Public Board Meeting

Thu 03 October 2024, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Chizo Agwu, Glen Burley and Russell Hardy.

13:01 - 13:02
1 min

2. Declarations of Interest

13:02 - 13:03
1 min

3. Minutes of the Meeting held on the 5th September 2024

Decision *Frances Martin*

3. PUBLIC BOARD MINS - SEPTEMBER LF, AP.pdf (12 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

4. PUBLIC BOARD ACTION LOG -OCTOBER.pdf (1 pages)

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Managing Director's Report

Discussion *Jane Ives*

5.1 MD Report - October.pdf (4 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 5 August 2024.pdf (29 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan*

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 - 13:55
20 min

6. ITEMS FOR APPROVAL

6.1. Business Case - WVT Acute and Emergency Department Clinical Staffing

Decision *Andy Parker*

- 6.1 Business Case - WVT Acute & ED Clinical Staffing - Covering report Public Board.pdf (5 pages)
- 6.1a Business Case - WVT Acute & ED Clinical Staffing - Final v4 Public Board.pdf (42 pages)

6.2. Business Case - Bed Reconfiguration for Winter 2024

Decision *Andy Parker*

- 6.2 Business Case - Bed Reconfiguration for Winter 2024 - Covering report Public Board.pdf (2 pages)
- 6.2a. Business Case - Bed Reconfiguration for Winter 2024 - v7 Public Board.pdf (25 pages)

6.3. Board and Committee Dates for 2025

Decision *Erica Hermon*

- 20240930 - Covering Report Board and Ctte Dates 2025.pdf (2 pages)
- Copy of Board Committee Dates 2025 v2.pdf (1 pages)

13:55 - 14:20
25 min

7. Items for Noting and Information

7.1. Sustainable Development Management Plan (SDMP) Update

Discussion *Alan Dawson*

- 7. FS SDMP Progress Update.pdf (2 pages)
- SDMP progress update.pdf (13 pages)

7.2. Perinatal Safety Report

Discussion *Lucy Flanagan*

- 7.2 Perinatal Services Safety Report August 2024 Final.pdf (12 pages)

7.3. Board Assurance Framework and High Risks

Discussion *Erica Hermon*

- 7.3 Covering BAF Report for Public Board - October 2024~v1.pdf (3 pages)
- 7.3a BAF Aug-Sept Risks - v3 - FINAL.pdf (2 pages)
- 7.3b Risk Register 15+.pdf (18 pages)

7.4. Committee Summary Reports and Minutes

7.4.1. Audit Committee Report and Minutes 13 June 2024 and 25 June 2024

Discussion *Nicola Twigg*

- 7.4.1 AC Front Sheet.pdf (1 pages)
- 7.4.1a Audit Summary draft June.pdf (1 pages)
- 7.4.b Audit Committee minutes - 13 June 2024 - FINAL.pdf (10 pages)
- 7.4.1c Audit Committee minutes - 25 June 2024 - FINAL.pdf (5 pages)

7.4.2. Charity Trustee Report and Minutes 13 June 2024

Discussion *Grace Quantock*

- 7.4.2 CT FS and Report - June.pdf (3 pages)

7.4.2a Charity Trustee minutes June 2024.pdf (6 pages)

7.4.3. Quality Committee Report and Minutes 25 July 2024

Discussion *Ian James*

7.4.4 QC Summary July 24 Public.pdf (3 pages)
7.4.4a Quality Committee Minutes July 2024.pdf (19 pages)

14:20 - 14:25
5 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

Frances Martin

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 5th December 2024 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 5 September 2024 at 1.00 pm
Via MS Teams

Present:

Russell Hardy	RH	Chairman
Chizo Agwu	CA	Chief Medical Officer
Glen Burley	GB	Chief Executive
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FMa	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Ellie Bulmer	EB	Associate Non-Executive Director (ANED)
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)
Lou Robinson	LR	Deputy Company Secretary
Jo Rouse	JR	Associate Non-Executive Director (ANED)

BOD01/09.24 **Apologies for Absence**

Apologies were received from Erica Hermon, Associate Director of Corporate Governance.

BOD02/09.24 **Quorum**

The meeting was quorate.

BOD03/09.24 **Declarations of Interest**

There were no declarations of interest noted.

BOD04/09.24 **Going The Extra Mile Awards**

Team of the Quarter – Quarter 1 – Pathology Team – The Chairman read out the reasons why the Pathology Team were nominated for this award.

Employee of the Quarter – Quarter 1 – Laura Moss – The Chairman read out the reasons why Laura had been nominated for this award.

BOD05/09.24 **Minutes of the meeting held 4 July 2024**

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

BOD06/09.24 **Matters Arising and Action Log**

BOD21/07.24 – Questions from Members of the Public – (B) – The Chief Strategy and Planning Officer has arranged to meet the member of public to discuss his concerns and an update will be provided at the next meeting. **AD**

Resolved – that:

(A) The Action Log be received and noted.

(B) The Chief Strategy and Planning Officer has arranged to meet the member of public to discuss his concerns and an update will be provided at the next meeting. **AD**

BOD07/09.24 **Chief Executive's Report**

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

(a) Emerging Priorities of the new Government – Our new Secretary of State is the 34th in the history of the NHS. The investigation of the NHS is currently being undertaken by Professor Lord Darzi. The Expert Reference Group met on Tuesday and heard some of the emerging findings. The Report will be produced and published at the end of the month in time for the Party Conference Season and the October Budget. This Report looks at some of the performance issues of the NHS and a diagnosis of the problems. A Treatment Plan will come from the NHS 10 Year Plan scheduled to be completed in spring next year.

(b) NHS Constitutional Standards – The new government has pledged to return to the NHS Constitutional Standards. These have not been met across the NHS for a number of years. The 95% 4 Hour Emergency Access Standard is the most challenging Standard with some of the issues around achieving this set out in the Report. We are expecting to receive a Winter Letter which sets out some of the priorities for the coming winter including this year's Urgent Elective Care 4 hour waiting times standard which has been set at 78% and more focus on planning for the winter. We will be sharing best practice across the Foundation Group for safety and learning. We are also hoping that Performance by Result will also be discussed.

(c) Elective Referral To Treatment Times – We are expecting an updated Elective Recovery Plan soon.

(d) Cancer Access – The 62 day referral to first treatment 85% standard will still be the core indicator. The 28 day Faster Diagnostics Standard is currently measured against a 76% standard and hence it is likely that this will be increased.

(e) Introduction of a Financial Recovery Board – It has been a challenging year cross the NHS and we are in a challenging position. It was agreed as a Board that we would put in place a short term Financial Recovery Board to provide focus and grip on the situation. A couple of meetings have already been held with similar arrangements also in Worcester. We will report on performance as we progress.

(f) More From Our Great Teams – Update from the Medical Division – It is positive to see what the Division have been doing to improve safety, flow and performance which has improved since last year. More staff have been employed following the implementation of an Improvement Plan, following the visit from the Care Quality Commission, which has not helped our finances. With the building of a stronger Frailty Team, our frailty performance is excellent. We will be reviewing the impact of these changes on the length of stay and outcome for our patients which must have improved.

(g) The Chairman queried what is worrying the CEO most about the financial challenges that we face. The CEO advised that his main concern was due to the financial challenge that we face, we may not receive any additional funding which may mean that we have to stop doing some of the things that we have planned. Funding of the Elective Recovery Fund is one such area. This is part of our financial recovery but also reduces long waits for patients. From a Trust perspective, we are ensuring that our response to the challenge is more about Getting It Right First Time and flow than cutting back on plans.

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

BOD08/09.24 **Integrated Performance Report**

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

a) As we near the second half of the year, Urgent Care and flow and finances are linked and are our main concern.

b) Urgent Care – Congestion of the Emergency Department (ED) and boarding over the summer was at a level that we were not expecting. We understand why this happened and expected length of stay to increase as a consequence but it did not. Length of stay for older patients has actually lowered slightly since a couple of years ago. Overall the length of stay has remained the same.

c) Urgent Care Demand – We are admitting 12 extra patients a day more than we were 2 years ago. Of these, 7 are managed through Same Day Emergency Care (SDEC) pathways but 5 a day are being admitted with an average length of stay of 7 days. Our approach to improve this is around admission avoidance in the community and secondly to improve patients length of stay. To enable this we are investing in community services including the Virtual Ward, new technology with OPAT (which delivers antibiotics at home rather than a nurse having to deliver this) and the Urgent Care Response Team increasing. We are also specifically responding with regards our Frailly SDEC to provide care at home if a patient is able to go home immediately. The other part of this is integration of community services, particularly with our GP partners. Teams are moving to be co-located in October. There will also be other integration of neighbourhood teams to provide proactive care for patients. This will include a big piece of work around Nursing Homes. We did this once before but this needs revisiting. Finally, it is around the Discharge To Access Pathways Better Care Funding – Pathway 1 has seen big improvements and we need to see the same improvements for Pathways 2 and 3.

d) Business Case investment in nursing in ED – Some of this is to manage congestion with staff having to take care of patients in ED whilst awaiting a bed. If flow was better we would not need these extra staff. The other part of the financial improvement is income. The Elective Surgical Hub is now open with more activity being carried out across all elective pathways. Finally we need better grip of our managerial and clinical teams at Divisional and Specialty levels with a good CPIP and delivery of this.

e) There are encouraging signs being seen around the amount being spent in August on temporary doctors and nurses. Mortality figures are also positive. We are also benchmarking well with our cancer waiting times.

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

BOD09/09.24 **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 CNO advised that the Critical Care Peer Review was carried out last month. The highlights from the immediate findings and areas to respond to are included in the Report. We have just received the full Report which will be presented to the Quality Committee later this month with a summary to the next Board meeting.

(b) The National Inpatient Survey results were published last week. There are areas for improvement with limited progress made. A deep diver will be presented to the next Quality Committee meeting. One element deteriorated this year and is an area that has historically been poor and this is around our food provision for patients. This is particularly around the food itself and how it is delivered. We were aware this issue was coming up in the Survey and so held a Summit with our Clinical and Sodexo colleagues to agree how we could work better together to improve both of these areas. There was good engagement in this session with a short term Task and Finish Group set up to focus on this issue. Sodexo are already working on revised meus which are due to be introduced shortly.

(c) Quality Improvement work particularly around bed rails is being undertaken. Inappropriate use of bed rails can cause more harm than not using them. Summarised in the Report are the audit results which shows that Falls Risk Assessments, Bed Rails Assessments and positioning overall of patients is relatively positive. On a small number of occasions we do not get this right and this is the area that we are focusing on. We are trialling a new way of using bed rails currently in the Community Hospitals.

(d) The Chairman advised that in the Trust we have a PFI arrangement for the food provided by a Third Party Company. This is an expensive option. We try to ensure that the public get the level of service that they hope for and we are working with Sodexo to try to achieve this.

(e) The CMO advised that the latest mortality figures from April 2023 to March 2024 have dropped to 98. Our crude mortality is now at 1.04% from a previous high of 5% - a significant improvement. Our mortality outlier groups have also improved.

(f) Further work is still required for our fractured neck of femur patients. We received a Mortality Outlier Alert which we were aware of. An area that we can make improvements in is the timeliness patients are transferred from ED to the ward. There is a Quality Improvement approach to this to implement a faster pathway for these patients.

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

BOD10/09.24 **Activity Performance**

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

(a) Our Urgent Care Pathway remains under pressure and our ED attendances are above Winter 2023/24 numbers along with high numbers of ambulance handovers.

(b) Plans are being worked on nationally and regionally on how to improve ambulance handovers. We pride ourselves are trying to reduce delays significantly although we can do more to further improve. We are looking to adopt improvements seen across London with a zero tolerance to any delays over 45 minutes from October. A Workshop across the ICS is being held to work through the detail around this.

(c) Community Response Hub – There has been an increased number of referrals from West Midlands Ambulance Service (WMAS) to this hub. Last month, almost 250 referrals were made, up a 100 from June. There are concerns, however, that only 8 came from the crews directly. We are aware that this is an area that we need to work with the WMAS to improve. An audit with NHSE showed missed opportunities on our ambulance handovers – there are a number of areas that could be improved upon when seeing patients.

(d) Improvements have been seen in Pathway 1 for Herefordshire patients with discharges and discharge to access. This has been delivered due to all System Partners addressing issues around pre discharge assessment, maximising capacity in the Pathway 1 service and improvements around commissioning to strengthen the market and prevent overstaying patients. Powys delays make up the bigger proportion of our delays and we are working closely with Powys colleagues regarding this. Admitted discharge delays and same day discharges also need improving to enable us to send these patients back to Powys.

(e) The Elective Surgical Hub opened on 8 July with 2 Theatres and a Cataract Suite. The Vanguard Theatre has now been removed. Theatre maintenance is now able to be carried out due to having this in place.

(f) The first 8 weeks of this year compared to the same period over the summer last year shows that we have seen over 350 more patients in our Theatres than the same period last year. This is with the Vanguard removed from the site and Theatre maintenance in place, which equates to one more Theatre than last year. We are also undertaking reviews with Divisions to ensure that we are maximising the productivity gains of these new Theatres.

(g) The ED decant for 3 weeks will start from tomorrow. This will allow essential maintenance work to be carried out. There are comprehensive plans in place with Clinical Operational Team oversight. It will continue to be business as usual for members of the public, but the COO urged them to choose wisely before coming to ED if there are more appropriate alternatives.

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

BOD11/09.24 **Workforce**

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

(a) We are still seeing high sickness absences across the NHS compared to 2019. This is largely due to mental health issues. There is a national study over the next few months to explore the reasons for this and what further interventions can be put in place. This starts in early October.

(b) Following the recent government announcement about health checks, Wye Valley NHS Trust will be a pilot site for this over the next 6 months. The programme will be starting at the end of September.

(c) We are encouraging our Line Managers to sign up to the NHS Inclusive Leadership Pledge to encourage good relations and compassionate leadership. We are now seeing a positive improvement in appraisals rates. These support staff development, retention and career progression.

(d) The Chairman asked what was worrying the CPO most. He advised that it is the financial challenge and productivity challenge. We are working actively to try and ensure we are being more productive with all staff.

Resolved – that the Workforce Report be received and noted.

BOD12/09.24 **Finance Performance**

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

(a) The Month 4 position overall shows an adverse variance of £3.2m to plan. This is primarily due to under delivery of our CPIP but also due to the change in accounting for PFI with a year to date impact reflected this month of £0.7m.

(b) We have maintained strong elective performance (115% compared to 2019/20) and the Elective Supportive Hub has attracted additional income of £0.7m which has partly mitigated our Month 4 position. We are forecasting the final 2024/25 position will be on plan, acknowledging there are known risks as well as mitigations.

(c) Capital – To date we have invested £5.2m. This is a significant programme but a large element will be delivered slightly later in the year due to constraints.

(d) Cash - Due to close cash management, support is no longer forecast for Quarter 2 but is expected to be needed in Quarter 3. We are liaising with NHSE around this. It is more difficult to access this cash where the requirement is driven by being off-plan.

(e) The Chairman asked the CFO if there were 3 things we could do to make the Quarter 4 run rate more acceptable, what would they be. The CFO advised they would be Theatre productivity and utilisation to drive the Elective Recovery Fund, Urgent Care flow improvements (as discussed) and reducing reliance on the temporary workforce.

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

ITEMS FOR APPROVAL

BOD13/09.24 **Emergency Department Workforce Investment Business Case**

The CNO presented the Emergency Department Workforce Investment Business Case and the following key point was noted:

(a) The Chairman thanked all the ED frontline teams who deal with incredibly stressful circumstances. This is greatly appreciated by the Board of Directors.

(b) The CNO advised that the Trust Management Board had considered this Business Case and recommended it to be presented to the Board of Directors for approval. This has been through NED pre-Board discussion also.

(c) We are seeking investment in nursing staff. The Business Case presents 3 options. Option 1 – We reduce our staffing level to the original baseline establishment pre-Covid. Option 2 – We implement the full range of Royal College Emergency Standards. Option 3 – This is our preferred option. This is based on several factors – external visits, Care Quality Commission inspection and benchmarking across the Foundation Group. The Care Quality Commission in 2023 rated us inadequate regarding safety which was driven by staffing in particular. Therefore, additional staffing was put in place in December to address these safety concerns. This is beyond our planned budget and driving some of the cost pressures that we are seeing.

(d) This Business Case addresses the safety critical posts from those Reviews and is to staff the Department as it is operating currently; therefore including the post for oversight of the corridor and Waiting Room. Part of this investment would be to retain the Nurse Navigator.

(e) We undertook a benchmarking exercise across the Foundation Group and found that we were an outlier in comparison to others. Therefore, the proposal is for 24/7 Band 7 senior leadership cover for the Department, and an increase in management and education posts to support this team.

(f) Not part of the Business Case yet an important piece of work is to review shift patterns to see if we can better match our workforce to peaks in demand. The team are currently reviewing if staggering shifts is more appropriate. This is due to conclude at the end of September and may be subject to a management of change process.

(g) Despite the high number of vacancies in the Department, the recruitment trajectory for the end of the year is positive. We will be fully recruited to our original budgeted establishment by the end of the year and if Option 3 is approved, we do not envisage difficulties in recruiting into the additional posts and hope this would be achieved by April 2025.

(h) Assuming our Urgent Care and ED Workstreams come to fruition, there may be an opportunity to reduce the establishment and current level of investment being requested as we would not anticipate needing to staff the corridor and Waiting Room in the way that is required at present. This will be kept under regular review.

(i) The CFO noted that the increase in workforce of 10.76WTE is around £1,291k a year. This is over and above what we have budgeted for but we are spending this in an unplanned and expensive way with Agency and Bank staff. There would be a £831k reduction with the use of permanent staff. There will always be some level of Bank and Agency usage for short term sickness.

(j) The CEO was supportive of this. He was concerned that we would be funding an issue rather than resolving it. We need to put in new solutions regarding staff and ensure that we can redeploy them if they are not needed in ED. The CNO advised that all staff are employed to Trust contracts and could easily be redeployed to another area.

(k) Mrs Martin (NED) was pleased to see the rigour of the ongoing review and assessment of our UEC workstreams as corridor care and overcrowding is not what we want to do and we do not want to normalise this.

(l) Mr James (NED) was supportive noting that we are creating a team to replace and reduce our costs on Agency and Bank staff and that we already have targets to meet to reduce this as part of our Financial Plan. He just queried that we are not double counting these savings. The CFO had previously noted this risk but is confident that this is not occurring in this instance.

