effectiveness and Audit Committee in September 2023 and will ensure that it is presented annually to the Quality Committee.	**LF**
	<u>Resolved</u> – that: **(A) The Quality Account be received and approved to present at the Board of Directors meeting with the amendments discussed.** **(B) The National Audit of Care at the End of Life will be presented to the Quality Committee on an annual basis.**	**LF**
QC010/05.24	**<u>BOARDING REPORT</u>**	
	The Acting Associate Chief Operating Officer – Medical Division presented the Boarding Report and the following key points were noted: • We continue to have high levels of boarders although the total numbers are reducing. We had 68 less boarders in April than March. We are also seeing a number of escalation beds being opened. • Discharge Lounge – The month on month reduction has now stabilised with 11 patients being transferred per day on average. The first Discharge Lounge Usage Group meeting was held with some quick wins to implement. The Discharge Lounge will ring wards first thing in the morning and the Site Team will send out potential and definite discharges to the Discharge Lounge.	

	• The number of boarders peak after a Bank Holiday which was repeated in May. • There has been no change in the incidents received but a slight increase overall regarding boarding. • Boarders being moved into ring fenced beds is an issue. We are working with operational teams to change our approach to ensure these are used for the intended patients. • Next Steps – We regularly review which wards are boarding to ensure equality where possible. The Frailty Team are working on their pathway to improve their patient flow. We have also set up a Cross Divisional Working Group to review the discharge process across the Divisions. • Mr James (Chair and NED) noted the huge range of usage for the Discharge Lounge. The Acting Associate Chief Operating Officer – Medical Division advised that numbers drop off significantly over a weekend. The plan is to try to include the proportion of patients discharged who are sent to the Discharge Lounge for the next Report for more useful information. The Discharge Lounge can accommodate 9 patients which can be flexed up but this uses Medical Day Case space. There are only 2 beds available due to space restrictions. Mr James (Chair and NED) queried what more we can do to improve weekend usage. The Acting Associate Chief Operating Officer – Medical Division advised that some areas operate less on a weekend. This is more of a system wide issue. • Mr James (Chair and NED) highlighted that we need to accommodate boarders but this has a knock on effect to patients on the ward. Some wards are impacted more having boarders due to space but this is needed for the type of patients they have. How is the risk to patient safety managed? The Acting Associate Chief Operating Officer – Medical Division advised that certain wards require more space due to moving and handling equipment or oxygen cylinders. The Associate Chief Medical Officer, Medical Division advised that the Frailty Wards are newer, hence a different layout with different issues. The Matron, Head, Neck & Orthopaedic Directorate advised that it is extremely challenging on all wards with the impact on staff working in this environment intense. We are trying to minimise and balance the risks. • The Managing Director noted the increase in complaints with few relating to boarding. Patients are very understanding and staff are very stoic but this is not an acceptable norm. This is of concern especially given the significant improvements in the number of patients who are medically fit for discharge, we were expecting to see a subsequent reduction in boarding numbers but this is not occurring. The Chief Strategy and Planning Officer is undertaking a review over the summer around bed capacity and future plans.	

	• Mrs Martin (NED) questioned what else we could be doing to reduce boarders. The Associate Chief Medical Officer, Medical Division advised having more Geriatrician input in the Emergency Department (ED) would enable more patients to be discharged to reduce admissions.	
	Resolved – that the Boarding Report be received and approved.	
QC011/05.24	**DIVISIONAL QUARTERLY REPORT (INCLUDING CQC ACTION PLAN) – MEDICAL DIVISION**	
	The Associate Chief Nurse, Medical Division presented the Divisional Quarterly Report (Including CQC Action Plan) – Medical Division and the following key points were noted: • There were no externally reportable patient safety incidents during this quarter. During the previous quarter there were 2 incidents – details within the Report. • Following the HSSIB Report relating to a previous patient safety incident regarding a patient's nutritional needs, there is a big focus on quality improvement relating to MUST scores and dietary requirements. Diet and Fluid Charts are discussed at the daily ward huddles and a check and challenge has been initiated at board rounds. The Ward Sister is also ensuring weekly audits are being completed to sustain improved compliance. • CQC Action Plan – We are behind schedule with this due to sickness. We are ensuring that ED staff are appropriately qualified in regards to Intermediate Paediatric Life Support. There is a longer term plan to support Children Nurses in ED. • ED is running with vacancies but the trajectory is looking positive going forward. • The Clinical Obs Standard Operating Procedure has been delayed due to discussion following an incident relating to NEWS. Discussion is also being held around how to monitor fluid balance. This will be shared with our Foundation Group colleagues. • The Care Quality Commission had concerns around the lack of cascading of risks and incidents to the shop floor. There are improved governance processes in place with new staff in post to support. There are also monthly review meetings to ensure compliance. • The Trust were awarded an A scoring for SSNAP for October-December 2023 which is an incredible achievement. • The Transfusion Strategy on cardiac injury and death in patients undergoing surgery for hip fracture is a study being run by the Edinburgh Clinical Trials Unit and currently has around 20 sites open across the UK which the Trust is part of.	

	• A Senior Nurse at the Trust is being highlighted by Health Chiefs from NHSE Midlands for her promotion to an advanced role and becoming the first international Nurse Prescriber at the Trust. • The Associate Chief Medical Officer, Medical Division advised that the Frailty Same Day Emergency Care (SDEC) is doing well with Therapy Assistants working every morning which frees up the Advanced Clinical Practitioner to undertake clinical assessments. They are also developing good links with the community. Our Geriatric Medicine Index of Patient Flow score is in the best quartile in the country. • Orthogeriatrics – Our Consultant Orthogeriatrician is working to ensure patients admitted with a fractured neck of femur are reviewed by a Geriatrician. This also means attracting more best practice tariff. The Trust performs well on several of the key performance indicators, especially prompt Orthogeriatric review, prompt mobilisation and lower than national average rates of post-operative delirium. • We are an outlier for mortality around fractured neck of femur. All deaths in Quarter 3 were audited. We found that patients have a higher risk of dying and also spend longer in ED than recommended. Due to the current bed state, the previously agreed ring-fenced fractured neck of femur bed is usually occupied. Our Orthogeriatrician is developing a fast track protocol with the aim to reduce time spent in ED. • Geriatrics do not normally have high outpatient numbers. However, a lot of specialties have long waiting lists with old and frail patients on them. We are therefore developing more links, especially with Cardiology and Haematology to try to take some of the pressure off other services to enable patients to have a holistic approach. • There is concern around recognition of patients with Type 2 Respiratory Failure. An MDT Meeting was held and an action plan developed to improve this. • We have a substantive Consultant Neurologist in post who is having a big impact on their waiting list due to the validation work being undertaken. • The Acting Associate Chief Operating Officer – Medical Division advised that we have a Working Group in place following the challenge nationally to all Trust to improve our 4 hour wait in ED. Actions taken include a GP in ED, a Nurse Navigator in ED streaming patients and a Transfer Team taking patients up to the wards to free up nurses to care for patients in ED. We are also working with local GPS and Taurus identifying out of hours slots (1 slot per hour across evenings, nights and weekend) Our 4 hour target improved from 55% in February to 65.7% in March which has been maintained in April and May. We are now in the Top 10 Trusts with our improved performance. There has also been improvement in Minors, time to discharge and SDEC care.	

	• The ED Medical Business Case is being presented to the Trust Management Board for approval. This will allow us to make posts substantive with the ED Nurse Business Case including a Navigator Nurse and Transfer Team. We will, however, be challenged to meet the improved target of 78% target by March but are working on further improvements in ED. • The Associate Chief Nurse, Medical Division is aware of the concerns around our congested ED with a regular review of incidents undertaken. • The Managing Director highlighted the trajectory for recruitment in ED with the challenge to keep them in post once recruited and queried the focus in the Department. The Associate Chief Nurse, Medical Division advised that the ED Business Case would allow a Band 7 Governance Role and increased practice education to support staff. • The Managing Director noted that the Care Quality Commission talked about triage and the requirement for NEWS and questioned progress around this. The Associate Chief Nurse, Medical Division advised that it is around 23 minutes to triage with 60% for NEWS scores. The Associate Chief Medical Officer, Medical Division advised that the biggest change is the Transfer Team which will allow nurses to continue looking after their patients. • The Managing Director noted that to be top in the Region for our time to treatment in 60 minutes is an absolute credit to all involved, especially with the current pressures. • Mr James (Chair and NED) queried why ward moves are occurring at night and how can these be reduced. The Associate Chief Nurse, Medical Division advised that we try to avoid ward moves at night but these sometimes occur due to bed availability and ring fenced beds becoming available. The Acting Associate Chief Operating Officer – Medical Division also noted that plans for the evening are also discussed at the last Bed Meeting of the day. If an ambulance is unable to offload a patient, then we may need to transfer a patient to accommodate this. • The Associate Chief Nurse, Medical Division advised that the data around concerns was not included in the Report this time but there were 36 in April.	
	<u>Resolved</u> – that the Divisional Quarterly Report (Including CQC Action Plan) – Medical Division be received and noted.	
QC012/05.24	**<u>DIVISIONAL QUARTERLEY REPORT – MATERNITY</u>**	
	The CNO presented the Divisional Quarterly Report - Maternity and the following key points were noted: • A new format and approach has been used for this Report. This will be an interim arrangement until this has been finally agreed across the Foundation Group. This meets external standards and is a longer Report. This also incorporates the data set required for the PQSM.	

	• The plan is to rename this to the Perinatal Services Safety Report and expand on the perinatal information as the Report evolves. • There has been a normal number of deliveries during this period. Red flags are outlined within CNST standards and are all subject to an Incident Report and MDT review. Details are included within the Report. • CNST 10 Standards require us to report on attendance by Consultant at particular events, details in the Report. • Safety Incidents – These are included in the Report including the minimum data set. The data set will have to be reported in Private Board due to the low numbers making patients identifiable. • The information around grading of PMRT reviews needs more of a descriptor included which will be added in future Reports. • We will submit information on the claims score card in future, but this is outstanding at present. • Patient experience user feedback shows low numbers of complaints and concerns with positive feedback. • There is good engagement with Neonatal Maternity Voices with high level feedback included in the Report. • There is good recruitment with a small vacancy factor and good retention. There are no midwifery staffing concerns. • Saving Babies Lives Version 3 – The Trust have achieved compliance with progress with quality assurance checked by the LMNS on a quarterly basis. Despite not meeting the 2024 deadline the ICB confirm assurance that sufficient progress is being made. The LMNS have confirmed that they are satisfied with efforts and progress to date. • Safety Champions – Maternity and Neonatal Safety Champions work at every level and across Regional and Organisation boundaries. CNST Safety Action 9 requires all Trusts to have visible Maternity and Neonatal Board Safety Champions who support the perinatal leadership team. A Safety Walkabout took place on 3 April with 3 Safety Champions and an external NED. All areas visited were clean and tidy and no safety concerns were identified. • Mrs Martin (NED Maternity and Neo-natal Safety Champion) was keen for the Quality Committee to see the detail around the scrutiny and standardising reporting across the Foundation Group. Meetings are held with the team regularly and she is confident that all the measures are going in the right direction. • The CNO confirmed that this monthly Report will also include a slimmed down version of the PQSM.	

	• Wye Valley Trust were one of the first Trusts to go through the Maternity Safety Programme, this included the Neonatal and Maternity quad participating in the NHSE Perinatal Culture Club over the last 12 months. This included the roll out of the SCORE culture survey across maternity services. The results of the survey will be reported by exception in the June report and the full report shared when available.	
	Resolved – that the Perinatal Services Safety Report be received and noted.	
QC013/05.24	**STAFFING REPORT**	
	The CNO presented the Staffing Report which was taken as read, and the following key points were noted: • There has been agreed investment in a number of wards throughout the year which has not yet translated into the establishment. Discussion has been held with Finance colleagues and this should be included from Month 2. Individuals can then be held to account for the budgeted establishment. Many areas have fill rates above 100% due to the adjustment not being made. • There was a significant reduction in agency spend in March and April. We are also working towards eliminating the use of Thornbury. • We have been discussing the use of non-framework agencies with HTE and are exploring alternatives. In the short-term, we are negotiating the short term renewal of our contract with our Master Vend. We are presenting an options appraisal to the Trust Management Board in July with a fully cost benefited appraisal in September. • The Managing Director noted that the Report suggested that we are fully recruited for Registered Nurses and Health Care Support Workers and queried what the vacancy factor will be once these have been uplifted. The CNO advised that there will around 20 vacancies, mostly in ED.	
	Resolved – that the Staffing Report be received and noted.	
QC014/05.24	**CLINICAL EFFECTIVENESS AND AUDIT COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Clinical Effectiveness and Audit Committee (CEAC) Summary Report and the following key points were noted: • Governance arrangements for the Committee are an area for concern. We are therefore reviewing these. Currently Patient Safety Committee is held 1 month and CEAC the alternative month. Patient Safety Committee has good engagement and a full agenda, however there is less engagement with CEAC and sporadic attendance.	

	• Concerns around the action plan progress for the NELA Audit are included in the Report. There were also concerns raised around the revised Chest Drain Policy following a number of incidents. Since the Report was written, the policy has been published. The CNO, CMO, Deputy CMO and ADQG are meeting to discuss the Committee membership, remit and attendance. • Mr James (Chair and NED) advised that we take confidence in the Sub-Committees providing assurance. He was concerned that CEAC are struggling to deal with the workload but pleased to hear that this is being dealt with. The CNO confirmed that the NELA Audit was discussed at the Finance & Performance Committee meetings with actions being taken forward. • The CNO advised that she and the CMO are key members of the Committee and at least one of them are expected to attend every meeting for quoracy but this has been difficult recently due to other mandated diary commitments which have arisen in recent months. We will therefore need to review the timing of the meeting to ensure attendance. • The Deputy CMO advised that attendance at CEAC was also an issue at his last Trust given the nature of the agenda. There is good attendance the Patient Safety Panel and Committee. A review of how attendance is built into Job Planning may be required.	
	<u>Resolved</u> – that the Clinical Effectiveness and Audit Committee Summary Report be received and noted.	
QC015/05.24	**<u>PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT</u>**	
	The ADQG presented the Patient Experience Committee Summary Report and the following key points were noted: • The first Divisional Report was received this month from the Medical Division. It was pleasing to hear about the triangulation occurring, which was well received. There was assurance in terms of what is being done with this information. • There was good discussion around boarding and how concerns are being dealt with. • We are struggling to roll out the Friends and Family Test and get data into a format that Divisions can more meaningfully use. We understand the barriers to this and are trying to get timescales for the remaining areas to roll out. • The Associate Chief Nursing Officer queried if the meeting was struggling with medical colleague engagement. The ADQG advised that we are taking a different approach to this with the Directorate Manager attending to bring feedback from those areas.	