(m) The Chief Strategy and Planning Officer confirmed that the Front Sheet contained a summary of the discussions held at the pre-meeting with the NEDs around Business Cases being presented to the Board of Directors.

(n) Mr Lappin (ANED) was supportive of this noting that this is one of a number of areas where we are having to increase our cost base to meet service needs and questioned to what extent have we involved our Commissions around this and what is their response. The CEO advised that there is at least an annual recognition of costs in Urgent and Elective Care. This is not currently paid if demand goes up but we are expecting to see this mentioned in the Planning Guidance. This would then allow a conversation with our Commissioners around this. The Chairman noted that Accident and

Emergency is a very expensive place to provide care if our residents are able to access other, more appropriate options.

Resolved – that the Emergency Department Workforce Investment Business Case be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD14/09.24 **Integrated Care System and One Herefordshire Update**

The Managing Director presented the Integrated Care System and One Herefordshire Update and the following key points were noted:

(a) Most of this has already been covered in the meeting. This is around integration and expansion of our Community Services. The Report highlights the work that has been going on around this.

(b) There are moves to re-procure the GP Out Of Hours services which is now in the planning stages. This is important to us due to the level of integration and planning involved as we co-locate these services later in the year.

Resolved – that the Integrated Care System and One Herefordshire Update be received and noted.

BOD15/09.24 **Trust Infection Prevention Annual Report 2023/24**

The CNO presented the Trust Infection Prevention Annual Report 2023/24 and the following key points were noted:

(a) This has been presented to the Quality Committee who were happy with the content. They also receive a quarterly update which allows for scrutiny on infection prevention matters.

(b) There have been high levels of respiratory infections along with a large number of outbreaks. These were all managed well and where possible, we kept clinical areas open to prevent further congestion and enable patient flow.

(c) There was 1 MRSA bacteraemia – lessons have been learnt from this. Of our other external reportable infections, in all but 1 case, our performance had improved last year on the previous year. The exception was E-coli bacteraemia. Quality Improvement is being carried out around catheter care and we therefore expect a reduction in these levels.

(d) The Trust remains on intensive support with NHSE. This started over 2 years ago as we were an outlier regarding our C-diff figures. They have been overseeing improvements over the last few months and are pleased with our progress to date.

(e) The Chairman noted studies show that lowering a toilet seat before flushing reduces the spread of germs. He also reiterated the need to wash your hands regularly.

Resolved – that the Trust Infection Prevention Annual Report 2023/24 be received and noted.

BOD16/09.24 **Perinatal Safety Report**

The CNO presented the Perinatal Safety Report and the following key points were noted:

(a) The Report was scrutinised at the Quality Committee and there was no requirement to escalate any matters in particular for the Board's attention.

(b) There are several areas of focus for Quality Improvement in the service. The first is around post-partum haemorrhage and the work, including an audit, undertaken to improve on this.

(c) We had a cluster of incidents relating to reduced foetal movements. A campaign is going out to expectant mothers to not rely on at home Doppler's. If they are experiencing reduced foetal movements, they need to contact their Maternity Department.

(d) We are also focussing on the pre-term pathway following a cluster of incidents to ensure that the referral pathway, criteria and monitoring arrangements meet best practice. We are auditing these areas.

(e) The Neo-natal and Maternity Leadership team have participated in the first wave of the Perinatal Culture Club which is part of the LMNS Network. The high level results are included in the Report and shows the improvements made against 14 indicators from the original survey. We have made positive progress with 12 out of 14 indicators since the last survey. There has been slight deterioration with 2 in relation to work load and emotional wellbeing. We are ensuring that we publish our wellbeing offers to our colleagues to improve our position on this matter.

(f) Ranking Percentage Against Rating – This is the old ranking from the original Survey and should be disregarded at this stage as only 10 Trusts have gone through the new Survey so far, so we will not know where we rank until all Trusts have gone through the programme.

(g) Mrs Martin (NED) noted that we have the ability with the Foundation Group to be able to work with colleagues across the Group to compare and contrast and learn from each other.

(h) The Chairman noted the high number of caesarean sections and that these are not without risk. The CNO confirmed that we do have higher rates than the national benchmarking in this area. We previously presented to the Quality Committee around the Robson Groups. The Robson Group Audit will be presented to the Quality Committee at the end of this year to better understand our position and where we need to focus.

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

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD17/09.24 **Foundation Group Board Minutes and Action Log 7 August 2024**

Resolved - that the Foundation Group Board Minutes and Action Log 7 August 2024 be received and noted.

BOD18/09.24 **Integrated Care Executive Report**

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

- Progress Around Better Care Fund – We are trying to get a fast response to get people home or in some cases, prevent them being admitted if not required. There is some funding that the ICB and Local Authority have committed to enable us to do things differently to avoid unnecessary admissions.

- The Chairman queried if Nursing Homes in Herefordshire are engaged when we reach out to them to provide enhanced care. Mrs Martin (Chair and NED) advised that broadly they are. Our Care Home Forum is well attended with colleagues from GPs and the Local Authority. This is an active, proactive group.

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

BOD19/09.24 **Quality Committee Report and Minutes 30 May 2024 and 27 June 2024**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Report and Minutes 30 May 2024 and 27 June 2024, which were taken as read, and the following key points were noted:

(a) The Chairman asked what was concerning Mr James (Chair and NED) most. He advised that the impact of the areas that we have touched upon – the pressures that the hospital is under, patients boarding and the impact this has on quality and safety. This is something that is considered at every meeting. We need a resolution to improve the flow of patients. We are also keen at the Committee to scrutinise the quality and safety risks of having additional patients on our wards.

Resolved that the Quality Committee Report and Minutes 30 May 2024 and 27 June 2024 be received and noted.

BOD20/09.24 **Any Other Business**

There was no further business to discuss.

BOD21/09.24 **Questions from Members of the Public**

Q1. There is concern, nationally, that a number of overseas NHS nurses are on temporary visas. This means that, despite paying income tax and National Insurance, they have no recourse to public funds such as Child Benefit, Housing Benefit and Universal Credit for at least 5 years. How many overseas nurses employed by Wye Valley Trust have only temporary work visas? Can the Trust Board do anything to support these nurses? For instance, by lobbying the government to change this unfair rule.

A1. The CPO advised that our international nurses are sponsored on a 3 year temporary visa initially. After 5 years being in post, we support them to apply indefinitely. So far we have 396 international nurses on temporary visas and are supporting them with their applications. Of the 44 applications made so far, all have been successful. We are aware of the national concerns on the restrictions of temporary visas and we have raised this with NHS Employers so that it can be discussed with the government.

The Chairman thanked the international nurses who come and work at the Trust. They often leave their family and loved ones at home to work in a foreign country with a foreign langue of English.

Q2. When provided with equipment from Wye Valley Trust such as crutches, commodes and other aids to assist patients at home, what information are patients provided with to let them know when and how to return these items? How much of this type of equipment, lent to patients, is not returned or is delayed in being returned? And what is the cost to the Trust/NHS of such non returned/delayed returns?

A2. The COO advised of the current process for returning equipment - patients are asked to return them with a sticker on the mobility aids. We have previously had amnesty sites over the years but it is clear from this question that this process is not as robust as it could be. The process for collecting large pieces of equipment is in place. The point raised around the cost of non-returned or late returned items is an ideal opportunity for us to review in terms of patient experience and cost saving. This is on the agenda for our Finance Recovery Board.

Resolved – that the Questions from Members of the Public be received and noted.

BOD22/09.24 **Date of next meeting**

The next meeting was due to be held on 3 October 2024 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 3 OCTOBER 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
BOD06/09.24 Matters Arising and Action Log 05.09.24	(B) The Chief Strategy and Planning Officer has arranged to meet the member of public to discuss his concerns and an update will be provided at the next meeting	AD	Meeting took place where a number of concerns were explored, including feedback to the Trust from West Mercia Police on successful convictions arising from incidents of violence and aggression.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Managing Director's Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Managing Director**
Author:	Jane Ives, Managing Director
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 Managing Director 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. Lord Darzi – Independent Investigation of the NHS in England

The rapid investigation commissioned in first few days of the new Government has now reported.

Whilst the report pulls no punches in confirming that the NHS is in serious trouble in one of the most telling parts it also reports that: the state of the NHS is not due entirely to what has happened within the health service. The state of the nation's health has deteriorated and that impacts on its performance.

Average healthy life expectancy which had been stable at around 64 years for women and just over 63 years for men since 2010 has deteriorated and now stands at 62.7 for women and 62.4 for men.

The performance of the NHS:

- NHS not met its most important constitutional standards since 2015
- Less GP's per capita – a reduction of 1.9% per year between 2016 and 2024. With 33% of population struggling to access GP
- Community and mental health waiting times less visible but worsening (particularly mental health where demand has ballooned)
- Quality and outcomes are variable and not meeting international comparisons in many areas

Lord Darzi identifies the main drivers of poor NHS performance as:

- Austerity – 2010 – 2018 NHS spending increased at 1% per year (long term average 3.4%)
- Funding from 2018 – 2024 – was promised at 3.4% but actually just under 3%
- Capital under-investment with capital raided to prop up revenue (shortfall of £37 billion from OECD average)
- Pandemic impact much greater than comparable countries due to lack of resilience. (eg 68% reduction in knee replacements compared to 20% OECD average)
- Disengaged staff (higher sickness, turnover and less discretionary effort)
- Structural reform - Disastrous Lansley organisational reforms 'a calamity without international precedent'. It took until 2022 to put ICS onto a statutory basis and undue the 2012 reforms.

In terms of productivity acute productivity has reduced by 11% on average since 2019 post Covid. It is clear that congestion, large waiting lists and discharge delays make us unproductive. It is seems to be the case that under investment in capital has been replaced by labour in a post-industrial revolution reversal.

He finds no evidence that draws into question the principles of the NHS tax funded, free at the point of use and based on need.

Finally he concluded with recommendations;

- Re-engage staff and re-empower patients
- Lock in the shift of care closer to home by hardwiring in financial flows
- Simplify and innovate care delivery for a neighbourhood NHS
- Drive productivity in hospitals
- Tilt towards technology
- Contribute to the nations prosperity
- Reform to make the structures deliver

It is a welcome report and underpins the next phase which will be the development of a 10 Health year plan over the winter and to be published in the spring.

The plan will be subject to wide engagement with public, professionals and institutions. There are three shifts that will underpin the plan; From acute to community, from treatment to prevention and from analogue to digital. These are not revolutionary and arguably have been the strategy of the NHS for some time, but have not been delivered in fact Lord Darzi also finds that despite a policy commitment to 'left shift' we have right drifted. Proportionate spend since 2009 has reduced in Primary Care from 24% to 18% and increased in acute sector from 53% to 58% and community health services from 10% to 7%.

It is planned that the difference for the new plan is that it is nested in the governments approach to 'mission led government' – this is not an NHS plan but a health plan with all government departments having a role to play in delivery. The acid test of the new plan will be commitment demonstrated in legislation, funding and ultimately delivery.

2. Urgent Care

Whilst the development on the 10 year plan is encouraging, we are still facing the current winter with no planned additional funding and whilst it is a relief that the junior doctor pay dispute (now called resident doctors) has been settled we are entering the winter period after a difficult summer.

Over the last 3 weeks we have decanted our emergency department to enable life cycle works that are overdue. This has been challenging to the organisation and my thanks to all of those involved.

The plan for winter which expands our community services and requires improved productivity from discharge pathways as well as in hospital improvements is comprehensive but will continue to require boarding patients on our wards to ensure safety of patients in our ED and those still at home requiring urgent and emergency care.

This is in line with the national winter planning letter that has been received which includes standards and principles for the care of patients in temporary escalation spaces.

3. Financial Recovery

The financial position of the organisation is not meeting the planned trajectory and focus on improving efficiency, value and productivity continues across the organisation. A series of specialty reviews have commenced with clinical teams as well as increased scrutiny with divisional management teams. There is good progress with planning, but that needs to turn into improvement in our bottom line and run rate as we enter the second half of the year. Of importance is the opportunity to increase activity and income through surgical pathways in the new daycase surgical hub.

4. From our great teams - Integrated Care Division

The Integrated Care Division have been responding to the recent pressures within the UEC pathway in a number of proactive and responsive ways, whilst also planning for the winter ahead.

The last few months has seen our division implement new services, along with improvements to existing services to support the care at home initiatives.

The Division has been preparing to welcome the Virtual Ward. The ward is currently managed in the Medical Division but will be transferring to integrated care division at the end of September- we have also been working on expanding the Virtual Ward to accommodate other specialties and beds available for primary care to step up patients if deemed appropriate.

Our focus on admission avoidance continues via our Urgent Community Response team and we are strengthening our offer to WMAS to increase referrals. This has seen a significant increase of referrals via the CAD portal and referrals from the control centre, more work is planned to increase the referrals we receive from paramedics on scene (Call before convey)

Our Community Referral Hub (formerly Community Integrated Response Hub) is planned for a relaunch in early October to ensure that access to a range of services is simplified and promoted across the system. The WVT team will be moving to a new building in Nelson House and will be collocated with our GP providers to strengthen the integration between our services and teams.

Work is in progress to develop the offer from our integrated Neighbourhood Teams to contribute to admission avoidance - focus for winter will be on PCN led Frailty MDT's which will be crucial in ensuring patients have proactive care plans and those who don't need to admitted remain at home.

We have also implemented a new function to support our Frailty SDEC- a small team of care workers who will provide a rapid response to FSDEC to ensure patients that can return home receive any care they need on the day preventing an admission to the ward. The team will be available to be at the person's home within 4 hours of the referral.

Our system have been working together to improve Discharge to assess pathways, to reduce delays for patients when they no longer meet the Criteria to Reside. We have seen sustained improvements in our Pathway 1 delay position, Home First and WVT Bridging Team work together to ensure patients are discharged the same day that they are deemed ready for discharge.

Our focus is now on Pathways 2 and 3 to ensure we maximise occupancy in our D2A provider services and reduce length of stay- the aim being to reduce the purchase of spot beds and drive through the value of the Better Care Fund

We have also seen a significant improvement in the time that children are waiting to see a therapist, we had significant waits earlier in the year and have worked to reduce this. We currently have no children waiting over 52 weeks and are looking to reduce even further over the coming months.

Our division has historically not been very involved in demand and capacity planning and this year we have set ourselves an objective to review every service to ensure we have good planning around demand, capacity and activity. We are part way through this plan and are confident we will have competed all services by year end.

Jane Ives
Managing Director

NHS
Wye Valley
NHS Trust

Integrated Performance Report

August 2024

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

Over the course of the summer we have completed urgent lifecycle refurbishment work in our theatres and Emergency Department. The difficulty achieving this in the face of ongoing over capacity in our urgent care pathways and increases in elective work can't be over-estimated and I am very grateful to all of the staff involved.

Given the disruption due to the estates work there has been good progress in taking advantage of the productivity opportunities that the new day case surgical unit has brought with increased numbers of patients on theatre lists. This has contributed to the target to have no over 65 week wait by the end of September. We will be a little shy of this target with around 50 patients over 65 weeks at the end of September. We have a thousand patients waiting over 52 weeks which has reduced by about 200 over the year.

At the half way point of the year we have taken the opportunity to review our elective plans for the second half of the year now that the DCSU has opened and this will be completed soon. Now that we have all of our elective capacity fully open our expectation is that we will deliver more than the current plan, which will reduce waiting times further and contribute positively to the financial position.

The end of the estates work has also enabled our ward reconfiguration plan to be finalised with more medical beds and ring-fenced surgical beds.

The winter plan has been discussed in the board workshop session this morning and will be presented to the public board meeting next month. It is a comprehensive plan across the whole urgent care pathway but it is unlikely that it will be sufficient to eradicate ED congestion and the need for boarding on wards, although both should improve when all of the planned new and expanded services are in place.

The business cases on the board agenda today for the increased bed base and revised medical staffing model in ED are both important parts of the plan.

Given the challenges to the urgent care pathway over the course of the year it is encouraging to see a further improvement in our mortality levels. The launch of the system medal examiners service is a further opportunity to learn and continuously improve.

Also over the course of the summer there have been a series of staff engagement events in different specialties and teams. This is a rich source of feedback and learning and from this is being developed into a staff experience improvement plan which will be communicated to staff. One of the areas that have been fed back is frustration with technology. The improved digital nurses noting system is now live and early indication are positive and a significant system upgrade to maxims EPR will go live in early November. The national staff survey is now live and we are aiming at a higher response rate that we achieved last year.

Our financial position remains challenged and there has been a ramping up of cost and productivity improvement work over the last 2 months. There is some improvement in the month 5 position but there is a lot further to go to improve the underlying run rate over the second half of the year.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Complaints referred to the PHSO

The Trust has seen an increase in the number of complaint responses referred to the PHSO for review by the complainant. The table below highlights the numbers referred since 2021.

Year	PHSO cases
2021	5
2022	1
2023	2
2024 (to date)	6

Of the 12 cases relating to complaints made against the Trust*, six (50%) were resolved, withdrawn or no further action taken. Four cases are ongoing (33%), one was partially upheld (previously reported to the committee) and one case financial compensation was proposed and agreed by the Trust.

**two cases recorded were the Welsh Ombudsman requesting the Trust to support in a case relating to another organisation.*

HSJ Patient Safety Awards

The Safety in Sync team along with One Herefordshire colleagues attended the HSJ Patient Safety Awards last month after being shortlisted for the Developing a Positive Safety Culture award. It was a tough category up against some inspiring projects. The team were not successful on the night but delighted to be shortlisted and recognised for the integral part of improving our patient safety culture the forum carries out.