	• Mr James (Chair and NED) questioned to what extent the Patient Experience Committee could pick up on thematic areas, eg PLACE audit around dementia and respond to areas rather than being reactive. The ADQG advised that the Committee was relaunched last year. Feedback around signage from the PLACE Audit is difficult to improve upon. This is also an issue for Urology patients which the Trust needs to review as a whole. Opportunities for improvement emerges in the Committee with themes being addressed along with specialist updates. Feedback enables improvements in services along with better focus on being inclusive as well.	
	Resolved – that the Patient Experience Committee Summary Report be received and noted.	
	CONFIDENTIAL SECTION	
QC016/05.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC017/05.24	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC018/05.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 27 June 2024 at 1.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**05/09/2024**
Title of Report:	Quality Committee 27 June 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 June 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

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

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***

☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***

☒ ***Work with partners to deliver the improvement plan for Children's services***

Digital

☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***

☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***

☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***

Productivity

☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***

☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***

☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***

Sustainability

☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***

☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***

☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***

Workforce

☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***

☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***

☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***

Research

☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***

☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Matters for Noting

1. **Quality Priority – Tissue Viability** – Committee noted positively that the PSIRF process is now allowing rapid review of pressure ulcer damage, with much quicker review of incidents and supported by improved information from InPhase. What we have still to see, however, is a decrease in our 2 priority areas – number of category 2 ulcers and number of ulcers deteriorating to grade 3 or 4 or unstageable.

2. **Mortality Report -** SHMI continues to be around the national average but is anticipated to reduce below 100 when the national data is refreshed. The main areas of focus continue to be our outliers – stroke, heart failure and fractured neck of femur. The Medical Examiner service is now reviewing all deaths and escalating to a Structured Judgement Reviews (SJR) where potential issues and learning are identified. The process is overseen by the new Learning from Deaths Committee, with a new Mortality Panel considering issues of potential poor care identified in SJR's.

3. **Quality Priority - VTE** – New dashboards are in place and are indicating improved performance, however we need to cross reference with previous data sets. WVT has "buddied" with George Eliot to provide support. The link to EPMA is still not in place – now anticipated for October – and will further strengthen screening and monitoring. The focus is on improved screening, but the wider picture is also being scrutinised including VTE readmission rates.

4. **Quality Priority – Falls.** We have seen a reduced number of falls in frailty and the learning is now being used in the wider Trust. The major part of the QC discussion focussed on use of bed rails following a recent coroners case where this was an issue. There is concern at potential inappropriate use as well as the need to ensure that risk assessments are both carried out and followed through.

5. **Boarding Report** – We continue to see high numbers of boarded patients. The focus on reducing numbers continues to be improved flow of patients into, through and out from the hospital. Quality Committee scrutiny centres on these efforts alongside seeking assurance that risks to quality and safety of all patients from additional boarded patients are minimised. In this regard, discussion included consideration of effective and appropriate use of community hospital capacity. It was also agreed to review whether boarding is associated with increased medicines incidents.

6. **Integrated Care Division Quarterly Report** – Committee welcomed the focus on the report on the "read-across" to Quality priorities, notably tissue viability and falls. Committee noted:

    - Recruitment challenges for therapeutic staff and the focus on "growing our own" alongside international recruitment;
    - The need for tissue viability work to focus on unstageable and moisture associated skin damage.

7. **Clinical Support Division Quarterly Report** – In reviewing a comprehensive update, Committee noted in particular:

    - No concerns regarding the response and action plan following the regional visit to paediatric audiology services.
    - Restarting of the Dexa screening service, with the backlog having been addressed and potential patient harm currently subject of a review.
    - Pharmacy recruitment initiatives continue to support improvements in the vacancy position.

8. **ED CQC Action Plan –** Committee noted good progress across the actions, but wanted opportunity to give greater scrutiny to the key issues identified by CQC and requested a deep dive report for the August meeting.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 27 June 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 – Left during Item 11
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director – Arrived during Item 5
Kieran Lappin	KL	Associate Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Claire Carlsen	CC	Associate Chief Operating Officer, Clinical Support Division - Arrived during Item 8 and left after Item 11
Jo Clutterbuck	JC	Acting Associate Chief Operating Officer – Medical Division – Arrived during Item 6 and left after Item 17
Ingrid Du Rand	ID	Associate Chief Medical Officer, Research and Development – For item 4.1
Helen Harris	HH	Integrated Care Boards Representative
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Leah Hughes	LH	Advanced Practitioner Radiographer
Tony McConkey	TM	Clinical Director, Pharmacy & Medicines Optimisation
Sue Moody	SM	Associate Chief AHP, Integrated Care Division – Left after Item 17
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer – Let after Item 17
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division
Amie Symes	AS	Associate Director Midwifery – Left during Item 17
Emma Wales	EW	Associate Chief Medical Officer, Medical Division
Hannah Wood	HW	Research Manager – For Item 4.1

QC001/06.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Ellie Bulmer, Associate Non-Executive Director, Dan Harding, Associate Director Diagnostic Programmes, Rachael Hebbert, Associate Chief Nursing Officer, Frances Martin, Non-Executive Director and Jo Rouse, Associate Non-Executive Director.	
QC002/06.24	**QUORUM**	
	The meeting was quorate.	
QC003/06.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/06.24	**MINUTES OF THE MEETING HELD ON 30 MAY 2024**	
	Resolved – that the minutes of the meeting held on 30 May 2024 be received and approved.	

QC005/06.24	**ACTION LOG**	
	(a) QC005/02.24 – (B) – Action Log - The Chief Nursing Officer (CNO) advised that a draft Safeguarding Policy is ready for review. Providing our statutory Safeguarding Partners are in agreement with our approach and Policy, we can close this action. If not, this will be added onto the Risk Register. It was agreed to close this action with an update if our Partners were not in agreement with our approach. (b) QC005/03.24 – (B) – Action Log – The specific actions around specialities from Patient Surveys will be included in the next Clinical Support Division Report. (c) QC011/03.24 – (B) – Quality Priorities Proposal – The NatSSIPS Report is on the agenda. (d) QC018/03.24 – (C) – Divisional Quarterly Report – Clinical Support Division – The Closures Report on the delays in Dexa scanning and any patient harm caused will be discussed on the agenda. (e) QC005/05.24 – (B) – Action Log – I-Passports - The Associate Director of Quality Governance (ADQG) advised that the team have a demonstration due regarding the I-Passport System. There is a financial implication of expanding this across the Trust. There are benefits in the Labs but this may not be appropriate for all the Trust against other systems. Wider conversations are occurring. It was therefore agreed to close this action. (f) QC0009/05.24 – Quality Account – (B) – National Audit of Care at the End Of Life (NACEL) – The CNO advised that the NACEL audit has changed considerably with results not available until March 2025. This is on the forward planner for next year. It was agreed not to present the Audit from September 2023. This action can therefore be closed. (g) QC016/05.24 – (B) – InPhase functionality – The ADQG advised that there is not the functionality in InPhase to provide feedback on incidents to staff not set up on InPhase. The manufactures are working on this issue, which we are monitoring. It was agreed to close this action.	**LH**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The specific actions around specialities from Patient Surveys will be included in the next Clinical Support Division Report.**	**LH**

	BUSINESS SECTION	
QC006/06.24	**RESEARCH AND DEVELOPMENT REPORT**	
	The Associate Chief Medical Officer, Research and Development and the Research Manager presented the Research and Development Report and the following key points were noted: • Good progress has been made. We have signed off our Strategy and agreed with the team the Implementation Plan which will be presented to a future meeting. • We have opened 12 Studies and recruited 632 participants with 25 Studies open. We also opened a commercial trail which was over recruited to which entails a significant financial bonus to the Trust. • As a small Trust, we have done extremely well recruiting to Studies compared to the West Midlands teams. • There have been difficulties in the team with regards to sickness with limited cross cover. • A sponsored trial has been concluded. This is in the process of being written up for peer review and publication. • Patients are able to provide feedback once during their participation, with very good response rates and feedback. • A robust governance infrastructure is in place. InPhase now has a specific tab for Research and Development which is reviewed. • Next year we will be working on the research component of the Academic Programme within the Strategy. The Research Forum has started up on the intranet with good links with University Research Teams. • Work is ongoing around restricting the clinical and management teams, with a paper being presented to the Trust Management Board in due course. • The Associate Chief Medical Officer, Medical Division asked if it was possible to acknowledge the Surgical Trial as a Geriatric Trial. The Associate Chief Medical Officer, Research and Development advised that this is the way that studies are set up but acknowledged that this was a Geriatric Trial. • Mrs Hill (NED) noted that we are a small Trust and therefore not able to access all trials and queried now that Worcester Acute Hospitals NHS Trust have joined the Foundation Group whether we can link together to give more access. Secondly, given the issues with staffing and resources, is there an opportunity to use medical studies given our links with the Universities. The Associate Chief Medical Officer, Research and Development advising that joining with another Trust is being reviewed, but usually how trials are set up is site specific. Our biggest difficulty is our low birth rates, which if higher, would enable access to more trials.	

	There are always difficulties with numbers for commercial trials. Birmingham are setting up a hub which we will be part of the second cycle of this. There is also an opportunity with the University for medical students to undertake primary research with us. Trials that support funding require Research Nurses who take on the clinical responsibility. • The Research Manager advised that the bid is being written up with the Midlands and surrounding areas regarding the Hub opportunity. This will enable sharing of services and ensure patients have access to studies that they may not normally have. Funding is not available until March. • The Clinical Director, Pharmacy & Medicines Optimisation asked from a Pharmacy perspective, if enough support was being received as there were staffing issues previously. The Associate Chief Medical Officer, Research and Development advised there was but the team are always keen to be more ambitious and would like to expand our interventional trial portfolio. We would like to be in a position in the future if there is opportunity for additional funding for more Pharmacy support if available. The Clinical Director, Pharmacy & Medicines Optimisation was happy to expand their input. • The Chief Medical Officer (CMO) advised that the Research Workshop held recently with the Three Counties University at Worcester was very successful with an area identified to work together to increase our Academic Programme. The next step is to formalise this with a Memorandum Of Understanding to clarity all the areas we will be working together. We will be restructuring the Research Management Team due to this which is being supported by the team via a SLA but we will put a paper together for our team. • Mr James (Chair of the Quality Committee and NED) asked for future quarterly reports to include an update on the joint working with Worcester University and the associated changes within the Trust's management team.	**ID/HW**
	<u>Resolved</u> – that: **(A) The Research and Development Report be received and noted.** **(B) Future Research and Development Reports to include updates on the joint working with Worcester University and the associated changes within the Trust's management team.**	**ID/HW**
QC007/06.24	**<u>QUALITY AND PATIENT SAFETY PRIORITY UPDATE – TISSUE VIABILITY</u>**	
	The ADQG and the Associate Chief AHP, Integrated Care Division (AHP) presented the Quality and Patient Safety Priority Update – Tissue Viability and the following key points were noted: • The Report has been revamped following the feedback from the last meeting. The focus is on data and what we are trying to achieve. Further feedback from the Committee is appreciated.	

	• The Report contains the Trustwide overview of pressure ulcers from November to May when the Safety Priority came online. • There was a steady increase from November to February which dipped and then increased again. • Patient Safety Priority – Deterioration of moisture associated skin damage to Grade 3 or 4 or unstageable pressure damage – This is being managed through the Pressure Ulcer Panel. • Category 2 pressure ulcers make up 64% of all pressure ulcer incidents in the last 24 months. Of these, 45% develop or deteriorate in our care. • The AHP advised that the Pressure Ulcer Panel are now using the Patient Safety Incident Response Framework. A detailed Rapid Review is being asked for any deteriorating skin damage when the team report. This is more productive than when a Serious Incident Report was undertaken as the staff themselves are undertaking the review. • Regarding Category 2 pressure ulcers, the Tissue Viability Team are reviewing these on a weekly basis to ensure that there is actual pressure ulcer damage and that they are being categorised correctly. A Rapid Review showed that staff are not always documenting them correctly. • The Pressure Ulcer Panel are now able to review incidents quickly due to the quality of the information provided. • InPhase has more information and data around tissue viability incidents. This provides good information with this shared at Pressure Ulcer Panel and with the teams. • More training is needed around pressure ulcers and how we assess mental capacity and respond accordingly. Vulnerable patients in the Community may not be making informed decisions around their care and we are reviewing whether they have capacity. We are changing how we work with regular senior clinical oversight. • The Improvement Plan for Integrated Care and Medical Division is included in the Report. • Mrs Twigg (NED) questioned whether there was any benchmarking regionally or in the Foundation Trust around pressure ulcers. This has been an issue for some time and queried whether this was a national or local issue due to our demographics. The AHP advised that this is a problem nationally. The CNO advised that benchmarking is unreliable due to how pressure ulcers are counted. The incidents of pressure ulcers are included in our Foundation Group quarterly meetings which shows that ourselves and Worcester are outliers yet believed to be a counting issue. There is more focus and intelligence around this but we are not seeing an associated improvement in outcomes.	

	We need to review this across the Foundation Group to understand this issue and share best practice to see if we really are an outlier. District Nursing and Community Teams have very different needs and we may therefore need to separate out our improvement plans for the Acute and the District Nursing teams as they do not provide 24/7 care. • The Integrated Care Boards Representative advised that reviewing when things go well and what to do differently to get improvements might help inform the Improvement Plan. • The Integrated Care Boards Representative queried if the City Team have a bigger case load. The AHP confirmed that they do. She had requested a breakdown of information which allows a more detailed review now. There is good engagement at the Pressure Ulcer Panel with a lot of work going on which she will include in the next Divisional Update. • The ADQG advised that there are new changes occurring internally which the Patient Safety Incident Response Framework is part of for pressure ulcers as well as other areas. We often see skin damage on patients when admitted with system improvement work needed to support these patients. • The Integrated Care Boards Representative advised that pressure ulcers have been identified as an issue across all systems and identified as a system priority. • The AHP noted that the Tissue Viability specific Care Home Practitioner sits on the Pressure Ulcer Panel and links in with Care Homes and District Nurses caring for these patients.	
	Resolved – that the Quality and Patient Safety Update – Tissue Viability be received and noted.	
QC008/06.24	**MORTALITY REPORT**	
	The CMO presented the Mortality Report and the following comments were noted: • NHS Digital have not refreshed the SHMI so we remain at 101.7. The HED data shows us at 99.0 but this is always lower than NHS Digital figures. • Outliers – Stroke mortality has increased to 106.2 (still within accepted levels) but this has increased from previously. We are meeting with Public Health next week to look into this and we what we can do in the community regarding his. The Mortality Leads are undertaking reviews of all deaths since January which will be presented at the next Learning from Deaths Committee and an update to the Quality Committee. There are no concerns regarding quality from the initial report.	