Paediatric audiology services

Quality Committee received a further update in relation to Midlands Audiology Review and Incident response. The incident response process is likely to be stood down and service oversight and monitoring to return to business as usual processes. The trust awaits the final outcome of the external clinical review of ABR cases on the non discharge pathway—we anticipate this to be by the end of October. Following a request from NHSE regarding working towards IQIPS accreditation the Trust has committed to:

· Undertaking a gap analysis against the IQIPs standards

· To determine the resource implications for delivery

· Determine the timescale for delivery

· To work collaboratively with the ICS and Worcester Acute towards accreditation

Quality & Safety Performance – Mortality

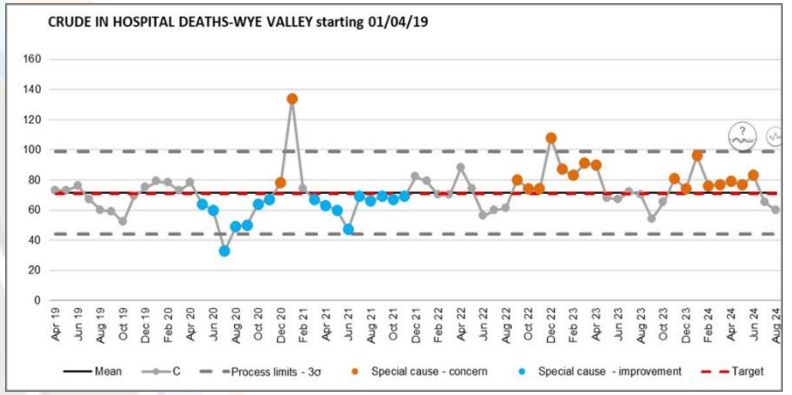
We are driving this measure because:

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

Data

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**April 2023 - March 2024**	98.3	-2.0
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**June 2023 - May 2024**	98.6	1.0
SHMI (in hospital)			92.7	0.8
SHMI (out-of-hospital SHMI)			112.3	1.56

CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	May-24	96.48	26.95	26	-3.40
Congestive Heart Failure		110.88	71.25	79	-1.77
Fractured Neck of Femur		125.17	31.16	39	-8.36
Pneumonia		95.04	198.86	189	-0.64
Septicemia		124.10	105.56	131	1.72
Stroke (*Acute Cerebrovascular Disease*)		104.15	85.45	89	-1.72



Monthly Headlines

The latest **SHMI** (*HES Based*) from June 2023 to May 2024 shows Wye Valley NHS Trust at a very encouraging 98.6. The NHS Digital, which is for the period of April 2023 to March 2024, also shows a positive position at 98.3. The latest **crude mortality** rate for August 2024 is 1.05% for all admissions, remaining below our mean.

An overall positive month for our key mortality outlier groups, with the latest figures (*June 2023 to May 2024*) indicating some significant reductions in areas of recent concern. **#NOF** mortality has reported one of its largest reductions this month with over an 8 point fall to 125. This is a welcomed reduction following the recent outlier alert from HQIP, which had flagged Wye Valley NHS Trust for having 'higher than expected' mortality rates for our #NOF patients. An initial response has been provided, which summarises our local actions taken and planned to improve the pathway. There are two workshops being held during October, at which key stakeholders from the pathway will review the current state and decide upon key actions to take to improve the pathway and ultimately reduce the mortality rates. Further updates will be provided through this report.

Respiratory – Continued reductions in our respiratory groups, COPD and Pneumonia, with both groups now reporting under 100. This equates to a total of 11 deaths lower than the expected for these areas. **Stroke –** A follow-up meeting is planned with Public Health in October to help better understand our wider mortality rates across Herefordshire. The latest SHMI data shows another small reduction in our in-hospital stroke mortality rates to 104, remaining within 'as expected' ranges. There has been a further small increase in the latest SHMI for **Sepsis** deaths to 124. An audit is currently being undertaken by the Divisions to better understand their performance with the sepsis care bundle, with findings and learning being shared through the Deteriorating Patient Committee.

Medical Examiner Service is now in place across all of Herefordshire, ensuring all deaths occurring in the County will be reviewed and supported through the service. Initial feedback has indicated a positive start to the roll-out.

Perinatal Mortality Rates – The latest data (*September 2023 - August 2024*) indicates a sharp rise in the extended perinatal mortality rates. In July and August 2024, there were 2 stillbirths reported for both months, which has caused a significant spike in the overall 12 month rolling rate. The latest unadjusted extended perinatal mortality rate for Wye Valley is 4.26 deaths per 1000 live births. Obstetrics and Gynaecology team presented at the September Learning from Deaths Committee providing brief case summaries and learning from all deaths over the past 12 months.

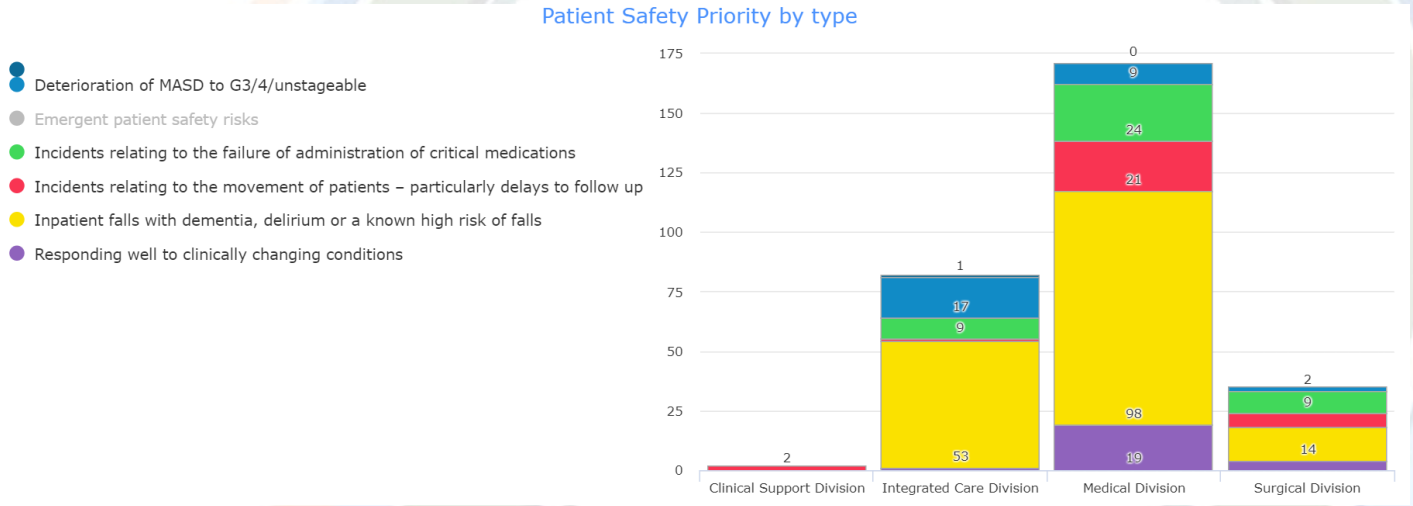
Quality & Safety Performance – Patient Safety Profiles

We are driving this measure because:

These priorities are part of the Trust's Patient Safety Response plan

WVT Patient Safety Priorities				
Tissue Viability incidents – Deterioration of moisture associated skin damage to G3/4 or unstageable pressure damage	**Inpatient falls** In patients with dementia, delirium or a known high risk of falls	**Delays in assessment, diagnosis or treatment** Responding well to clinically changing conditions	**Admissions and discharges** Incidents relating to the movement of patients, particularly delays to follow up	**Medication incidents** Incidents relating to the failure of administration of critical medications

Patient Safety Priorities update (NOTE: data in chart includes incidents reported up to 24/09/2024)



Deterioration of moisture associated skin damage to G3/4 or unstageable pressure damage: improvement oversight lead by Pressure Ulcer Panel. Roll out of documentation audit to District Nursing teams in progress to respond to thematic concerns emerging in relation to vulnerable patients in the community

Responding well to a clinically changing condition: three locally determined PSII cases linked to priority in progress. Re-established Deteriorating Patient Committee and quality priority driving improvement work for known risks. New learning from PSII reports will be reviewed upon completion.

Inpatients with dementia, delirium or a known high risk of falls: area specific improvement plans in place for Frailty and for Community Hospitals with sharing learning and improvement initiatives overseen by Falls Panel. Improvement initiatives also being expanded into general medical areas. Recent improvements to support this include re-launch of nurse noting on MAXIMS and new SOP for bed rail placement, where bed rails are secured in down position and only raised by a registered nurse upon completion of assessments.

Incidents relating to the movement of patients, particularly delays to follow up: small number of incidents linked to this priority to date. Suggests priority may be too broad and require review. Themes identified to date: patients moved to inappropriate areas delaying treatment; transfers to community hospitals lacking detail on patient's cognitive ability; and discharges with out anticipatory medicines. Areas link to wider projects or known issues in the Trust where improvement work is underway.

Incidents relating to the failure of administration of critical medications: linked to quality priority and improvement work lead by Medicines Safety Officer. New themes identified include limited use of order sets leading to incorrect dosages of medicines administered. Delay in medicines reconciliation leading to increased dosages of missed medications on admission.

Quality & Safety Performance – Staffing

Fill Rate & CHPPD Data

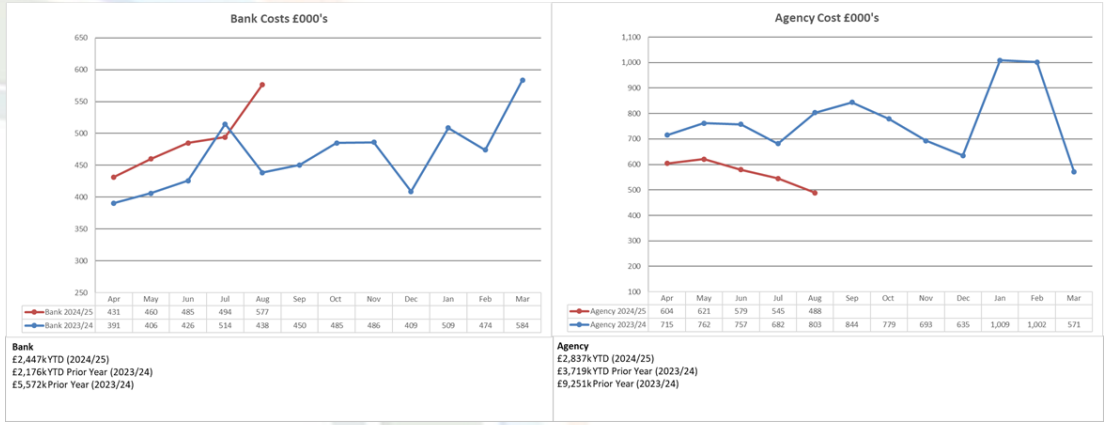
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	106%	78%	100%	80%	9.8
Maternity Ward	94%	90%	100%	92%	5.6
Children's Ward	114%	87%	83%	68%	21.2
Lugg Ward	115%	91%	113%	104%	7.0
Wye Ward	127%	73%	120%	80%	7.2
Cardiac Care Unit	100%	94%	100%	87%	11.4
Leominster Community Hospital	154%	95%	100%	154%	7.0
Bromyard Community Hospital	116%	100%	111%	104%	6.8
Ross Community Hospital	99%	107%	100%	113%	6.7
Teme Ward	135%	53%	98%	43%	10.9
Redbrook Ward	101%	131%	101%	135%	7.1
Special Baby Care Unit	87%	-	91%	-	12.0
Intensive Care Unit	106%	-	90%	-	24.1
Gilwern Ward	101%	154%	100%	116%	7.5
Acute Medical Unit	125%	87%	91%	122%	7.7
Ashgrove Ward	133%	82%	100%	106%	7.4
Dinmore Ward	135%	77%	101%	99%	7.1
Garway Ward	127%	85%	103%	109%	7.0
Frome Ward	126%	85%	100%	105%	7.0
Arrow Ward	136%	75%	135%	88%	7.7
Women's Health	118%	106%	100%	-	10.5

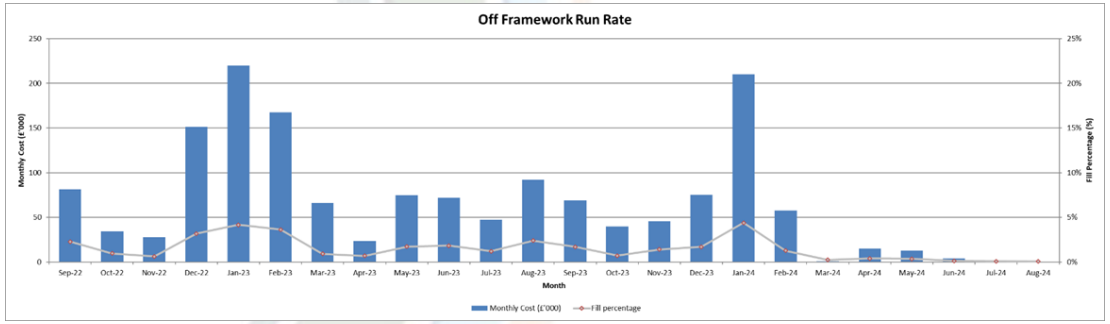
The NHSE staffing return is detailed above. This has been updated to reflect investments and changes to establishments for some of our wards. The fill rates are better aligned than in previous months.

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.

Bank & Agency





Month 5 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. 600 less agency shifts were requested in August compared to July 2024. 60% of fill was achieved at NHSI cap rates with the remainder being filled at tier 1.

Despite the improving trajectory we remain off track in the delivery of our 4million cost productivity improvement target. The plan was to spend no more than 5.2 million full year and the year to date position stands at 2.8 million with a trajectory of 6.8 million at current spend and demand levels. This represents a particular challenge as we enter the winter period which usually sees rising demand.

A further rate card reduction has been agreed with the agency provider and will be effective from 1st October 2024. Whilst bank provision is to be encouraged as an alternative to agency, the steep rise in August is a concern in terms of overall spend.

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Although this section of the Integrated Performance Report focuses on the activity, demand and performance for August this year, I want to reflect on the challenges we are faced with currently.

At the start of September we undertook a decant of our Emergency Department [ED] to allow for essential maintenance work and changes, across the ED floorplan. This meant we had to relocate our majors' cubicles, rapid assessment area and seated areas to other location across the ground floor. Some of the improvement, at the end of these works, include additional assessment space in our rapid assessment area "Pit Stop" and a dedicated mental health room.

The total time period for this work is three weeks and as I prepare this report we are half way through the scheme and aim to completed on schedule .

The efforts of the whole organisation and system partners to support, not just the moves of clinical areas to revised/temporary locations, but to maintain patient flow has been demanding and considerable.

The challenges to operate an ED has been considerable and reduced not only our elective inpatient capacity but our ability to provide our Same Day Emergency Care facilities and pathways in its substantive capacity. With changes made each week as the work progresses.

During the month the Integrated Care System meet with Regional and West Midlands Ambulance Service [WMAS] colleagues in order to meet the challenge of reducing all Ambulance handovers to less than 45 minutes. There was unequivocal support that we need to support the release of Ambulance crews as soon as possible so they can response to patients waiting in our community, and this needs to be at the forefront of our winter plans. But we also need support for our WMAS colleagues to reduce WVT being a net importer of out of areas conveyances due to intelligent conveyance across the system when other providers are under pressure and a significant increase in "Call before Covey" to ensure an admission to ED is the right pathway for patients and that our increase range of community service cannot support patients closer to home.

The Integrated Care Division have managed to "bring forward" its winter scheme to provide a frailty bridging team to support our care of the elderly patients get home sooner whilst these patients await support at home for care packages to be implemented.

The responsiveness of the Herefordshire system to reduce and react to delayed discharges has been impressive, and although the pathway for patients to return home with short-term health and social care support has improved, our delays for patients requiring nursing and care home support remains fragile.

Powys discharge delays remain a significant concern and although we have seen pockets of improvements over the summer period as we go into autumn we are seeing a significant delay in the volume and length of stay for this cohort of patients. We have set up meeting three times of week to gain traction and support Powys with resolution of delays. We have also asked for both Powys Health Board and Powys Local Authority for their plans this winter so we have clear visibility of their schemes, escalation triggers and plans so we can ensure our Herefordshire plans link together.

Our Surgical Division have had a period of a reduced bed base as Theatre Recovery had been temporary moved to our Elective Ward meaning a reduction in capacity of 50% for 12 days over the period. But despite this the volume of elective Theatre work has been seen almost 150 more elective patients in the first 19 days of September compared with September last year.

Focused ongoing work is aimed at Pre-Operative Assessment, Theatre Scheduling and the retrospective review and learning for past Theatre sessions in order to increase cases per list and maximise available budgeted sessions. A recent peer review has re-enforced the opportunities and changes that now need to occur to maximise our productivity for the second half of 2024/25.

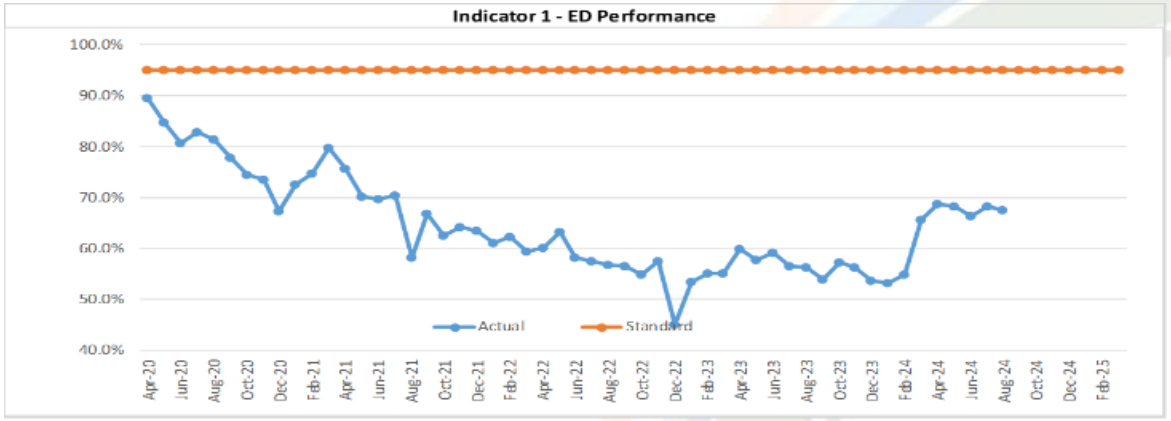
Our cancer 62 days referral to start of treatment performance was a significant concern in July, despite our 28 day Fast Diagnosis Standard [FDS] delivering consistently at the required standard and the volume of suspected cancer patients waiting over 62 days to start treatment also reduced. This was driven by an increase in breaches in urology and issues related to radiology and pathology, as described in my summary page on 62 day cancer performance. We also had workforce challenges in July which lead to delays in pathway management which is being addressed now we have some stability in the cancer team in August. Our prediction for August`s 62 day performance is back above the current nationally set standard.

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

We are driving this measure because:

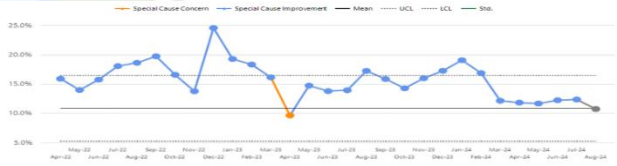
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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

% Patients Spending More Than 12 Hours In ED



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 67.6%

Performance & actions

- 5,983 Type 1 patients attended ED in August. This was the first month with less than 6,000 Type 1 attendances since February-24. The range of all attendances varied from 165 to 236 with 191 being the average daily attendances.
- 1,662 ambulances conveyed to the Trust in month which was 78 fewer than July. The range in month was 37 to 61. This includes 12% from Powys [199].
- Ambulance handover delays over 1hr were 12.7% [212] of all conveyances and 75.9% [1,114] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 980 of all admissions [42.2% of all admissions] via a Same Day pathway within no overnight admissions. This is a 4% reduction from July-24.
- Our Type 1 ED attendances 4 hour Emergency Access Standard ranks 70/122 Type 1 Trust in England for August.

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

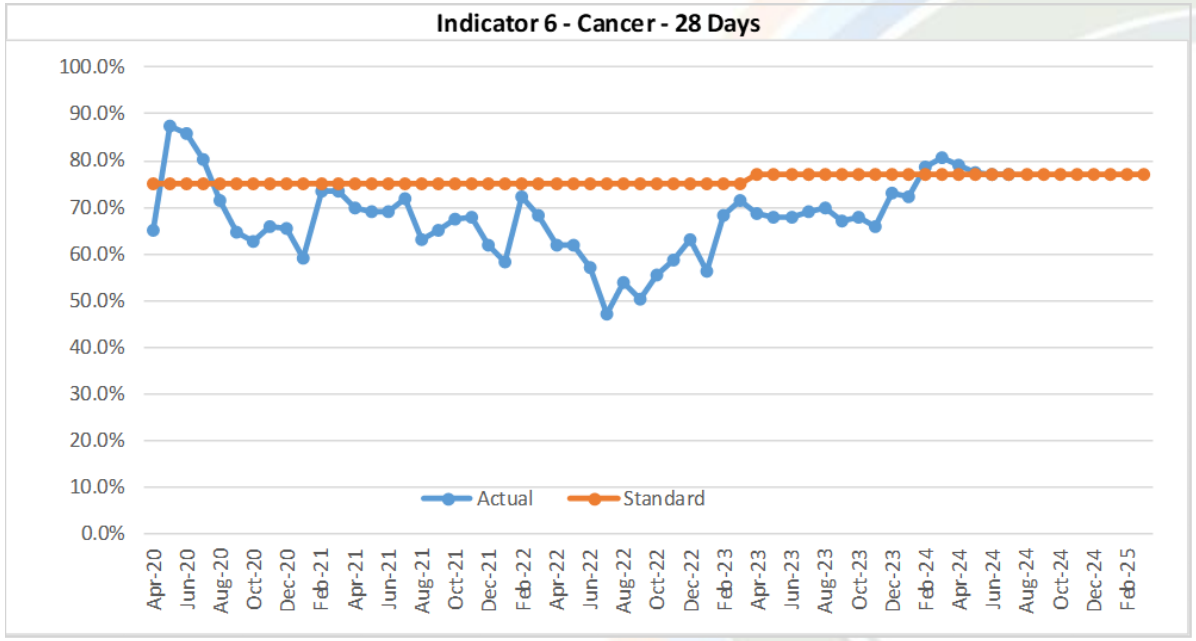
- Completion of Criteria to Admit audit untaken by the Clinical lead for Acute Medicine. Further opportunities identified through the use of SDEC pathways and timely diagnostics and referrals to Virtual Wards whilst care pathways are put in place.
- Following the Board sign off of the ED Nursing Business case recruitment has started to substantive our ED Nurse Navigator roles. Plans are underway to train these post holders through the community pathways using the experience of the Community Response Hub. This should increase the skillset of this team to Navigate to additional community pathways.
- Plans developed to expand and relocate our Discharge Lounge. This will increase the capacity to accept increased volumes of patients ready for Discharge, release shared estate back to Medical Day Case (MDC) which will increase capacity to support patients being follow-up post their emergency same day admissions in MDC rather than Medical SDEC. Increasing Medical SDEC capacity to stream patients in from ED.

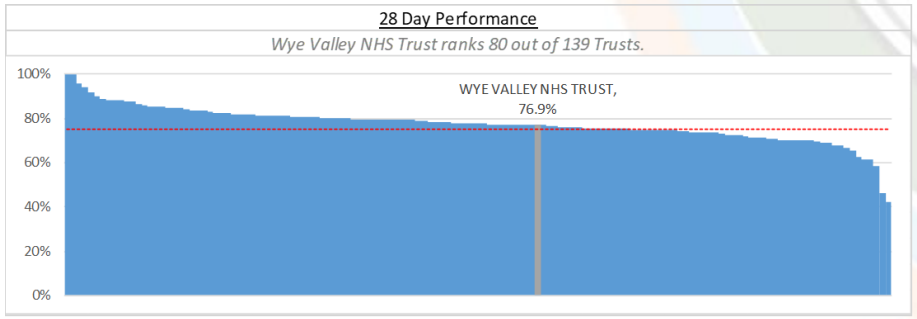
Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [July 24]

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 & actions

Referrals:
· Cancer referrals have increased by 20.8% compared with 3 years ago which equates an additional 2045 patients.
· Recent FIT audit has shown improved quality of lower Gastrointestinal (Lower GI) referrals and the enforcement of FIT results as part of the referral has seen a 14.6% reduction in Urgent Suspected Cancer (USC) referrals.

Main Issues impacting on performance and actions:
· Gynaecology cancer performance remains a concern. The cancer services team are working closely with the Gynaecology service to create a robust plan to address the issues and improve performance. 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 business justification to recruit substantive cancer navigator roles is due to be presented at Trust Management Board in October following confirmation of financial position in relation to Cancer Alliance funding.
· The Best Practice Timed Pathway Dashboards remain in development. Without the dashboards in place, assessment of the pathway bottlenecks requires manual validation.

Improvements:
· Faster Diagnosis Standard (FDS) performance remains steady meeting 77%, meeting the national target since February 2024.
· A new process to use text messaging to reassure patients of benign results has now been agreed via the appropriate governance channels and will support the Trust in reassuring patients earlier in the pathway alleviating the wait for patients.
· Endoscopy waiting times have improved with patients waiting on average around 5-6 days.

What the charts tell 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.

Risks

Cancer referrals continuing to remain above 19/20 levels/Histology Endoscopy and Radiology capacity still remain issues.

Operational Performance – Cancer Performance 62 days Start of Treatment Standard [July 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
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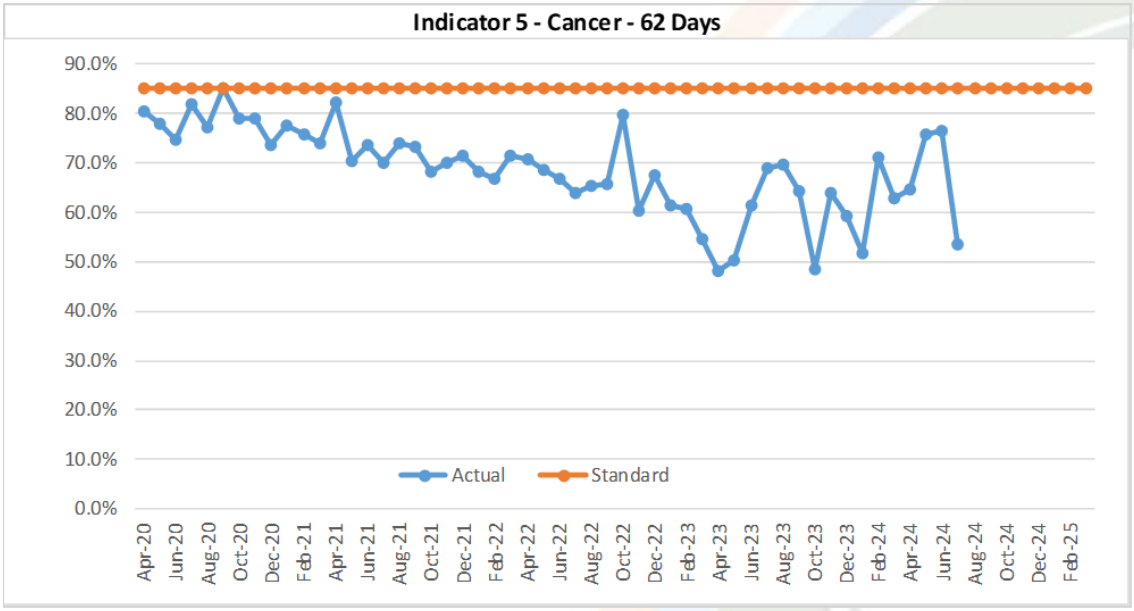
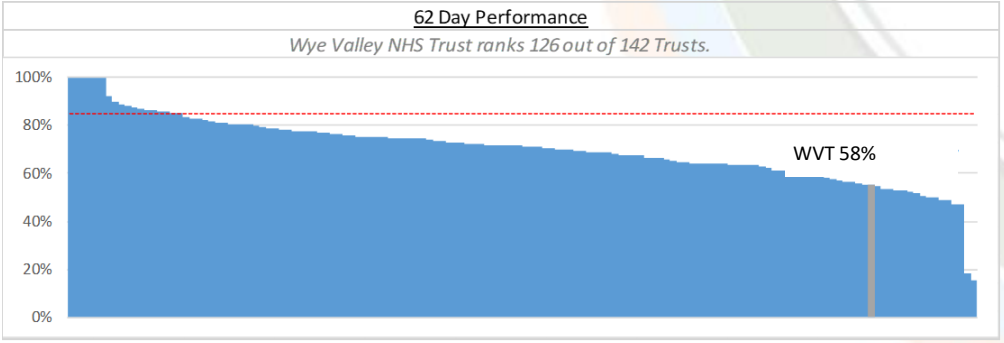




Performance & actions

62 Days:

- Wye Valley NHS Trust did see a decline in 62 day performance in July. A deep dive was completed on the breach pathways with new actions now identified and included in the cancer action plan.
- The Trust continues to work towards meeting the national target of 85%, although 70% for 24/25, and continue to complete deep dives to understand the challenges.
- The main area for breaches in July was in Urology which had 50% of the overall breaches. Main area of concern was delays in Template Biopsies, high patient choice delays and Radiology/Histology delays

Key Actions:

- Urology team reviewing a move towards Biparametric (bp) magnetic resonance imaging (MRI) which can shorten the pathway along with ensuring that the ring-fenced Radiology lots for cancer are utilised correctly by both the specialty and imaging.
- Continued deep dives focussing on specialties struggling to meet performance targets to understand issues and develop action plans.

Improvements:

- Two new consultant Histopathologists joined the department in July and are a great addition to the team. Further recruitment planned to increase our substantive workforce.
- Improved process and the implementation of a Standard Operating Procedure [SOP] has been agreed to manage the validation and data submissions of key cancer data to national registries to provide earlier indications of performance and help manage the cancer action plan internally.
- The Trust's over 62 day backlog position is now below the local agreement of 70, with less patients at risk of tipping over this threshold.

What the charts tell us

62 day Treatment Standard: The Trust's performance was 58% against a target of 85%.

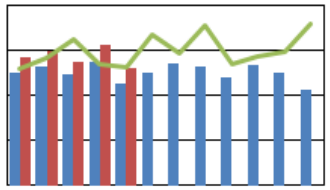
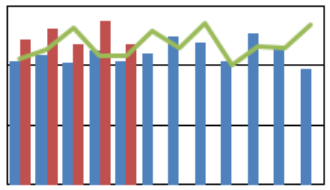
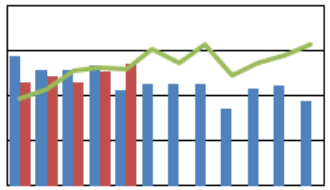
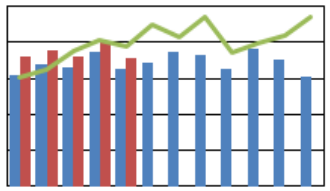
Risks

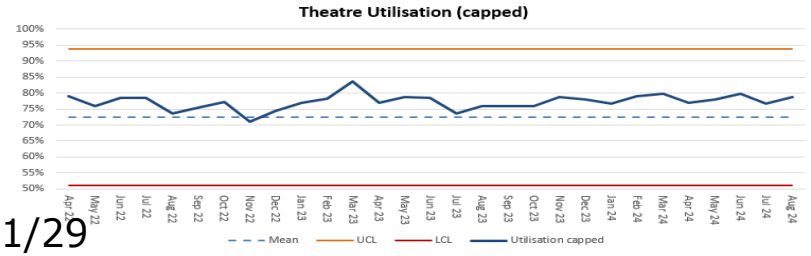
Contractual issues with Gloucestershire Hospitals NHS Trust mean we are unable to deliver robotic prostate surgery at WVT currently. This is being escalated and discussed at COO and Head of Contracting level in October

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 Trust's agreed plans as part of the annual Business Planning process with commissioners

Outpatient Activity		Year To Date	Charts
New	2019/20	25309	
	Plan This Year	28009	
	This Year	28673	
	Diff vs 19/20	3364	
	Variance	13%	
	Diff vs Plan	664	
	Variance	2%	
Follow Up	2019/20	53153	
	Plan This Year	56804	
	This Year	62681	
	Diff vs 19/20	9528	
	Variance	18%	
	Diff vs Plan	5877	
	Variance	10%	
Admissions		Year To Date	Charts
Elective Inpatient	2019/20	1285	
	Plan This Year	1184	
	This Year	1229	
	Diff vs 19/20	-56	
	Variance	-4%	
	Diff vs Plan	45	
	Variance	4%	
Elective Daycase	2019/20	8386	
	Plan This Year	8971	
	This Year	9271	
	Diff vs 19/20	885	
	Variance	11%	
	Diff vs Plan	300	
	Variance	3%	



Performance & actions

Activity Summary

- New Outpatients [OP] Year to Date [YTD] activity was 2% ahead of plan
- 42.6% of OP were either new or a follow-up patients with a procedure. 49.8% for RTT pathways for August 24
- Elective inpatient was 4% above plan YTD/Elective Day Cases was 3% above plan YTD at end of August 24.

Long Waiting Patients

- Nine English patients and two Welsh patients were waiting greater than 78 weeks at the end of August 24.
- 65 week position at the end of August was 99 English and 32 Welsh patients.
- Our 65 weeks end of September risk cohort patients that are undated has reduced from over 1000 in June to 43 patients by the 14th September.

Our current prediction for the end of September is that we will have 50 English 65 week waits and 32 Welsh patients with five English patients waiting greater than 78 weeks: three awaiting cornea tissue replacement; and two awaiting Orthopaedic surgery which were cancelled last week due to significantly increased trauma. The biggest risk areas remain with Orthopaedics and Ophthalmology. We continue to manage our Theatre capacity dynamically to increase capacity for high risk specialties, mutual aid across the Region and Foundation Group and use of the Integrated Care Boards [ICB] contracts with Independent providers in order to reduce the number of long waiting patients further.

Productivity

- The average number of cases per theatre list has improved to 3.5 in July and continued to increase last month with August's average at 3.7 (compared to 3.1 August 2023).
- The total number of patients treated last month through Theatres, continues to increase alongside continued theatre closures last month. Last month the specialties treated 687 patients, up 145 on August 2023 with this being driven largely by change in theatre templates and focussed work on increasing no of patients per list.
- Theatre utilisation improved against last month to 78.7% and an improvement against August 2023 of almost 3%
- In August the first two weeks of the month saw our Value Weighted Activity [VWA] at 137% of 2019/20 activity. This is based on, not just activity number, but complexity and treatment. The Regional average for the same period was 110%

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 charts tell us

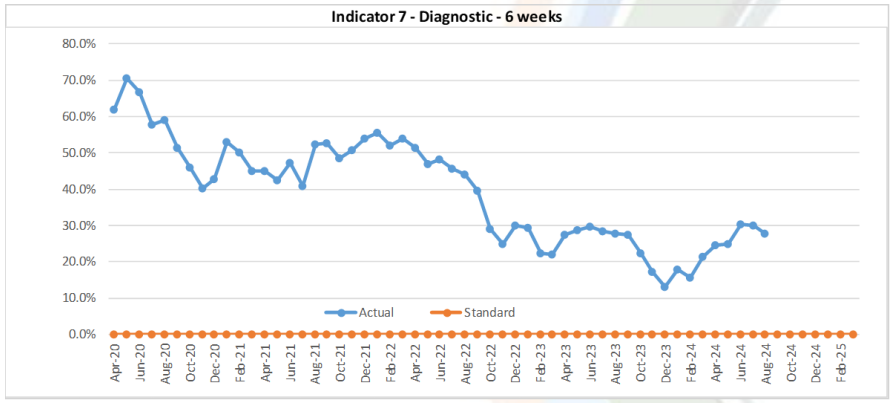
Performance against English RTT standard in July was 55.6%;
Performance against the Welsh RTT standard in July was 69.4%

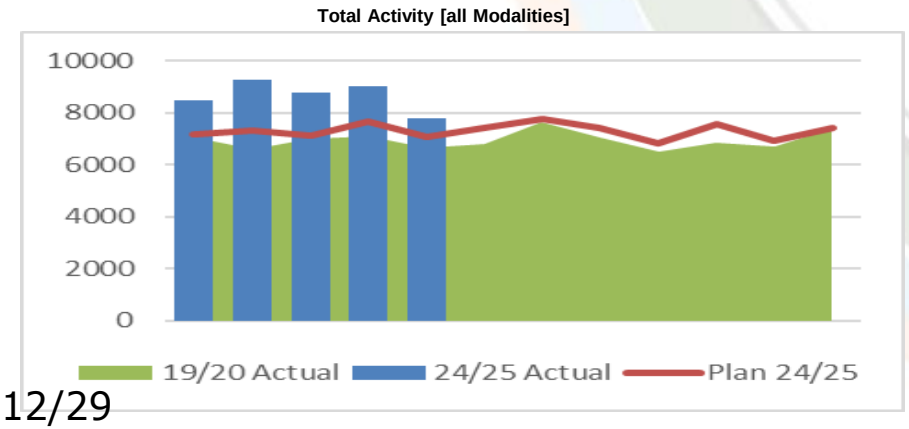
Operational Performance – Diagnostic Performance

We are driving this measure because:

Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] 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 weeks. 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 weeks for a diagnostic 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 & actions

Overall, Diagnostics delivered 110% of August`s activity plan and 118% of the same month 2019/20

Imaging

- Magnetic Resonance Imaging [MRI] achieved 158% of 2019/20, 111% of 2024/25 plan activity last month (156% and 115% respectively month prior).
- Computerized Tomography [CT] achieved 125% of 2019/20 and 101% of 2024/25 plan activity last month (142% and 104% respectively month prior).
- Non-Obstetric Ultrasound [NOUS] achieved 110% of 2019/20 and 112% of 2024/25 plan activity last month. (121% and 122% respectively month prior).
- Overall, Imaging`s 6 week wait position at end of month was 86% compared to 82% month prior. Currently zero CT waiting >13 weeks. 14 MRI >13 week, significant improvement from month 4, with a trajectory of zero by end of month 5.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] were 6 and 9 days respectively.
- Average report turnaround times for MRI prostate and CTC was 2 days.