	• Heart failure and fractured neck of femur are improving. Heart failure is now in the expected range but we will continue to monitor this to ensure this continues. Fractured neck of femur is improving but still high at 125. There was a deep dive into this at the Learning from Deaths Committee in May. Looking at national data, we met best practice 68% of the time and are in the top quartile for this. We are in the lowest quartile for getting patients admitted in less than 4 hours. The Mortality Leads reviewed 12 patients – 11 had a DNACPR in place and 1 was for resuscitation. Only 1 was admitted within 4 hours, the average time was around 10 hours. The other issue is getting patients to theatre within 36 hours. We are achieving this around 60% of the time, which is still above average. We met with the clinical teams in the Emergency Department (ED) and Frailty to review the pathway and are focusing on trying to ring fence beds. • Medical Examiners are still doing well and scrutinising 100% of all deaths. Of these, 19 were escalated for a Structured Judgement Review (SJR), included in the report. The Mortality Leads are taking this forward. The trends and themes are then presented to the Learning from Deaths Committee by the teams. • A Mortality Panel has been set up. Following the SJR, if the reviewer feels that there was poor care provided this is presented to the Mortality Panel to see if this was potentially avoidable. Two cases were escalated in May. One was felt to be potentially avoidable and is going forward for a Patient Safety Investigation. • The Managing Director felt that this has got renewed impetus. Getting 100% of deaths reviewed and then getting the learning out is fantastic. She congratulated the whole team for this achievement. • The Integrated Care Boards Representative noted that benchmarking for the Trust for palliative care coding is relatively low. The CMO confirmed that this is the case for the SHMI but not on the HSMR. The Geriatricians are very competent in this area but we are not able to apply that code to their patients. We are ensuring that we are doing all the right things. • Mr James (Chair and NED) queried the stroke numbers and queried if there were any issues. The CMO advised that the outcome for patients admitted into our care has always been good but numbers are rising. We need a deep dive into understanding the background to this. Secondly, on the Public Dashboards it shows that Herefordshire is an outlier for stroke deaths for women. This could be due to this cohort dying in the community. A meeting has been arranged to understand this data and see if there is any further work we can do together to improve this. • The Associate Chief Medical Officer, Medical Division advised that it can sometimes be difficult to get stroke patients onto the Hyper Acute Stroke Unit, which is one of our targets, and this may be playing a part in this.	

	• Our SSNAP data has deteriorated in month. We are awaiting the audit and deep dive around this for a complete picture but this may also be having an impact. • Mr James (Chair and NED) queried what information the table in the report around deaths on the ward was advising. The CMO advised that this was to provide baseline data that will show any changes over the coming months. This will be reviewed in the Learning from Deaths Committee and the CMO will report back any concerns to the Quality Committee.	
	Resolved – that the Mortality Report be received and noted.	
QC009/06.24	**QUAILITY PRIORITY - VTE**	
	The Deputy CMO presented the Quality Priority – VTE, which was taken as read, and the following key points were noted: • The first VTE Assessment is now down to 14 hours from 24 hours. Performance requires improvement in some areas, with Medicine and Womens Health showing good improvement. • There are plans to improve and work upon the improvements made. This includes a significant refresh of some of our data sets along with some of which are out of date in some areas. • We have buddied up with George Eliot Hospital with their VTE CNS providing helpful advice. We have also widened the membership for the Thrombosis Committee. The link between the VTE assessment tool and EPMA will not be in place until September/October. • There are 6 dashboards for assessment of VTE. Performance appears to be improving but we need to cross reference this to the previous data set. • We are targeting the August period regarding VTE assessment training as this is when the new starters are in post. • The Integrated Care Boards Representative advised that a Regulation 28 has been issued at another Trust in relation to Hospital Acquired Thrombosis. There was limited evidence of stockings being prescribed and systems not in place. The CMO advised that we do have some cultural issues which the clinical leads are working on. Readmission rates for VTE related conditions are high and we are trying to get the data around this in addition to having the screening figures and the number of missed doses of prophylaxis. There is a lot more to do around this to understand the entire picture. • The Associate Chief Medical Officer, Medical Division advised that the Medical Division have a lot of outstanding VTE Root Cause Analyses which we can learn a lot from. There is concerted effort to reduce this number.	

	• Mrs Hill (NED) queried if patients are reluctant to continue taking medication and if more communication is needed around this. The Deputy CMO was not aware of this but the focus currently is on staff. This is an area we can focus on in the future. The CMO agreed noting that if patients are empowered knowing what to expect, they can be part of the processes to help us improve screening etc. There are national campaigns and posters for patients in terms of what to look out for. • The ADQG noted that it might be an opportunity to include PALS to get patient views if they are readmitted.	
	Resolved – that the Quality Priority – VTE be received and noted.	
QC010/06.24	**QUALITY PRIORITY – NATSSIPS 2**	
	The Deputy CMO presented the Quality Priority – NatSSIPs 2, which was taken as read, and the following key points were noted: • NatSSIPs 1 was introduced in 2015. NatSSIPs 2 recognises the changes that have occurred with a different approach. We are looking at the key areas, with proportionality the key theme. • There are clear standards that we have to meet. The Deputy CMO thanked the Clinical Quality Improvement & CQUINs Manager for all her hard work regarding this. • Further plans are outlined in the paper. We are aiming to reinstate the NatSSIPs Group and find the benefits of the Must, Could and Should Dos. We are not behind with this compared to the Foundation Group. • Mr James (Chair and NED) suggested that we use the Foundation Group to work through this, although individual for each Trust, to share the workload. The Deputy CMO confirmed that conversations are being held around this. • The CMO advised that a patient case was discussed at the Patient Safety Panel which will help us test out this approach and to see what we can learn from this. • A further update report will be presented to the Quality Committee in the autumn.	
	Resolved – that the Quality Priority – NatSSIPs 2 be received and noted.	
QC011/06.24	**PATIENT SAFETY PRIORITY – FALLS**	
	The ADQG presented the Patient Safety Priority - Falls and the following key points were noted: • The Report provides an overview of the ongoing work around this Patient Safety Priority. This is looked at in more detail at the Patient Safety Committee.	

	• The focus is on data, with an overview of the last 6 months. • There were 623 falls in this 6 month period. 2.7% were moderate and above incidents. 67% of the falls were unwitnessed. • New data is emerging suggesting that there is an increase in the number of falls in bathrooms. This was discussed in detail in the Committee. • All falls are reviewed in the Falls Panel. • Of the 65 falls reported linked to the Priority, 8 have required a timeline as a new risk or learning has been identified in the Rapid Review. • A recent Coroner's Case regarding a fall included bed rails. There is a big focus on this area. • The Associate Chief Nurse, Medical Division advised regarding the Risk Assessment for bed rails, a small audit was undertaken on 5 patients, this audit is undertaken on a weekly basis. There is a lot of teaching regarding falls and the need for yellow socks across the Trust. Regarding falls in bathrooms, we ensure that risks are discussed with patients. If a patient does not have capacity, we must ensure that they are escorted to the bathroom. If a patient requires privacy and declines help, we must ensure that this is documented in the notes. • The Report includes information about the local Improvement Plans and Trustwide work occurring. The Digital Team are looking at the falls template on EPMA to see whether we can streamline this to make the assessment easier for staff to complete. • Mr James (Chair and NED) queried whether bed rails are an issue and if they are in place, do patients still fall? The AHP advised that a Risk Assessment is undertaken to see if bed rails are required. Very few patients require them. If they are put in place and a patient climbs over them or gets stuck, this can cause more harm. We are trialling a pilot in the Community Hospital putting cable ties on the bed rails to keep them down. This includes how to release the bed rails if required. • The CNO advised that there has been good improvements in frailty around falls. The Lead Nurse, Digital is leading on a piece of work to streamline this. • The Associate Chief Medical Officer, Medical Division advised that the bed rail audit is for 5 patients on each ward in the Frailty Block. This found that the Risk Assessments are being carried out but recommendations are not always being followed. The audit findings are being disseminated across the other wards.	