Audiology

- Audiology 6 week wait position deteriorated in month 5 to 80.1% in adult services, whilst paediatrics was at 30%.
- Audiology patients waiting >13 weeks (driven by Paeds) were at 50 at the end of August compared to 57 the month prior. A locum Paediatric Audiologist has been sourced and will commence a 2-week trial shortly. A paper proposing an insourcing solution is being drafted, together with a recruitment plan to improve the sustainability of the service. The aim is to reduce the 13 week backlog to zero by the end of October.

Echocardiography [Echos]

- Activity for Echos was at 134% of 2024/25 plan.
- Additional insourcing commenced, average increase of 50 patients seen per week started in August. All patients over 13 weeks dated. We have the capacity to see all patients over 13 weeks by end of September which we are working on, however there will be some patients booked for October due to patient choice.
- Operational trajectory aims to clear the 6 week backlog cleared by December this year.

Risks

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

What the charts tell 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 Summary

Geoffrey Etule
Chief People Officer

The 2024 NHS Staff Survey is now live and we are encouraging all employees to complete the Survey. Through feedback received over the past few years we have made significant investments to improve employee wellbeing, education, training and the working environment for everyone.

Junior doctors (now called resident doctors) have accepted the pay offer of 22% over 2 years from the government but the RCN have announced that nurses have rejected the pay offer of 5.5%. This could lead to industrial action over the coming months if no agreement is reached.

Sickness absence has dropped to 4.7% from 5.1% and the main reasons for sickness absence are mental health conditions, gastro issues and flu. We will be part of a national NHS wide study on sickness absence in 2025/26 and our OH team has been successful in retaining its NHS Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation for another 5 years. Our OH team are leading the flu vaccination campaign and we are actively promoting this and encouraging staff to be vaccinated. Working with Taurus, the OH team will also be supporting onsite health checks for staff.

Staff turnover remains below 10% (currently 9.8%) and HR teams are actively engaged in divisional recruitment & retention working groups to ensure that appropriate actions are being implemented to retain staff and maintain low turnover. Turnover for qualified nurses & midwives remains low at 7.66% but staff turnover for band 2 HCSW staff has increased to 15.97%. We have reintroduced the centralised recruitment process and are reviewing our pastoral care, induction and training in place for support staff. A deep dive is being conducted in the medical division considering the high number of support worker vacancies.

Active work continues to fill our vacancies through ongoing international recruitment and engagement with international recruitment agencies. We are on track to employ 77 new international nurses by March 2025 and this is having a positive impact in reducing agency expenditure.

We promoted National Inclusion week and we will be promoting Black History month to show support to our BME colleagues and our ongoing commitment to equality, diversity & inclusion. We will also be promoting Freedom To Speak Up month in October to raise and maintain awareness about the benefits of employees speaking up on areas of concern so prompt actions can be taken.

In view of supporting career development and to raise awareness of CPD opportunities for staff, the University of Worcester will be holding its first Open Day event at the County Hospital site on 25 October.

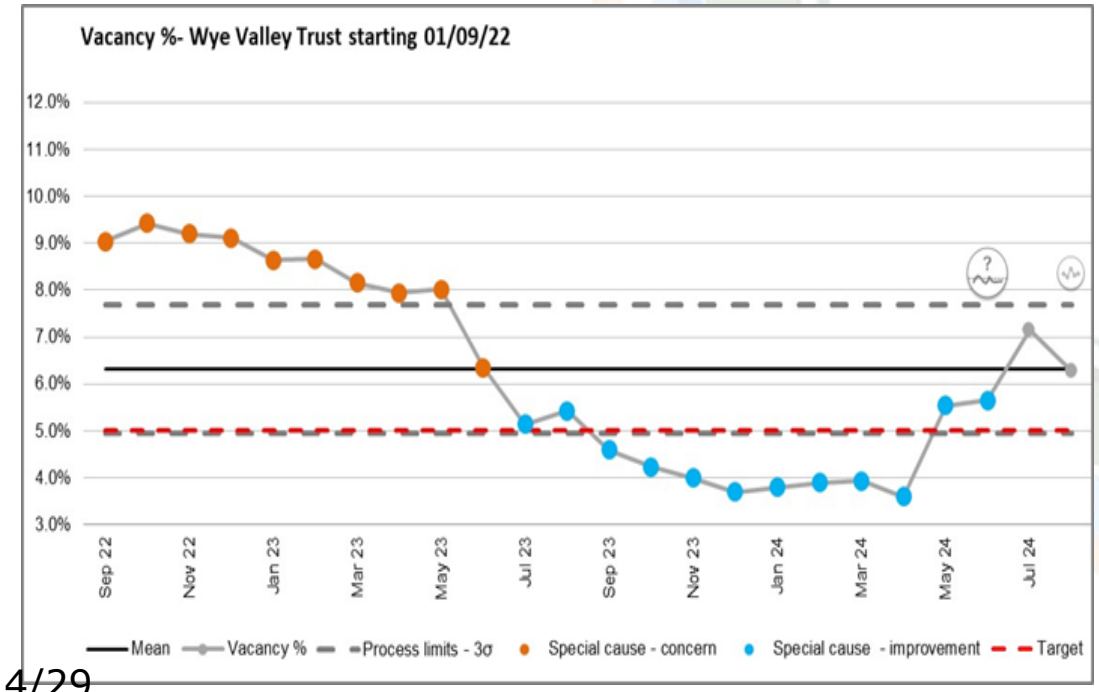
Workforce Performance – Vacancies

We are driving this measure because:

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

Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
5.4%	4.6%	4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%

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 & actions

HCSW: with an increase in vacancies (85 fte following increases in budgets) we have re-introduced the centralised recruitment process and are reviewing the pastoral care, induction and training being provided to support staff. A deep dive is being conducted in the medical division as we have a number of vacancies in AMU, Lugg, Ashgrove, Garway. 20.68 fte new support staff will be joining WVT over the next 4 to 8 weeks.

N&M: we currently have 28.13 fte vacancies (with 50 offers made) and we are on target for our international recruitment nurse programme as we will have welcomed 41 new nurses into the Trust at the end of September. We are also looking at alternative overseas work streams with Worcester University as there are international nurse students graduating in September and February 2025 where we could offer job opportunities at WVT.

M&D: through fortnightly meetings with the CMO, Medical Staffing Manager & Strategic Medical HR Lead, we are reviewing progress with vacancies and cases of concern. Overseas recruitment of medics to continue throughout 2023/24. We currently have 51.89 fte vacancies.

CDC: the recruitment programme is on track and 31.78 fte clinical staff have been recruited to-date. International and local recruitment is ongoing.

Pharmacy: actions in place including international recruitment, advertising all jobs as open to flexible working, highlighting opportunities for personal and career development are having a positive impact in recruiting & retaining staff.

Working with external partners (ICS leads, DWP, University, recruitment agencies) we have extended our recruitment events and we are promoting our vacancies through social media and different platforms. We are running events Herefordshire wide and are also extending WVT presence at regional and national fairs to promote our job opportunities.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the charts tell 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. There was a decrease in April 24, before an increase in the next 3 months, large increase in July 24 due to the Elective Surgical hub business case before a decrease last month with the opening of the hub.

Workforce Performance – 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 staff.

Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
10.9%	10.9%	10.6%	10.6%	10.3%	10.1%	10.1%	9.2%	9.0%	9.2%	9.4%	9.5%	9.8%

Assurance	Variation	Data Quality Mark
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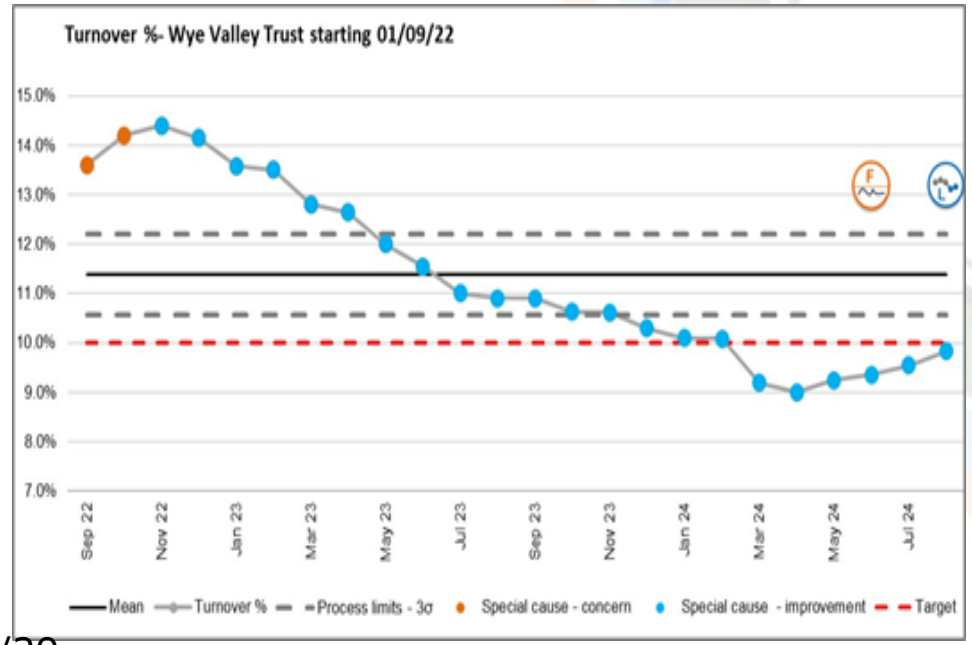

Performance & actions

The overall rolling 12 month turnover at Trust level is at 9.8% and we are taking steps to ensure this stays below 10.0%.

Clinical support workers at band 2 level have the highest turnover rate at the Trust (15.97%) and this is still the case across the NHS. We have reintroduced the centralised recruitment process and are reviewing pastoral care and training being provided.

Turnover rates for qualified nurses remains steady at 7.66% and Divisional teams are using a variety of flexible working options and development opportunities to retain staff.

Through Divisional recruitment & retention working groups, HR and line managers review and analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group continues to oversee 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.

Risks

Growing staff turnover

What the charts tell us

The rolling 12 month position shows a decreasing trend in the last 12 months. An improved position present in March and April 24 due to now removing retire and returnees, with an increase in the last 4 months.

Workforce Performance – Sickness

We are driving this measure because:

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

Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
4.6%	5.1%	5.9%	5.4%	5.6%	6.0%	5.6%	4.8%	4.6%	4.6%	4.8%	5.1%	4.7%

Assurance	Variation	Data Quality Mark
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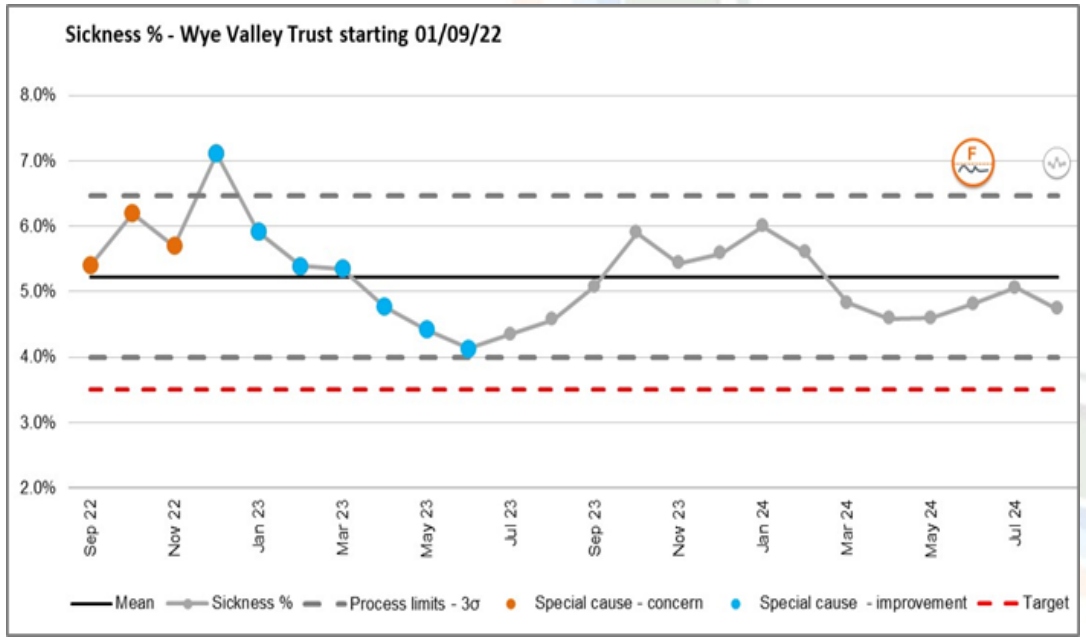


Performance & actions

During this month, overall sickness at Trust level has decreased to 4.7%, which is lower compared to a rolling 12 month average sickness of 5.2%.

The main reasons for absence are mental health conditions, gastro issues, colds/flu and long term conditions.

At F&PE meetings, Divisions provide comprehensive data on sickness absence which includes heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

HR teams will continue to sensitively support the management of long and short term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, and more psychological and team based wellbeing support for staff. The wide range of health & wellbeing initiatives (Halo wellbeing clinics, 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.

WVT will be participating in an NHS wide study looking at ways to reduce sickness absence in 2025/26.

Risks

What the charts tell us

Sickness absence remains above 4% at the Trust and NHS wide.

Our Finance– Executive Summary

Katie Osmond
Chief Finance Officer

Month 5 Income and Expenditure position

Overall Month 5 has resulted in a YTD adverse variance of £3.8m against the revised deficit plan, largely driven by an underperforming CPIP programme.

The Month 5 position resulted in an overall YTD deficit of £18.8m. This was behind the current planned deficit of £15m, with an overall adverse variance of £3.8m. Recognising the large challenge facing the organisation, a Financial Recovery Board (FRB) has been established. The FRB will focus on the identification and delivery of CPIP as well as driving improved financial performance using existing programmes and projects. The Trust also provides significant focus on the financial position through monthly Finance and Performance Executives meetings targeting delivery of existing plans and identification of mitigations.

At Month 5 YTD, planned pay costs are unfavourable to budget by £2.2m, (a deterioration of £0.6m in month), non-pay £1.8m (a deterioration of £0.3m in month) and excluded drugs of £0.7m. These were partially offset by additional income of £1.6m, mainly achieved through an over performance in ERF and contractual gains. The primary reason for expenditure related overspend relates to the under delivery of CPIP (£3.6m YTD). The majority of the variance relates to planned CPIP schemes that remain in the opportunity / unidentified phase, requiring further action to result in deliverable schemes — these are now further examined in Check and Challenge meetings with Divisions as part of the FRB.

Outside of CPIP, there is also a £0.9m 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 currently includes unmitigated risks relating to the £5m unidentified element of CPIP, £2m relating to the technical PFI adjustment and £6m of out of system income risk for which national support is required. Therefore it is even more critical the Trust continues to monitor and reduce spend and deliver on plan.

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 £0.2m 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 £6.7m 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 however as cash support will be required in Q3, the Trust will make an application to NHSE for revenue PDC support. This can't exceed the planned deficit. It is more difficult to access additional cash support where the requirement is driven by being off-plan.

Finance Performance – 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 5 - 31st August 2024 - 2024/25

	2024-25 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	284,592	116,322	116,701	379	(801)
Excluded Drugs	12,801	5,334	5,782	448	266
Non Contracted Activity (NCA's)	1,714	714	749	35	(0)
Other Income for Patient Care	9,911	4,308	4,448	140	407
Donations For Non Current Assets	4,168	3,074	3,074	0	0
Other Non Patient Income	7,409	3,078	3,091	13	76
Elective Recovery Fund	6,723	2,289	2,913	625	625
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**327,317**	**135,120**	**136,760**	**1,640**	**572**
Pay Expenditure	215,225	89,096	91,276	(2,180)	(637)
Non Pay Expenditure	91,127	37,298	39,057	(1,759)	(272)
Excluded Drugs	23,933	9,972	10,730	(758)	(162)
Total Operating Expenditure	**330,285**	**136,367**	**141,063**	**(4,697)**	**(1,071)**
EBITDA	**(2,968)**	**(1,247)**	**(4,304)**	**(3,057)**	**(499)**
Depreciation	14,130	5,928	5,801	127	33
Gain or loss on asset disposal	5,141	0	0	0	0
Interest Receivable	1,212	803	803	(0)	0
Interest Payable on Loans	262	109	77	32	4
Interest Payable on PFI	1,993	830	830	0	0
Dividends on PDC	4,244	1,657	1,657	(0)	(0)
Operating Surplus/ (Deficit)	**(27,526)**	**(8,969)**	**(11,867)**	**(2,898)**	**(462)**
Donated Assets Adjustment	3,335	2,728	2,727	(0)	1
Net impact of asset impairments	(5,141)	0	0	0	0
IFRS16 2425 PFI re-measurement adjustment	(2,490)	0	0	904	143
Impact of IFRS16 Implementation of PFI Contract	8,214	3,306	4,210	0	0
Adj. financial performance retained Surplus/ (Deficit)	**(31,443)**	**(15,003)**	**(18,804)**	**(3,802)**	**(605)**

Performance & actions

The position at the end of Month 5 (August) was a deficit of £18.8m. This was behind the current plan with an overall adverse variance of £3.8m.
Income shows a positive variance of £1.6m Within this, £0.6m is in relation to ERF over performance, £0.4m for excluded drugs/devices, £0.9m contract income gains, offset by (£0.3m) other risk.
Pay was overspent overall due to undelivered CPIP, use of temporary staffing, 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 — 5.33% of total pay costs in month which is a decrease from 6.4% in the previous month. Medical bank use at premium rates further increases this to 9.23% of overall pay, driven by volume and price.
Non Pay overspend of £2.4m 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 £0.9m 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 £6m 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 agreed and received
- Change in performance adjustment regarding PFI accounting

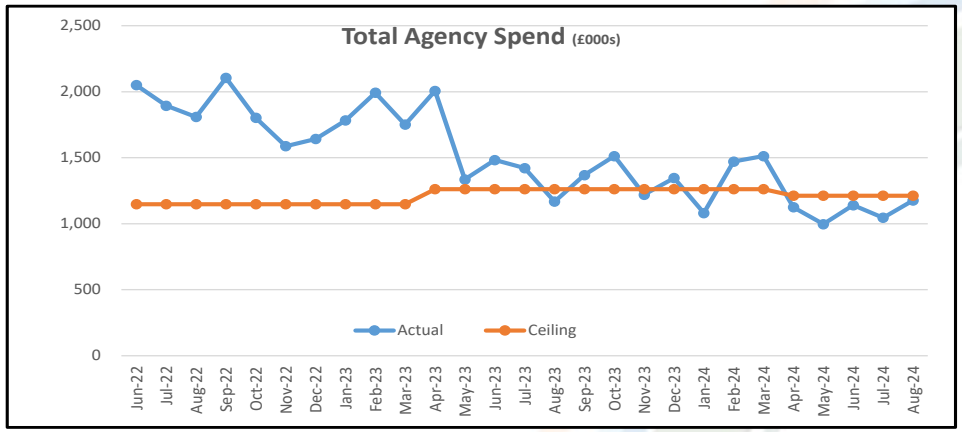
What the chart tells us

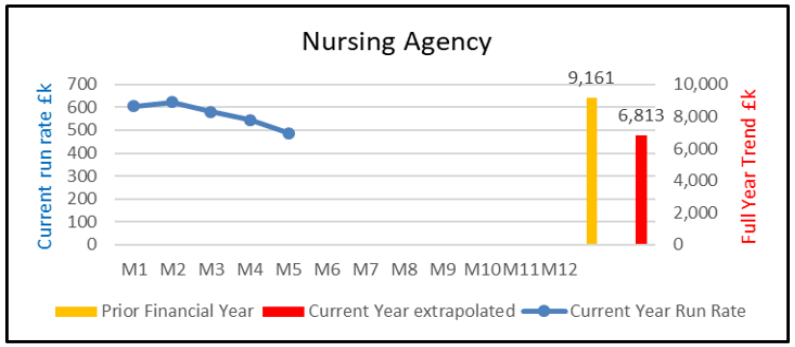
Known financial risks are putting greater pressure on delivery of our planned financial position.

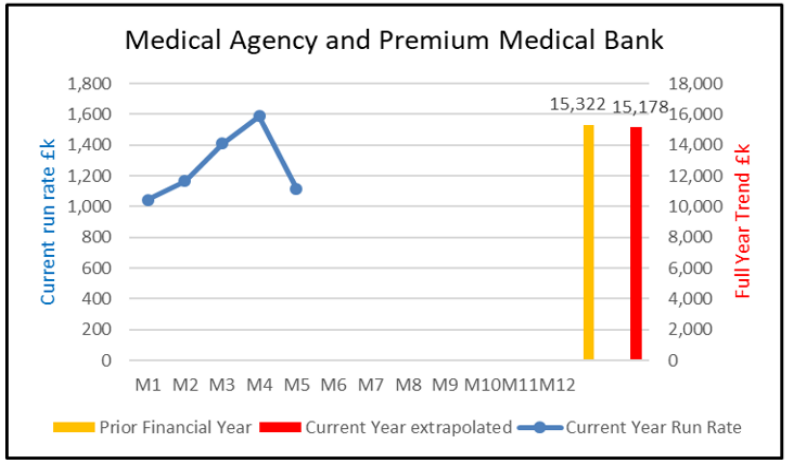
Finance Performance – Agency Spend

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 & actions

Agency represents 5.3% of total pay costs year to date, 2.1% 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 £5.3m. 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. NARP target for 2425 is a £4m reduction in spend from 2324 (totalling £9.2m) which leads to a target spend in 2425 of £5.2m. YTD spend extrapolated to full year would result in a projected full year spend of £6.8m. 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. Bank and Substantive performance will also need monitoring to ensure costs elsewhere are not offsetting the good performance see in agency reduction.
- **Off framework Nurse Agency:** there has been a significant reduction in off framework use with only three shifts booked again in August, and a total of 39 shifts YTD. This is a significant reduction on the level of 23/24 booking.
- **Medical staffing agency and premium cost bank:** Significant decrease in bank and agency spend in M5 due to the recruitment of a Temporary Staffing Coordinator enhancing governance and control measures for medical staffing bookings. The Trust spent £14.2m 2223 and £15.3m in 2324, with 2425 target spend being £11m. The current extrapolated trend for 2425 is £15.2m demonstrating that the downward trend needs to continue to address the initial increased spend trend in year. Substantive staffing has increased in month suggesting a continuing saving in bank and agency.

Risks

Level of Agency (% of pay)

Increased workforce gaps resulting in greater requirement for temporary workforce.

Supply and Demand price pressures

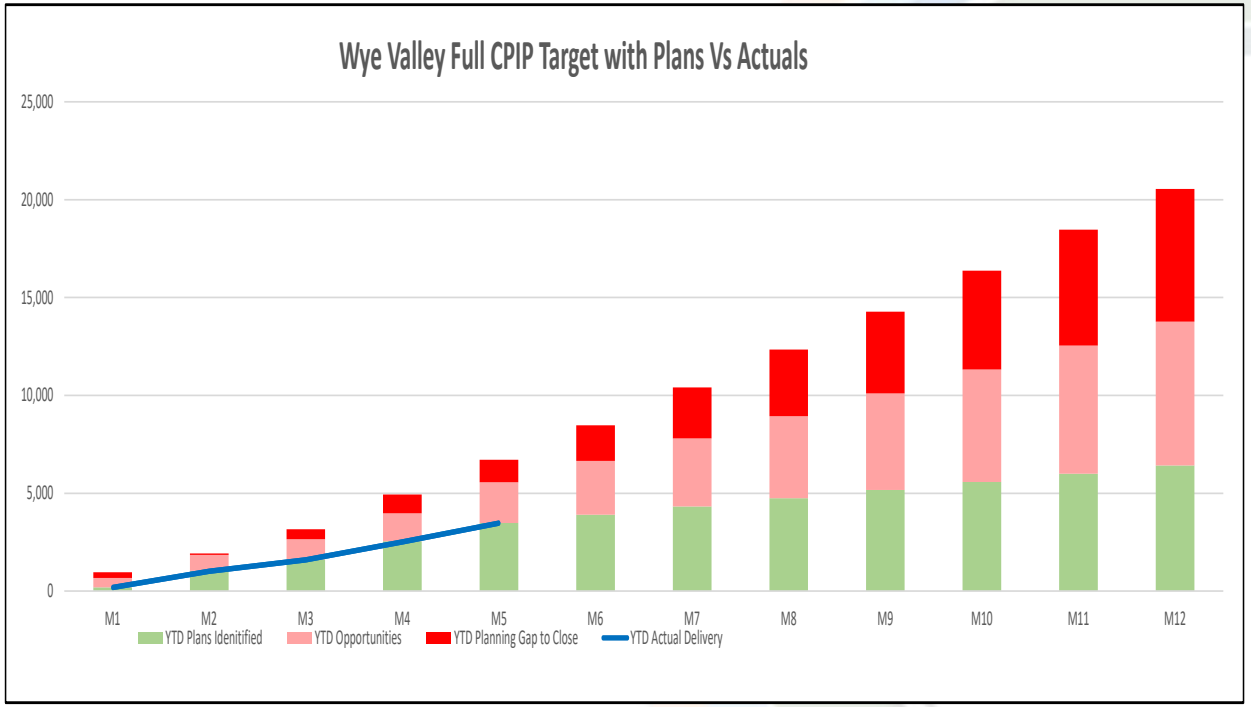
What the charts tell us

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.

Finance Performance – 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 & actions

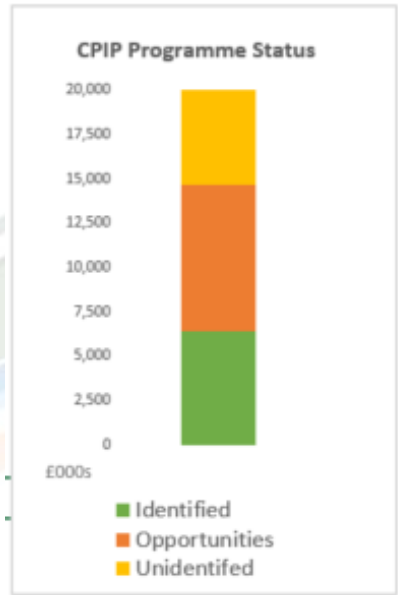
The £20.6m target breaks down into two areas: £19.4m cost out efficiency (of which £4.4m relates to 2324 NR items, of which we are targeting a £8.0m agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

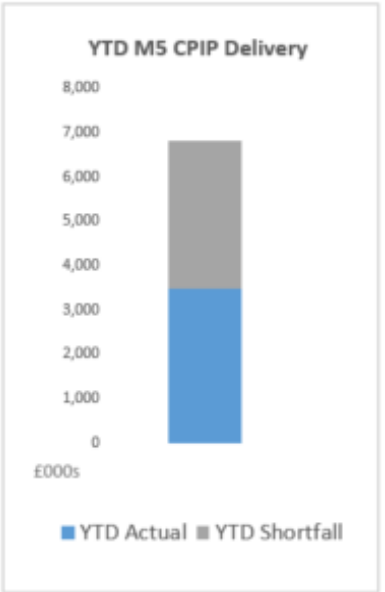
The current position on CPIP delivery YTD reflects a plan of £7.1m with a Trust delivery of £3.5m resulting in a £3.6m variance to plan.

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

As at Month 5, the annual total of developed schemes (including MARP & NARP) amount to £13.8m, phased to deliver more as the year develops.

Recognising the large CPIP challenge facing the organisation, a Financial Recovery Board (FRB) has been initiated. The FRB will focus on furthering identification and delivery of CPIP. As part of the FRB, monthly Check and Challenge meetings with Divisions are taking place to specifically focus on identification and delivery of savings schemes.





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

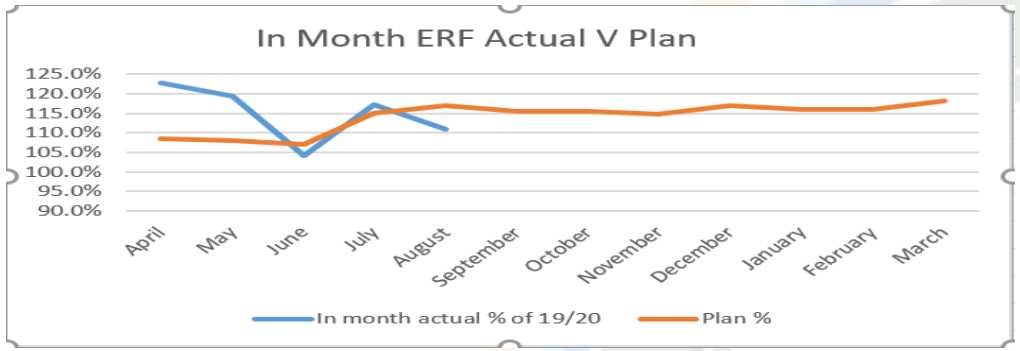
What the charts tell us

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

Finance Performance – Productivity Improvement

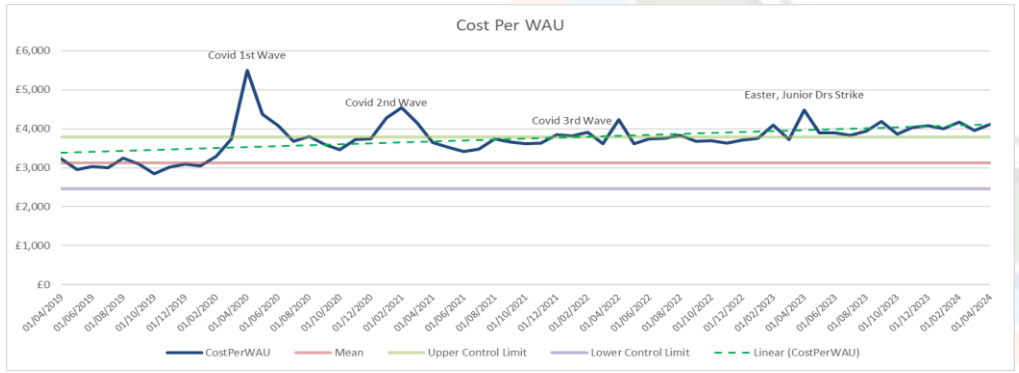
We are driving this measure because:

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



19/20 baseline V 24/25 actual

	April	May	June	July	August
1920 BASELINE	£3,435,906	£3,633,579	£4,122,573	£3,893,721	£3,736,037
24/25 plan	£3,726,461	£3,924,133	£4,413,213	£4,477,156	£4,369,471
2045/25 Actuals	£4,221,451	£4,339,096	£4,296,242	£4,562,615	£4,145,877
24/25 Plan as % of 19/20	108.5%	108.0%	107.0%	115.0%	117.0%
In month actual % of 19/20	122.9%	119.4%	104.2%	117.2%	111.0%
YTD actual % of 19/20	122.9%	121.1%	114.9%	115.5%	114.6%



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 & 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 reflects performance of 110% in month but YTD (of 114% of 19/20 activity (see chart). For Gloucestershire, Shropshire and Specialised Commissioning we have continued to use national data.

We have undertaken analysis of income at a specialty level and further work is ongoing to understand the implications of this. In addition H2 activity reviews are commenced 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 underachievement of ERF. Non budgeted spend to achieve the elective activity

Mitigation - Close monitoring of activity performance and productivity.

What the charts tell us

Despite the significant operational challenges activity levels are recovering and are above target and planned level. Whilst some productivity initiatives have started to deliver, we are not yet seeing the overall level of productivity required.to improve the WAU.

Finance Performance – 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	157	0	157	476	0
ICT - Hardware	Owned	782	160	4	156	800	(18)
ICT - Software	Owned	52	12	0	12	52	(0)
Clinical Equipment	Owned	0	0	0	0	0	0
Estates Works	Owned	797	340	54	286	684	113
ESH 2324 Underspend	Owned	615	615	615	0	615	0
CDC 2324 Underspend	Owned	1,408	512	1,214	(702)	1,408	(0)
Clinical Equipment	Owned	343	100	22	78	313	30
ESH - Local Funding	Owned	2,924	500	0	500	1,037	1,887
CDC - Phase 2 initial funding	Owned	0	0	0	0	170	(170)
23/24 Cfwd	Owned	0	0	483	(483)	483	(483)
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*0*	*(924)*
System Capital Over-commitment	*Owned*	*(633)*	*(166)*	*0*	*(166)*	*(196)*	*(437)*
Total - Local CDEL funded		**5,840**	**2,230**	**2,392**	**(162)**	**5,841**	**(1)**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	3,988	2,861	1,127	10,972	0
Donated assets	Owned	240	60	0	60	240	0
Clinical Equipment	Owned	33	0	0	0	33	0
Total - Grant funded and Donated		**11,245**	**4,048**	**2,861**	**1,187**	**11,245**	**0**
National funding							
Clinical Diagnostics Centre	Owned	11,352	4,140	0	4,140	11,352	0
Imaging PDC	Owned	0	0	0	0	415	(415)
ESH - PDC Funding	Owned	2,161	2,161	1,449	712	2,161	(0)
ICT - Clinical Systems	Owned	750	172	30	142	1,750	(1,000)
Total - National PDC schemes		**14,263**	**6,473**	**1,479**	**4,994**	**15,678**	**(1,415)**
Leases							
Vehicle	Lease	10	3	0	3	10	0
Clinical Equipment	Lease	400	94	3	91	398	2
Total - IFRS16 Leases		**410**	**97**	**3**	**94**	**408**	**2**
Total Capital Programme		**31,758**	**12,848**	**6,736**	**6,112**	**33,173**	**(1,415)**

Performance & 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 further mitigated down this month to £196k as savings on ESH flow through.

Changes on last month
The forecast has increased to include £415k of national PDC funding for Diagnostics. £170k has been realigned from locally funded schemes to develop Phase 2 CDC.

Variance - Year to Date
Expenditure on schemes scoring against local CDEL is slightly 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. Options to vest larger items of CDC equipment are being explored.

Variance - Full Year
£1m of variance to plan is funded via FLD with a further £415k variance relating to the new Diagnostics national funding approved. 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 risk relating to the over-commitment against capital resources has reduced this month.

Financing Risk
£3.484m of system capital PDC is required to part-fund local capital schemes. An application has been submitted to NHSE but it is not yet approved.
£1,750k FLD - National PDC programme has been confirmed but final plan sign off and an MOU is yet to be received to enable the cash to be drawn

What the chart tells us

The Capital forecast is broadly in line with plan apart from the additional allocations of national funding for FLD and Diagnostics.

Finance Performance – Cash

We are driving this measure because:

The financial performance of the Trust, both in I&E and revenue have a direct impact on the Trust's 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
June	23.0	28.1		
July	21.7	30.2		
August	18.5	27.4		
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				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
June	98.6%	95.0%		
July	99.3%	95.0%		
August	99.3%	95.0%		
In August, the Trust paid 99.3% of invoices within 30 days. This equates to 87% by invoice value. This is the eigth 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 & 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.

Cash support is forecast to be required for the first time this year during Q3. During September, the Trust will be submitting an application to NHSE for £26m of revenue PDC to meet the operating cash requirements to the end of December.

The cash funding to cover the October backdated pay award is still unclear.

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 Trust's 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.
- Continued escalation of the requirement for cash backing to support the October back-dated pay award.

What the chart tells us

The month end cash balance is reducing, which is as expected due to being in deficit YTD.
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.

Finance Performance – Statement of Financial Position

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.