	• Mr James (Chair and NED) questioned how the success in frailty is being circulated to other areas. The Associate Chief Nurse, Medical Division advised that a plan has been developed with teaching aids to go out to the wider Trust. The Falls Panel have also advised that documentation has improved.	
	<u>Resolved</u> – that the Patient Safety Priority – Falls be received and noted.	
QC012/06.24	**<u>BOARDING REPORT</u>**	
	The Acting Associate Chief Operating Officer, Medical Division presented the Boarding Report and the following key points were noted: • There were a high number of boarders in May. The bay on Gilwern Ward was closed and we attempted to close the extra Community Hospital beds. • We have seen an increase in bed occupancy and an increase in the greater than 7 day stay along with admissions. The Criteria to Admit Audit is being undertaken to see the types of patients we are admitting. • The MADE event recently specifically looked at Pathway 0 patients to see if there is anything we can learn from this. • There has been an increase in the use of the Discharge Lounge. This correlates to the days with high numbers of boarders. • Quality and Safety Incidents – Despite the increase in boarders, there has not been a corresponding increase in the number of incidents. There is a cross Divisional Working Group looking at the Discharge Lounge. From next week, there will be an improved process to make it easier to use the Discharge Lounge. • The CMO noted that the Community Hospitals are struggling to fill their beds and queried if there are opportunities to identify more patients to move there. The Acting Associate Chief Operating Officer, Medical Division advised that there are 11 escalation beds available. Over the last few weeks we have struggled to fill these due to patient acuity. We are reviewing whether we need these additional beds, but have agreed to keep them open until after the Junior Doctor strikes. • The CMO noted that the number of medically fit patients for discharge has improved and questioned if any of these patients could have been moved to these escalation beds. The Acting Associate Chief Operating Officer, Medical Division advised that usually these patients need to be discharged to a specific place and are not suitable. If they are planned to go home the next day they are not moved. Some patients also refused to move to a Community Hospital.	

	• The Managing Director advised that Pathway 1 patients are discharged home from the Acute and are not sent to the Community Hospitals. She queried when the Criteria to Admit Audit is going to occur and whether this will include frailty patients that are seen in Same Day Emergency Care and admitted as there is no suitable care at home. It would be useful to know the scale of the opportunity. The Acting Associate Chief Operating Officer, Medical Division advised that we are struggling to pull this data retrospectively but can prospectively. The Associate Chief Medical Officer, Medical Division advised that the audit is taking place in the next month. • The Associate Chief Medical Officer, Medical Division advised that the decision to transfer to a Community Hospital should be a proactive decision. We need to ensure that the patient and their family are aware of the process and what needs to be thought about in advance. The AHP advised that the aim is to discharge home as soon as we have good support in the community. • The CMO would be interested to understand the number of patients refusing to be moved and if they are able to go home, what is preventing this. There is a balance of risk around boarding patients and medically fit for discharge patients on the ward and possibly transferring them. • The Clinical Director, Pharmacy & Medicines Optimisation questioned whether if there has been an increase in medicines related incidents due to the extra boarders on the wards. The Acting Associate Chief Operating Officer, Medical Division advised that there are not large numbers of incidents. There is an option on InPhase to tick if the incident relates to boarding. The Acting Associate Chief Operating Officer, Medical Division will ask the Governance & Risk Coordinator, Medical Division to link in with the Medicine Safety Officer around any medicines incidents related to boarding that are not being identified. • Mr James (Chair and NED) queried if there is anything more we can do to try and manage the risks for falls and tissue viability incidents. The Acting Associate Chief Operating Officer, Medical Division advised that there is an increase in numbers when we have a large number of boarders as there may not be as associated increase in the number of staff. The Associate Chief Nurse, Medical Division noted the capacity challenge and acuity of patients. Regarding medicine incidents relating to boarders, there was a cluster of oxygen incidents reported.	**JC**
	<u>Resolved</u> – that: **(A) The Boarding Report be received and noted.** **(B) The Acting Associate Chief Operating Officer, Medical Division will ask the Governance & Risk Coordinator, Medical Division to link in with the Medicine Safety Officer around any medicines incidents related to boarding that are not being identified.**	**JC**

QC013/06.24	**DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE DIVISION**	
	The AHP presented the Divisional Quarterly Report – Integrated Care Division and the following key points were noted: • A lot of the information had already been covered in the meeting. • Complaints – There were 10 across the quarter which is high for the Division. The details are included in the Report, but there were no trends with a couple cross Divisional. • Friends and Family – there are not many teams on this. We are working with the Quality and Safety Team to roll this out. • Overdue Incidents – There has been a huge reduction with the numbers in the Report greatly reduced this month. • Tissue Viability – The graph included in the Report is the 1st cut taken from InPhase. There are still issues relating to District Nurses with a lot of training being undertaken. • Community Hospitals are doing well and have lower numbers of pressure ulcers. They link in closely with the Pressure Ulcer Panel and the Frailty Wards. • Falls – The Inpatient Falls Prevention Lead is in the Integrated Care Division. She is very proactive with the teams, training and local projects. We are putting in additional staff in Community Hospitals due to the difficulties with visibility due to the layout. • The Good News Stories are included in the Report. This includes the Occupational Therapy and Physiotherapy student feedback 2023/24 which was very positive. A Physiotherapist at Bromyard Community Hospital won the Most Outstanding Physiotherapy Mentor Award at University of Worcester. The Assisted Cycling Group – Acquired Brain Injury Team are photographed on their assisted bicycles. Parkinson Medications – Right Time – There has been real improvement in late or missed doses. • Of concern is recruitment. We are always struggling to keep specialities across the teams. • The CNO noted that discussion was held in the Finance and Performance Executive Committee around pressure ulcers. Category 2 pressure ulcers are in a fairly stable position. However for this Division there does need to be a focus on unstageable and moisture associated skin damage. • The Clinical Director, Pharmacy & Medicines Optimisation questioned if there were any medicines related issues or safety storage issues and if there was enough support provided for the Division. The AHP advised that there are not huge numbers of issues but there is no support in the Community Hospital from the teams. The Clinical Director, Pharmacy & Medicines Optimisation asked for detail in future Reports around any concerns.	**SM**

	• The Integrated Care Boards Representative noted the therapy gaps highlighted and the recruitment initiatives and queried the impact on waiting times and care delivery. The AHP advised that there is a lot of "growing our own staff" occurring but they move on (usually with the Trust) once they have completed their training. The more support we provide, the more that Primary Care require. We do have students and international recruits but they will take some time to be fully trained. Regarding waiting times, the spinal specialities services have long waits. • The Managing Director noted that national benchmarking has been carried out regarding the length of appointment times for physiotherapy appointments, length of treatment to pathway etc and question how we compared. The AHP advised that we match well for the length of appointment. The standard time is 40 minutes for a new appointment and 20 minutes for a follow up. Some specialities require longer times. Waiting times are slightly below the national average. The Managing Director suggested looking at trying to increase capacity by reducing appointment times. The AHP advised that this is in practice and over the years, there has been a lot of research into what does and does not work. The new to follow up ratio is 1 – 3.	
	<u>Resolved</u> – that: **(A) The Divisional Quarterly Report – Integrated Care Division be received and noted.** **(B) Future Integrated Care Division Reports will include any medicines related issues or safety storage issues.**	**SM**
QC014/06.24	**<u>DIVISIONAL QUARTERLY REPORT – CLINICAL SUPPORT DIVISION</u>**	
	The Advanced Practitioner Radiographer presented the Divisional Quarterly Report – Clinical Support Division, which was taken as read, and the following key points were noted: • Incidents have stabilised this quarter. On investigation, it was found that staff are capturing multiple issues on incidents or the same patients – training has been provided. • There were no Patient Safety Incident investigations this quarter. Several themes and incidents have been presented to the Patient Safety Panel. • There are 4 overdue incidents that are progressing. These will be completed by the end of June. • There were 11 complaints received. Eight have been fully investigated and responded to and 3 are still being progressed.	

	• Radiology and Audiology – £180k funding has been approved for MRI AI acceleration software to be installed. This will speed up image acquisition to benefit productivity as well as improving image quality. Training is ongoing. The ED is fully requesting imaging via Maxims Order Coms from 1 April. We were successful in a bid for 2024/25 national capital for £415k for mammography improvements. • The Targeted Lung Health Screening Programme Manager was appointed in June. Planning permission was granted in May for the Trust's Diagnostics Centre. The Radiology team have delivered significantly increased capacity for MRI, CT, USS and Dexa. NHSE Regional Site visit to the Paediatric Audiology Services took place (Report within the papers). We are reviewing whether we need to make any changes to the estate. There is an improved Audiology waiting list position. There is increasing Inpatient and ED diagnostic demand with increased capacity via the Diagnostic Centre in 2025. The Dexa Service has been a concern. Scanning and reporting have now recommenced. The backlog is now up to date and reporting is in "real time" now. A Review is being undertaken to see if there has been any patient harm. • Pathology – In April 20204, the Trust's TAT's were at 87%, the highest and most improved within the Region. We also have 2 Consultants starting in post shortly along with a Microbiology Fixed Term Locum for 12 months with the opportunity for permanent recruitment on the CESR pathway. A successful event day was held in June with a number of students from Worcester University showing interest in future scientific careers. We have also recruited a second Senior BMS in Dissection for Cellular Pathology. • Microbiology staffing continues to be a concern. We are currently working through an SBAR in relation to a 7 day service. We have a single point of failure with our Duty Biochemist and are working closely with the Chemistry Department at Worcester regarding this. There is lack of capacity for clinical work in Histopathology. • HTA/Mortuary – The EDEN implementation is underway with training taking place at the end of June. We are also working with the Site Team regarding out of hours viewing for the Mortuary. I-Passport has been introduced for Standard Operational Procedures which are all uploaded and review of these is underway. The Mortuary Manager is now in post and making a positive impact in the Department. • There is concern around the Mortuary flooring with a plan agreed in principle to replace. There are several audits and visits for the Mortuary due with a large amount of work required for these.	

	• Pharmacy – Pharmacy vacancy rate improved to 32% with a further 12 junior grade Pharmacists to be recruited by December. Recruiting Band 6 Clinical Pharmacists through an International Recruitment Scheme is now live. Pharmacy is making progress in restoring ward based working to improve flow. We are very proud of the resilience of our Pharmacy team while we go through a period of reduced Pharmacy staffing. The Trust has also trained the first Hospital Pharmacy Assistant in the Midlands to become an accredited Checking Dispenser. The Trust were presented with Innovation Around Workforce at the national Clinical Pharmacy Congress in London in May 2024. The Advanced Practitioner Radiographer was also very proud of the team's ability to continue our dispensing accuracy reliability rate at 99.95% despite our staffing issues. We are supporting undergraduate University student placements through the Department with excellent feedback from students around the quality of training provided. There is concern around short term recruitment issues due to a national shortage of registered Pharmacy staff. Prioritisation of tasks continues to be our focus to maintain this service. • Patient Access – Two further Outpatient Health Care Support Workers are commencing further education, a trainee Plaster Technician is commencing a course in December and there has been the appointment of a Matron for Clinical Support. Daily Pre-op mini screening has been absorbed by the Nursing and Outpatient Administration Team. We are proud of our staffing of our Minor Ops rooms to undertake Orthopaedic Trauma cases to reduce bed capacity, main Theatre usage and patient experience and the work the Outpatient, Scheduling and Referral Management Centre Team did to support the 6-4-2 project. • Cancer Services – Our Cancer Data Validation Co-ordinator is in post and a notable improvement in cancer COSD data has been realised. The Non-specific Symptom Pathway went live on 1 May. Activity to date has been small and further communications are planned to improve awareness of this service. We are proud of receiving a letter of congratulations from the National Disease Registration Service regarding the improvement seen in the COSD data and our 28 day cancer performance which has consistently hit the target since February 2024. Nationally the target is to reach 77% by March 2025. However, locally we are aiming to hit 77% and above from April 2024 which we have successfully achieved to date. We are concerned about our Haematology Service as there is no agreement from other Trusts in relation to transferring patients if we lose any of our Locums. Also, delays with Maxims in relation to cancer waiting times changes which impacts on our cancer performance. We are still having to use agency to fill the skill gap with our SACT Chemotherapy trained nurse due to long term sickness. The Lead ACP is leaving which may leave a gap in staff due to the recruitment time.	

	• The Integrated Care Boards Representative queried if there were any concerns around the upcoming Mortuary visits regarding getting the work completed prior, that we need to be aware of. The Advanced Practitioner Radiographer advised that the team are working hard to achieve this in time, with no issues raised. The Associate Chief Operating Officer, Clinical Support Division advised that the new Mortuary Manager is leading on this with dedicated support along with the Internal Audit starting on 15 July. • Mr James (Chair and NED) noted that the Quality Committee have seen sighted on the Audiology action plan and updated previously but we need to be aware of some of the target dates, but was aware that this is work in progress. The CNO advised that the action plan is closely scrutinised along with the progress at the Bronze Cell Response meeting. There have been no concerns raised and the ICB have no concerns with this response.	
	<u>Resolved</u> – that the Divisional Quarterly Report – Clinical Support Division be received and noted.	
QC015/06.24	**<u>ED CQC ACTION PLAN</u>**	
	The Associate Chief Nurse, Medical Division presented the ED CQC Action Plan and the following key points were noted: • Must Dos – the Clinical Observation Standard Operating Procedure has now been completed and just requires review. The key options are included in the Report. • Audits – These will be presented in July at the Governance Meeting along with the audit outcomes for pressure ulcers, patients in pain, falls and sepsis. Action plans will come from this. • Training compliance is improving. There is increased focus around Band 5 Registered Nurses for triage and NIV. We are also seeing increased incidents of Type 2 incidents in ED. Triage figures have improved with more training available. Figures have improved again since writing the Report. • ILS, PILS and ALS training – We are confident that figures are better than those being captured in the Report, with accurate figures included in future Reports. Monitoring of DNAs for training dates will also continue with reminders before the event to ensure maximum attendance. An ongoing training programme is being rolled out to prevent future clusters of training being required. • PILS Paediatric Nurse 24/7 – We are ensuring that the nurse covering is PILS trained. • Staffing – A Medical Business Case is being presented to the Trust Management Board along with a Nursing ED Business Case. • We are conducting audits across the whole Division. ED are capturing this in their checklist performed in the Waiting Room with 80 to 100% compliance.	