Statement of Financial Position

August 2024	2023/24	2024/25			2024/25 Full Year		
	Accounts £000s	M5 Plan £000s	M5 YTD £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	151,182	159,777	154,769	5,008	167,117	167,117	0
Intangible Assets	14,359	12,735	11,707	1,028	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	408	408	0
TOTAL Non Current Assets	**165,949**	**172,920**	**166,898**	**6,022**	**178,445**	**178,445**	**0**
CURRENT ASSETS:							
Inventories	4,878	4,878	4,950	(72)	4,878	4,878	0
Trade and Other Receivables	35,635	25,156	28,317	(3,161)	28,856	28,856	0
Cash and Cash Equivalents	26,228	27,447	18,482	8,965	27,447	27,447	0
TOTAL Current Assets	**66,741**	**57,481**	**51,749**	**5,732**	**61,181**	**61,181**	**0**
TOTAL ASSETS	**232,690**	**230,401**	**218,647**	**11,754**	**239,626**	**239,626**	**0**
CURRENT LIABILITIES							
Trade and other payables	(37,101)	(39,045)	(39,153)	108	(37,275)	(37,275)	0
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(8,282)	(4,411)	(12,693)	(12,693)	0
Provisions	(192)	(192)	(46)	(146)	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(51,930)**	**(47,481)**	**(4,449)**	**(50,160)**	**(50,160)**	**0**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**5,551**	**4,268**	**1,283**	**11,021**	**11,021**	**0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**178,471**	**171,166**	**7,305**	**189,466**	**189,466**	**0**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(53,916)	(47,305)	(52,853)	5,548	(42,935)	(42,935)	0
Provisions	(1,619)	(1,619)	(1,755)	136	(1,619)	(1,619)	0
Total Non-Current Liabilities	**(55,535)**	**(48,924)**	**(54,608)**	**5,684**	**(44,554)**	**(44,554)**	**0**
ASSETS LESS LIABILITIES	**127,165**	**129,547**	**116,558**	**12,989**	**144,912**	**144,912**	**0**
TAXPAYERS EQUITY							
Public dividend capital	306,421	317,185	307,680	9,505	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)	(209,685)	(209,229)	(456)	(228,829)	(228,829)	0
TOTAL	**127,165**	**129,547**	**116,558**	**12,989**	**144,912**	**144,912**	**0**

Performance & actions

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

Non-Current Assets
Non-Current assets are £6m lower than plan due to the capital programme being behind plan (see capital section, above).

Working balances
Net working balances (receivables less payables) have improved with debtors increasing by £3m compared to plan. This, together with the underspend on capital, have a positive effect on the cash position. Cash and cash equivalents are however, lower than planned levels due to lower drawings of PDC and the deficit being £4m worse than planned.

Borrowings
The total movements in borrowings, across current and long-term balances (plan versus actual) differ, by £1m, due to accounting of the phasing of the PFI liability repayments between plan and actual.

Taxpayers Equity
PDC is lower than plan as less additional PDC has been drawn because of slippage in our capital programme and revenue cash support not being required so far.
The revaluation reserve has reduced, reflecting a correction between this and the I&E reserve identified during the year end audit.
The income and expenditure reserve also reflects the YTD deficit.

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.

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High		72.9%	72.4%	78.6%	80.8%	79.0%	77.3%	77.1%	77.0%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause		88.3%	90.1%	96.9%	95.8%	86.9%	93.4%	88.4%	87.8%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		90.5%	95.8%	83.3%	79.3%	47.6%	32.1%	20.0%	48.4%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	73.8%	69.1%	80.8%	89.2%	84.8%	85.5%	90.7%	88.2%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause		8	12	4	12	14	11	10		
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Concern - Low	Yes	59.2%	51.7%	71.1%	63.0%	64.5%	75.7%	76.6%	53.5%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		100.0%	60.0%	100.0%		80.0%	100.0%	100.0%	83.3%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		73.9%	48.1%	76.9%	61.8%	72.4%	63.3%	65.5%	68.1%	
	Cancer: number of urgent cancer patients waiting over 62 days	Cancer			Common Cause					71	72	93	85	93	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		107.1%	121.7%	115.1%	102.8%	112.6%	113.8%	100.9%	114.6%	
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low	Yes	91.1%	90.0%	89.7%	90.3%	87.0%	84.7%	85.6%	86.8%	87.0%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		103.0%	103.4%	109.3%	104.3%	107.7%	107.4%	99.6%	100.0%	102.2%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause	Yes	73.6%	64.4%	65.8%	71.4%	73.3%	72.7%	66.4%	65.8%	75.9%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		13.2%	20.1%	17.0%	12.2%	10.2%	10.5%	15.4%	18.7%	14.5%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		113.9%	116.8%	123.3%	119.5%	114.4%	111.6%	112.2%	113.6%	115.2%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		41.0%	43.0%	46.0%	45.0%	46.2%	46.9%	47.4%	46.2%	42.2%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	53.6%	53.2%	54.9%	65.5%	68.8%	68.1%	66.4%	68.3%	67.6%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Common Cause	Yes	17.3%	19.1%	16.9%	12.2%	11.9%	11.7%	12.3%	12.4%	10.8%
	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		1.8%	1.7%	1.7%	1.7%	1.8%	1.8%	2.0%	1.9%	1.9%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		230	305	306	250	292	318	291	330	312
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		8.7%	7.7%	8.5%	8.2%					

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		57.9%	57.2%	56.3%	55.4%	54.5%	55.6%	55.8%	55.7%	55.6%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		65.5%	66.8%	67.6%	68.3%	67.8%	68.2%	70.0%	70.3%	69.4%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care			Improvement - High		27031	26837	27256	27780	28130	28574	29179	28848	28708
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Concern - High	Yes	1636	1446	1287	1152	1171	1198	1285	1140	1169
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		16	7	16	9	6	13	15	14	14
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		3	1	1	0	1	2	3	1	3
	GP Referrals	Elective care			Common Cause	Yes	97.7%	104.1%	119.6%	134.4%	115.6%	102.9%	90.8%	102.0%	86.1%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care			Improvement - High		100.6%	111.5%	116.0%	129.1%	113.4%	113.7%	110.7%	114.1%	114.6%
	Outpatient Activity - New attendances (volume v plan)	Elective care			Common Cause	Yes	121.2%	114.3%	112.6%	83.4%	110.0%	106.1%	85.1%	115.2%	98.8%
	Total Outpatient Activity (% v 2019/20)	Elective care			Improvement - High		101.2%	109.3%	109.2%	123.8%	115.9%	118.4%	114.2%	119.3%	113.8%
	Total Outpatient Activity (volume v plan)	Elective care			Improvement - High	Yes	132.6%	126.2%	120.0%	89.3%	113.2%	112.4%	88.3%	123.0%	105.6%
	Total Elective Activity (% v 2019/20)	Elective care			Improvement - High		91.5%	98.9%	106.5%	121.0%	112.5%	110.4%	98.9%	102.1%	104.3%
	Total Elective Activity (volume v plan)	Elective care			Common Cause	Yes	112.2%	103.8%	112.6%	83.9%	119.2%	112.7%	86.0%	100.7%	90.7%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause		77.8%	76.7%	79.0%	79.8%	77.2%	77.9%	79.7%	76.9%	78.7%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care			Common Cause		31	65	36	31	32	24	39	42	40
	Diagnostic Activity - Computerised Tomography	Elective care			Improvement - High		119.4%	124.9%	111.0%	107.5%	111.8%	126.5%	129.5%	104.0%	100.7%
	Diagnostic Activity - Endoscopy	Elective care			Improvement - High	Yes	158.0%	142.8%	150.3%	99.3%	130.4%	98.1%	76.6%	156.2%	126.9%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care			Improvement - High		148.0%	113.6%	95.3%	148.8%	120.5%	130.6%	119.2%	115.1%	111.1%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care			Improvement - Low		13.2%	17.9%	15.6%	21.5%	24.7%	24.8%	30.2%	30.0%	27.8%

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Elective care	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Common Cause		92.2%	91.3%	92.1%	93.8%	94.4%	93.9%	90.6%	95.5%	95.1%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause	Yes	23.8%	24.3%	24.3%	19.5%	19.0%	16.0%	16.3%	14.2%	16.3%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Common Cause	Yes	64.9%	63.8%	64.6%	62.9%	60.6%	55.5%	54.7%	54.8%	55.7%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Common Cause	Yes	92.5%	88.4%	88.2%	87.0%	85.5%	87.3%	86.3%	88.5%	88.1%
	Maternity Activity (Deliveries)	Elective care			Common Cause	Yes	95.1%	140.6%	115.0%	99.3%	99.2%	83.9%	113.8%	93.4%	85.6%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Concern - High	Yes	6.9%	6.5%	6.2%	6.0%	6.2%	6.3%	6.6%	6.5%	7.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High		83.6%	83.3%	86.5%	87.0%	86.7%	88.0%	87.6%	88.8%	89.9%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation			Improvement - High		101.5%	108.4%	106.2%	121.5%	117.2%	120.7%	116.0%	121.8%	113.5%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation			Improvement - High	Yes	138.6%	132.2%	123.8%	92.3%	114.8%	115.6%	89.8%	126.9%	108.9%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Fail	Improvement - Low		20.4%	21.1%	19.8%	19.2%	20.2%	20.6%	19.3%	18.8%	18.3%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term			Improvement - Low		8.1%	11.9%	8.8%	6.3%	11.2%	5.3%	10.1%	6.5%	4.1%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	98.6%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		99.2%	89.5%	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		28	24	65	74	54	99	84	70	134
	Patient ward moves emergency admissions (acute)	Safe, high quality care			Common Cause		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		6	7	7	7	6	6	6	6	7
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Concern - High		2	2	3	3	3	2	3	3	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Concern - Low	Yes	21.0%	22.7%	21.4%	18.7%	18.8%	15.3%	14.1%	15.6%	17.1%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Common Cause		43.6%	50.1%	51.6%	50.1%	46.2%	42.6%	47.4%	48.9%	50.1%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low	Yes					4.2%	4.6%	4.6%		

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Safe, high quality care	HSMR - Rolling 12 months	Safe, high quality care	<= 100	Variable	Common Cause	Yes	101	101	100						
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Improvement - Low		102	102	100	98	98				
	Never Events	Safe, high quality care	0	Variable	Common Cause	Yes	0	0	0	0	1	0	0	0	0
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Common Cause	Yes	0	0	1	0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care			Common Cause		2	1	2	2	1	0	0	2	1
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care	44	Fail	Improvement - High	Yes	4	3	3	2	6	6	5	9	10
	Number of falls with moderate harm and above	Safe, high quality care			Common Cause		3	2	2	1	1	4	2	2	3
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Concern - Low		88.0%	87.4%	89.2%	89.3%	89.9%	88.8%	89.4%	88.2%	85.9%
	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		48.1%	53.5%	66.7%	63.0%	64.4%	50.9%	63.2%	74.4%	73.9%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause		0.0%	66.7%	60.0%	33.3%	0.0%	66.7%	20.0%	33.3%	0.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause		90.6%	80.0%	78.0%	83.1%	77.8%	75.0%	78.3%	87.1%	86.4%
	Number of complaints	Safe, high quality care			Common Cause	Yes	24	27	29	38	45	31	30	29	22
	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	Yes	17.6%	34.6%	37.9%	35.3%	44.8%	39.4%	50.0%	53.8%	51.6%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		72.9%	77.0%	75.7%	81.2%	81.0%	81.1%	78.7%	79.3%	79.1%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Concern - Low		82.0%	85.7%	81.7%	88.6%	86.0%	82.7%	84.5%	80.7%	84.2%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		87.2%	96.7%	92.6%	91.3%	96.9%	85.7%	96.6%	94.4%	85.7%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Improvement - High		19.0%	21.0%	21.0%	20.0%	19.0%	19.0%	20.0%	18.0%	20.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		15.0%	18.0%	16.0%	17.0%	18.0%	16.0%	18.0%	15.0%	17.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		31.0%	23.0%	23.0%	16.0%	28.0%	25.0%	24.0%	31.0%	32.0%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		6.1%	7.9%	8.1%	6.0%	5.5%	6.3%	5.5%	5.9%	5.8%
	Appraisals	Looking after our people	>= 85.0%	Fail	Improvement - High	Yes	72.7%	70.6%	71.8%	70.8%	75.9%	79.2%	80.3%	80.2%	80.3%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.0%	88.8%	88.8%	88.4%	89.2%	89.8%	89.7%	89.7%	89.5%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause		5.6%	6.0%	5.7%	4.0%	4.7%	4.6%	4.8%	5.1%	4.7%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		10.3%	10.1%	10.1%	10.4%	9.0%	9.2%	9.4%	9.5%	9.8%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		3.7%	3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Finance	I&E - Surplus/(Deficit) (£k)	Finance			Common Cause	Yes	(£2906k)	(£2430k)	£9902k	(£9316k)	(£3387k)	(£3387k)	(£3387k)	(£4957k)	(£3686k)
	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	(£208k)	(£3427k)	(£3019k)	(£13529k)	(£410k)	(£469k)	(£524k)	(£1793k)	(£606k)
	I&E - Variance from Plan (%)	Finance			Common Cause	Yes	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)	(£0k)
	CPIP - Variance from plan (£k)	Finance			Common Cause	Yes	(£841k)	(£708k)	(£830k)	£906k	(£370k)	(£409k)	(£566k)	(£844k)	(£811k)
	Agency - expenditure (£k)	Finance			Improvement - Low		£1087k	£1482k	£1596k	£1127k	£1069k	£1027k	£1048k	£953k	£725k
	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	£520k	(£2959k)	(£689k)	(£1572k)	(£14k)	£178k	(£522k)	£785k	(£284k)
	Cash - Balance at end of month (£m)	Finance			Common Cause		£24k	£23k	£23k	£19k	£22k	£30k	£23k	£22k	£19k
	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		£0k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	WVT Acute & ED Clinical Staffing
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Trust management Board
Lead Executive Director:	**Chief Operating Officer**
Author:	Shannon Bakan, General Manager Acute & Emergency (Kate O'Shea Interim General Manager ,Acute & Emergency Directorate)
Documents covered by this report:	Business Case - WVT Acute & ED Clinical Staffing - Final v4 Public Board.docx

1. Purpose of the report

The purpose of this business case (WVTBC0124) is to detail the proposed clinical model for Emergency and Acute Medicine. The model and implementation plan has been developed in order to fundamentally change the way in which unscheduled care services are provided and to provide a step-change in the delivery of high-quality, consistent care. The case also aims to address the current funded gap in demand and capacity for medical staff as profiled and supported by the Emergency Care Intensive Support Team (ECIST)

This proposal reflects a consultant 7:3 job plan split in light of WVT job planning requirements; ED job planning discussions will reach consensus for a 7:3 job plan split that will require a well-planned incremental recruitment and implementation plan to reduce the risk of a lack of sustainable ED senior workforce detailed in this proposal.

The proposal also provides assurance to ensure arrangements in place with the placement of doctors in training are not affected by this business case; the directorate intends to decrease 8 clinical fellow posts as we are able to recruit into Specialty Doctor and Consultant tiers. These clinical fellow posts are employed by ED and are not training posts - requiring a notice period of one month. There are no plans to decrease any of the training posts, which will continue to be honoured. This approach is fully supported by the Associated Chief Medical Officer for Medical Education.

The case was approved in principle by TMB on 16/02/24 subject to some clarifications. The case was then further received and endorsed by TMB on 3/5/24 and resolved to be presented to the Board of Directors meeting for approval.

Update from Non-Executive Review Meeting 24/09/2024. The group considered the case and explored the following themes:

- The ability to recruit to the roles
- Whether there was commissioner support for the scheme and the need for a review of the baseline non-elective activity
- The challenges the group had linking this case to the previously agreed ED Nursing staff business case.
- That the case addressed concerns highlight by external reviews that had been highlighted as issues previously.
- That all the non-pay has been included in the financial summary and the on-going cost of future recruitment and relocation costs.

2. Recommendation(s)

It is assessed that **Option 3** delivers 'Do Minimum' which is essential to the delivery of a safer and more efficient ED environment and approval at TMB is sought in order to mitigate the risks of not supporting this proposal. It is proposed that this investment will meet the recurrent demand by increasing clinical capacity. Additionally providing senior decision makers in ED to support timely access to treatment, safer care decongesting the department and improving flow across the ED footprint by providing adequate staffing levels to properly staff rapid assessment, triage and SDEC in order to limit delays and improving Royal College of Emergency Medicine (RCEM) compliance in line with RCEM recommendations.

Investment for **Option 3** in 2024/25 will enable an uplift of the following additional posts in addition to the current establishment:

- 5 WTE Consultants to improve RCEM national compliance (4.0 WTE EM Consultant + 1.0 WTE PEM Consultant)
- 8 WTE Specialty Dr
- 1.6 WTE Specialty Dr –UTC
- 4 .0 WTE Advanced Clinical Practitioner (2 of these posts will replace ENP).

There will be a phased transition removing the 6.3 FTE junior doctors from the baseline budget and replacing with 8 FTE Middle Grade doctors (11 PA's).

Total additional workforce requirements are 10.3 WTE.

This would:

a. Improve RCEM compliance; an increase in the Consultant establishment in line with RCEM New Patient ED attendances per 1 WTE Consultant that defines the ratio should be 1 WTE Consultant to between 3,600-4,000 new attendances;
b. Improved senior consultant supervision of patient and staff safety within the department until midnight seven days per week with ability to provide cover past midnight at weekends where required.
c. Meet RCEM on call recommendation and provide a 1:8 on call rota;
d. Sufficient staff to support Urgent and Emergency Care [UEC] Quality Improvement Plan actions for improvement to further optimising of virtual ward, SDEC and hot clinics with more senior staffing to support timely decision making seven days per week to reduce ED crowding and exit block. Virtual ward and Same Day Emergency Care can safely be led by senior decision makers to improve flow throughput.
e. Review of UEC March performance evaluation are built into the service delivery model and funded as part of ED establishment in future. Performance of all key KPI's have improved from March onwards as a result of elements of this service delivery model having been implemented.
f. Quality improvement with consultant uplift will result in Acute Care Common Stem [ACCS] Junior level training and registrar training accreditation and recognition as a training centre.
g. A significant improvement in safety and quality during the week, specifically: Time to Be Seen, Ambulance offload challenges (including the requirement to regularly monitor those patients unable to be offloaded), & average Length of Stay;

h. Facilitating the commitment to Certificate of Eligibility for Specialist Registration [CESR] for the Specialty Doctors would no longer be challenging and potentially impact morale and our retention efforts positively to allow the CESR pathway more frequently;
i. Quality will improve throughout the week and weekends, the financial risk of remaining within budget while managing all items that contribute to the time out funding requirement would be challenged;

Best impact in delivering Cost Productivity Improvement Plan [CPIP] – in this case, a reduction of agency / bank. This proposal will require revenue investment for the substantive recruitment but will significantly reduce the use of variable pay and save the associated premium cost. Revenue requirements include **Option 3**: staffing the service to better meet the recurrent demand by uplifting Tier 2 and Tier 3 staff.