	• ALS – This is not essential as this is in a medical run unit. The priority will be around PILS and ILS. • Mr James (Chair and NED) queried if there were any concerns in terms of achieving everything needed. The Associate Chief Nurse, Medical Division advised that having a Paediatric Trained Nurse at night is a concern and the funding associated with this. We are ensuring that we focus on ILS and IPLS training as we are behind on these for Registered Nurses. • The Managing Director noted the significant issues we had regarding time to triage and queried if we are able to receive weekly or monthly performance results. The Acting Associate Chief Operating Officer, Medical Division advised that we do not receive data but with the new reporting we can see results in real time. We have received assurance from the General Manager ED & Acute Medicine around reinvigorated discussions being held KPIs in Directorate meetings. The Managing Director felt it was important to continue seeing this Report at Quality Committee for some time. This will also need to include Observations with NEWS over 5 and red rag screening. • The Managing Director questioned whether all patients required hourly observations in the Waiting Room. The Associate Chief Nurse, Medical Division advised that this is captured within the Standard Operating Procedure for review with the CNO. • It was agreed that the Quality Committee will receive a deep dive into the improvements, audits and outcomes that have been implemented since the CQC visit as a focussed report at the August meeting. • The Clinical Director, Pharmacy & Medicines Optimisation noted that the issue raised about the ability to record prescriptions and administration for drugs for patients in ED, especially those waiting for long periods, should be on the Risk Register. In the medium term this is due to be added onto EPMA in mid-2025. The Associate Chief Medical Officer, Medical Division advised that using paper records was an initial suggestion but not agreed. There does need to be some patient ownership around taking control and bringing in their own medication without this being prescribed if appropriate. Symphony is not set up for repeat prescriptions, only time critical medication. The Clinical Director, Pharmacy & Medicines Optimisation felt that the integration of EPMA and Maxims should be a separate risk. An offline discussion will be held which will be reported back as part of the deep dive.	**SH** **SH** **TM/SH**
	<u>Resolved</u> – that: **(A) The ED CQC Action Plan be received and noted.** **(B) Quality Committee will receive a deep dive into the improvements, audits and outcomes that have been implemented since the CQC visit as a focussed report at the August meeting.**	**SH**

	(C) The integration of EPMA and Maxims as a separate risk on the Risk Register will be discussed and an update to be reported back as part of the deep dive into ED and any other Divisional concerns.	**TM/SH**
QC016/06.24	**PERINATAL SAFETY MONTHLY REPORT**	
	The Associate Director of Midwifery presented the Perinatal Safety Monthly Report, which was taken as read, and the following key points were noted: • This is shared here for scrutiny and challenge and for oversight at the Trust Board. • There are no escalations that need to be raised for the activity section of the Report. • Safety Section – We are one of the smallest Trusts in the Region. Therefore our minimum data set section is discussed at the Private Board due to the small numbers involved. • Workforce Section – We have been in a position since November where we have not needed to use agency for midwifery. There has been a slight increase in the use of Bank over the last few weeks. Sickness and vacancy rates remain improved. We have 4.2WTE starting in September. • Some extra hours have been required across the medical workforce but this has been reducing. • Compliance Rates for training – Health Care Support Workers initially were not included in the CNST training data yet we are now required to report this. • Saving Babies Lives – The figures are updated on a quarterly basis, so no update in this Report. • There are no anticipated issues with the CNST performance. • Safety Walkabouts are valued by our teams and the Safety Champions. During a walk round, the Safety Champions discussed with staff about the oxygen masks and tubing not 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. • ATAIN – We remain within the best practice performance measures which is positive. We still try to learn from all cases.	

	• Appendix 1 includes the Minimum Data Set. Two cases met the PMRT criteria and one did not but the PMRT review approach is being utilised. The background to these cases was provided. A thematic review is being undertaken, again the detail was provided. The grading outcome for these cases is a cause for concern and a detailed discussion took place with the CNO and CMO. • There were no complaints in May with 1 concern. • The CNO advised that following the meeting with the CNO and CMO the view was that there may be an opportunity to review the grading of one case following further review. That for one case there was key learning with an immediate action to update the relevant Policy to bring in line with RCOG guidance, clarify the position on Fibronectin testing and a longer term action to review the preterm pathway. In addition, the CMO had asked for an independent internal review of cases to take place prior to the rapid review process to try to mirror the mortality review process for adults. We have therefore added an independent review as a priority to the MDT Review.	
	Resolved – that the Perinatal Safety Monthly Report be received and noted.	
QC017/06.24	**STAFFING REPORT**	
	The Associate Chief Nursing Officer, Surgery Division presented the Staffing Report and the following key points were noted: • It has been an extremely busy month through ED in May. All escalation areas have been open to support this. Radiology Recovery has also been opened at times. This has also necessitated high levels of boarding which has also impacted on our staffing throughout May. • Fill rates are steadily reducing with a 5% reduction each month. This has reduced from about 116% to 106%. • We need to review the fill rate data – when we open additional beds in the community we do not always adjust our levels of patients and staffing in relation to our data. • We have seen a steady increase in the number of incidents with an increase in Paediatric ED. We have 1 nurse allocated to Paediatric ED at all times but at periods of the highest numbers, there can be up to 16 – 18 patients at any one time. When additional nurse support is required this is organised and this is being monitored. • There has been an increase in vacancies in month. There was also a small increase across trained and Health Care Support Workers (the biggest factor), which has gone back to centralised recruitment. • There was a slight increase in temporary staffing usage by about 5WTE.	

	• There has been steady usage of 1-2-1 care. This is about educating teams around understanding that the establishment includes 1-2-1 care. We are starting to see a steady reduction in some areas but need to continue working on this. • The highest level of agency continues with the Frailty Unit, Community Hospitals and ED. • There has been a reduction in our over establishment – this was at 222 at the highest, down to 99 last month. This includes the additional establishments in place. • A new Break Glass process is in place for Thornbury agency. There has been very little usage over the last few months. • The Surgical Hub is opening on 8 July with a clear staffing plan in place. We have recruited to the majority of the posts with a few international nurses due to start shortly. • We are looking at ward reconfiguration to increase the medical bed base. A staffing plan has been approved to ensure that the right staffing levels are in place to support this move in October. • The Managing Director noted that it appeared that when a Band 4 was not available a Band 5 was put in place rather than a Band 3, if available. The Associate Chief Nursing Officer, Surgery Division advised that this depends on what level of work a Band 3 is capable of covering. Due to the level of acuity, it is difficult to sometimes put a Band 2 or Band 3 in place but we do review on the day what is needed. The Associate Chief Nurse, Medical Division advised that it will help having more Nursing Associates who add more value with the relevant skills on the wards that are needed.	
	Resolved – that the Staffing Report be received and noted.	
QC018/06.24	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	Resolved - that the Patient Safety Committee Summary Report be received and noted.	
QC019/06.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	Resolved – that the Infection Prevention Committee Summary Report be received and noted.	
	CONFIDENTIAL SECTION	
QC020/06.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC021/06.24	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	

QC022/06.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 25 July 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