Emergency Department - Medical Staffing

Option 3- Full Coverage

Pay

					Year 1 Non Recurrent						Year 2 Recurrent					
					Additional Establishement Year 1				Establishement Year 1		Additional Proposed Establishement Year 2 onwards				Proposed Establishement	
Ledger Description	**Summary Description**	**PAS**	**FTE**	**£'000**	**PAS**	**FTE**	**£'000**	**£'000**	**FTE**	**£'000**	**PAS**	**FTE**	**£'000**	**£'000**	**FTE**	**£'000**
MS - A & E CONSULTANTS	Consultant	11	5.0	890	11	5	166	829	10.0	1,719	10	5	151	753	10.0	1,644
MS - A & E SPEC DOC NEW CO	Middle Grade Doct	12	16.0	1,737	11	8	98	787	24.0	2,524	11	8	98	787	24.0	2,524
	Middle Grade Doctor- Reduce PA				*-10*		*-89*	*- 89*	-	- 89	*-10*		*-89*	*- 89*	-	*- 89*
MS - A & E Senior Clinic Educ Fellow	Middle Grade Doctor		0.5	34					0.5	34				-	0.50	34
MS - A & E FY2	Junior Doctor		1.0	59					1.0	59				-	1.0	59
MS - A & E GPST	Junior Doctor		3.0	234					3.0	234				-	3.0	234
MS - A & E FY2-Non Trust	Junior Doctor		2.0	174					2.0	174				-	2.0	174
MS - A & E Clinical Education Fellow	Junior Doctor		1.0	70					1.0	70				-	1.0	70
MS - A & E FY2	Junior Doctor		2.0	139					2.0	139				-	2.0	139
MS - A & E Clinical Fellows - Junior	Junior Doctor		6.3	366		-6.3	58	- 366	-	-		-6.3	58	- 366	-	-
A&E ACP Nurse Band 8a	ACP		3.8	263		4	67	269	7.8	532		4	67	269	7.8	532
A & E - ENP's NURSE BAND 6	ENP		3.0	154					3.0	154				-	3.0	154
A & E - ENP's NURSE BAND 7	ENP		4.0	268		-2	63	- 125	2.0	143		-2	63	- 125	2.0	143
Specialty Doctor-UTC					11	1.61	98	158.33	1.6	158	11	1.61	98	158	1.61	158
Total Budgeted Establishment			**47.6**	**4,388**		**10.31**	**461**	**1,462**	**56.3**	**5,850**		**10.31**		**1,387**	**57.9**	**5,775**
Additional Weekend Medical Coverage																
Consultant								86		86				86		86
Middle Grade								200		200				200		200
Junior								109		109				109		109
Total Weekend Medical Expenditure								**395**		**395**				**395**		**395**
Total Pay Cost- Option 3 Full Coverage								**1,857**		**6,245**				**1,782**		**6,170**
Non Pay																
IT- Laptops per consultant								8		8				0		0
Study Leave allowance								13		13				13		13
Rota Software								1.2		1				3		3
Relocation Expenses								64		64				0		0
Recruitment Finder Fees- assume 50%								40		40				0		0
Total Non Pay Costs								**126**		**126**				**16**		**16**
Total Costs								**1,983**		**6,371**				**1,798**		**6,186**

The recurrent over spending run rate will therefore reduce by the contribution figures as below.

Summary Options:

		Annual		
		FTE	Outturn £'000	Difference £'000
Option 1:	Current Run Rate- M4		6,747	
Option 2:	Current Budget	47.62	4,388	-2,359
Option 3:	Proposed Model	57.65	6,186	-561

The workforce plan will be reviewed on a regular basis and the financial impact monitored and tracked in line with the divisional forecast and recovery plans.

The ED nursing workforce model, within the nursing business case was approved at Trust Management Board on the 16th August; the case will further inform savings or better ways of working within the A&E directorate; paying due consideration of ENPs and Band 5/6 nurses with opportunities for rotation in the emergency ACP model, adapted shift patterns etc. that will work in collaboration with the medical workforce model proposed.

The Board is asked to support this proposal outlining the use of additional investment for 2024/25.

3. Executive Director Opinion[1]

The current challenges within our ED to meet the required level of demand with the current levels of capacity is critical to address in order to maintain safe clinical timely patient treatment, decision making and early decisions about patient pathways. In order to maintain patient flow and ensure our ED is not congested requires early assessment and treatment to ensure that patients are clinically ready to proceed for admission, streaming to our SDEC areas, Primary Care or discharge.

This case not only supports going a considerable way in meeting the current demand and capacity gap, as supported by ECIST, but allows for improved senior decision making and oversight across our ED over increased hours of the day, seven days a week.

The changes in workforce skill mix also allows for increased clinical supervision of staff and allows the Department to grow and retain more of its own staff whilst reducing the reliance on temporary workforce solutions that are currently a requirement to maintain safe rotas levels to meet demand and ensure that adequate “time out” and Whole Time Equivalents [WTE] are sufficient to allow for Annual Leave, training and absence.

I fully recommend that this case is approved by the Trust Board.

As a precursor to Board consideration, the case was reviewed by non-executive directors on the 3rd June 2024 and the following themes were explored and were subsequently addressed in this version of the business case.

- Concerns about the costs of the case and whether they reflect the full cost of the development

- Links between the case and the annual activity-related funding changes that form part of the operational planning cycle
- Updating timescales set out in the workforce plan as some had passed due to the passage of time with the approvals process
- Being clearer on the benefits delivered by the scheme and linking to the test of change work completed during March 2024
- A clearer narrative on the budget increase and existing spend, acknowledging that the case represents a reduced spend on the current run rate
- Describing the additional recruitment activities the Trust will undertake for these often difficult to recruit to roles.

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.

BUSINESS CASE

Title:	WVT Acute & ED Clinical Staffing
Ref. No.	WVTBC0124
Author:	Shannon Bakan / James Bartlett / Kate O'Shea/ Jo Clutterbuck
Executive Sponsor:	Andrew Parker
Date:	25th September 2024

1. Introduction and Background Information

The purpose of this paper is to detail the proposed clinical model for Emergency and Acute Medicine. The model and implementation plan has been developed in order to fundamentally change the way in which unscheduled care services are provided and to provide a step-change in the delivery of high-quality, consistent care. This has been developed as part of our operation planning and is the detailed case to evidence those plans.

The underpinning premise of the workforce plan is to ensure early, consistent senior decision making throughout the emergency care pathway. The plan and recommendations have been based on national evidence, local analysis and are aligned to the strategic objectives of the organisation and wider NHS. This is further evidenced by the test of change work that commenced in March as part of a national scheme to improve 4 hour performance.

The key performance measures associated with unscheduled care delivery are centred on the Emergency Department (ED) and are hospital focused. Despite this it is clearly recognised that unscheduled care requires a whole systems approach crossing all parts of the unscheduled care pathway from pre-hospital care and prevention, through community based unscheduled care services, emergency and acute hospital care, and effective/efficient discharge and post hospital care.

Whilst it is acknowledged that progress has been made over the last 12 months, there remain significant challenges to the sustainable delivery of unscheduled care across the system, including core primary care, GP Out of Hours services, timely and efficient Ambulance Handover at the Emergency Unit, achieving and maintaining the 95% 4 hour A&E target on a regular basis, and fully eliminating 12 hour waits for patients attending the emergency unit. The expectation is that by the end of March 2025 78% of patients will be seen within 4 hours. The performance for July 2024 was 68.3%. The expansion of the current substantive medical workforce is required to support the achievement of this key performance indicator, improve the safety of the emergency department and improve patient experience.

In addition the growing and emerging evidence based around the importance of seven day working identifies four main drivers for a step change in the way hospital (and other) services are delivered. These drivers are:

1. Reduction in mortality
2. Increased efficiency
3. Easier access to services
4. Same standards of care irrespective of the day of week

As a result it is well recognised that there remains an urgent need to further strengthen the whole system. The critical areas for improvement based on comparative units, evidence review of top performers, national guidelines, key areas of risk, and analysis of performance within Medical Division services are as follows:

- Improving the timely assessment and treatment of patients within ED at WVT focused on ensuring senior decision making input in Emergency Medicine, with improved capacity and processes for the early assessment and treatment of medical patients.
- Providing appropriate and timely access to capacity to care for the sickest critically ill patients requiring stabilisation, treatment and emergency care. Reflecting the recommendations from the governance review undertaken by the medical and nursing directors, and supporting timely ambulance handover without compromising safety through the re-establishment of a ‘corridor’.
- Within the context of overall ED performance and compliance, improving the Minors Stream resilience and changing care models to deliver sustainable Emergency Nurse Practitioner (ENP) cover, improving compliance with key performance targets. This proposal includes the consideration of an ENP/Advanced Care Practitioner (ACP) minor injuries-led service in order to enhance respective workforces in light of recruitment, retention and training challenges.
- Extending the medical acute assessment capability for those patients requiring longer specialist input and assessment to 7 days, with new service models aimed at maximising the opportunities for Same Day Emergency Care (SDEC) and discharge home rather than hospital admission.
- Moving hospital based unscheduled care services towards a true 7-day consultant led service, addressing the current inefficiencies and clinical issues arising from limited extended working, and step change in care over weekends.

To support the achievement of these aims, the Medical Division with the senior clinical teams in Emergency Medicine and Acute Medicine have agreed the optimal clinical model based on best practice from other comparable units and specific local requirements.

In conjunction with wider whole system changes and improvements being targeted in community care (both Primary Health and Social Care), the proposed acute model will support an unscheduled care system that is fit for purpose and resilient for our population.

This in turn will enable:

- Delivery of the Ambulance Handover, 4 hour and 12 hour unscheduled care Tier 1 targets.
- Consistent streaming of patients to the most appropriate assessment / treatment location from the outset of the patients attendance with senior input into care in accordance with Royal College guidelines and regardless of day of week.
- Maximising opportunities to prevent admission, and for those patients requiring admission, shortening length of stay and improve patient flow.
- Continued focus on supporting discharge and enabling the right patient care, in the right place, with specific focus on frailty, older peoples care and liaison with community partner services, in line with the NHS Improving Care for Older People: NHS Long Term Plan and the Personalisation Plan.
- Improve the safety and experience of patients treated in ED.

The proposals have full clinical support and have been developed and driven by the service (supported by the Emergency Care Intensive Support Team (ECIST), recognising all of the key service and safety objectives, underpinned by a focus on early continuous assessment, rapid treatment, and discharge. Implementation of the model would mean that Wye Valley NHS Trust would deliver a comprehensive Consultant led 7 day working in Emergency and Acute Medicine in line with national and local colleagues from within the Foundation Group.

2. Current Position

The current model has been described in the Same Day Emergency Care (SDEC) business case (WVTBC0067) and remains unchanged (Appendix 1). The ED includes a number of streams including:

- Resus,
- Majors,
- Paediatrics,
- Pitstop (rapid access and triage),
- SDEC
- Minors ;GP in Urgent Treatment Centre (UTC) Monday –Friday 08:00-18:00 (implemented as part of the test of change work-streams in March 2024)

The Acute & Emergency Care directorate modified working practices in September 2022 (Business Case WVVTBC0099) to incorporate appropriately funded resident doctors to allow for a 1:16 compliant rota and for Speciality Doctors a 1:16 compliant rota. (Including allowing up to 2 doctors to be absent on from the rota pursuing the portfolio pathway (Certificate of Eligibility for Specialist Registration (CESR)): Specialty Doctors have to earn ‘credit’ to follow this pathway so the department should be able to plan this well in advance.

The case WVTTBC0099 also enabled the covering of additional shifts at the weekend:

1 x Consultant Saturday & Sunday 13:00-21:00

2 x Specialty Doctors Saturday & Sunday 11:00-23:00

1 x Specialty Doctor Saturday & Sunday 09:00-21:00

2 x Resident doctors Saturday & Sunday 12:00-22:00

1 x Resident Doctor Saturday & Sunday 14:00-00:00

The additional shifts are covered by agency or bank and were costed within the previous business case WVVTBC0099 based on a fill rate of 75% bank and 25% agency. The preferred option within this case will reduce the need for three of these shifts to be covered by substantive staff as they will be incorporated within the rotas.

1 x resident doctor 12:00-22:00 has been incorporated into the new resident doctor rota which was implemented in August 2024.

2 x specialty doctor shifts will be incorporated into the new workforce model when all the additional specialty doctor posts are appointed to.

The consultant shift at the weekend will change to 08:00-17:00 due to the evening part of the shift being incorporated within consultant job plans.

In order to meet the recurrent demand and capacity gap, the need for future investment is required now that the service understands the growing demand, the capacity gained through investment and the disparity in the current resource and actual requirement. This follows a recent visit from the Emergency Care Intensive Support Team (ECIST) which highlighted the need to address the service demand and capacity deficit.

ECIST Summary Acute Provider Indicator Table (SAPIT) provides historical and relative performance looking at the most recent quarterly data and comparing this with the rest of the country. This data indicates that quartile activity in ED activity and acuity is very high: during October 2023, the average acuity score was 5.1 (a measure how sick patients are in the department), 22.93% growth in ED admissions and 98.21% bed occupancy. All of which has made the efficiency and safety of the department extremely challenged.

Indeed, the current critical position within ED has been declared by the Care Quality Commission (CQC) during an unannounced inspection in December 2023. The outcome of the inspection highlighted the requirement for urgent mitigation and action in relation to the workforce, quality and safety within the department. This CQC inspection, alongside ECIST and local demand and capacity analysis underpins the rationale for this business case proposal in light of quality and safety concerns.

Current Activity

The demand for emergency services has increased over the last five years. There are many possible explanations, such as an ageing population and an increase in the prevalence of conditions, change in help-seeking behaviour and recent cultural shifts which could influence people to see treatment (Fielding & Bass, 2018). In addition, the coronavirus pandemic has had huge impacts on the National Health Service (NHS); patients suffering from long term conditions have placed unprecedented demands on acute and emergency care.

These increases in demand and changes to supply have had large knock-on effects on the care provided to the wider population and it is suggested that those most likely to be affected by these disruptions will be older individuals and those living in deprived areas, likely exacerbating pre-existing health inequalities that are likely to persist (Proper et al., 2020).

Table 1 below demonstrates the full year effect activity delivered since 2018 – 2022 and full year activity delivered April 2023 to March 2024.

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

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%**	

To cope with the increasing demand, this paper considers the workforce skill mix required across Consultant and Specialty Doctor grades and further training requirements. The service is now in a position where it requires a workforce uplift in order to meet the demands across ED outliers *(defined as ED patients with a decision to admit awaiting an inpatient bed)*, SDEC, Virtual Ward, Acute Medicine and acute on calls. Alternatively, there would be a requirement to reconsider the accountability for pathways across general medicine, specialties, acute and emergency medicine.

There is also a national recommendation to have an urgent treatment centre attached to the ED to support with the increasing demand of lower acuity patients due to pressures on local GP services. This has been partly achieved through the implementation of a 'UTC' within the Surgical Same Day Emergency Care footprint with a GP working 08:00-18:00 Monday to Friday.

The service position as at August 2024:

- A dedicated SDEC running 7 days per week 08:00-20:00.
  Objective to maximise access for patients that would have traditionally required inpatient admission encompassing: direct access for primary care, ED, NHS 111, ambulance services and any other appropriate healthcare providers.

- Streaming function (Pit Stop) which has delivered a significant performance increase for 'Time to be Seen' within 60 minutes by a senior decision-maker compared to our Foundation Group partners;

- A separate ED paediatric area which also encompasses a Paediatric Assessment Unit directly reducing pressure on the ward – finally satisfying a long-term CQC report directive.

- In March 2024 there was a national drive (with some short term funding) to improve Urgent and Emergency care (UEC) specifically improving 4 hour performance in ED. The Trust used this funding to undertake several tests of change one of which was to increase the senior decision making in the department by implementing a nurse navigator at the front door and a GP or specialty doctor (currently evaluating the benefit of both) to support the minor injuries/minor illness stream. This has been extremely successful improving our 4 hour performance from 57% in February to 68.3% in July 2024.This has allowed us to demonstrate the success of part of the proposal in this case.

The nurse navigator and GP/ UTC work –streams have contributed to the improvements which are demonstrated in the table below:

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

Current Workforce Emergency Medicine

Following business case approval for SDEC and the subsequent ED staffing business case in September 2022, the service was able to recruit to the funded establishment in Table 1 and Table 2.

Consultant Workforce ED

We are currently fully recruited to our ED consultant workforce (5.2 WTE); a 1:6 rota is in place with the 6th weekend being covered by locum consultants.

Table 1 substantive ED consultant workforce

Post Holder	Staff Type	WTE Budget	WTE Actual	WTE Variance
RM	Consultant	**1.00**	1.00	**0.00**
CT	Consultant	**1.00**	1.00	**0.00**
TQ	Consultant	**1.00**	1.00	**0.00**
FD	Consultant	**1.00**	1.00	**0.00**
LD	Consultant	**0.00**	0.20	**0.20**
JC	Consultant	**1.00**	1.00	**0.00**
Total		**5.0**	**5.2**	**0.20**

Specialty Doctor Workforce

The service have recently recruited into the two WTE Speciality Doctor posts. Some elements of the budget for Speciality Doctors is funded by Medical Education. The vacant Educational Fellow of 0.50 FTC will not be recruited due to insufficient funds to recruit to WTE and is therefore being absorbed into the overall budget. The rota in place currently is a 1:16 rota.

Table 3 – Substantive Speciality Doctor ED workforce

						WTE Budget	WTE Actual	WTE Variance
Specialty Dr	Trust	P	N/A	**Dr A**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr B**		**1.00**	0.90	**-0.10**
Specialty Dr	Trust	P	N/A	**Dr C**		**1.00**	0.76	**-0.24**
Specialty Dr	Trust	P	N/A	**Dr D**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr E**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr F**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr G**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr H**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Br I**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr J**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Vacant**		**1.00**	0.00	**-1.00**
Specialty Dr	Trust	P	N/A	**Dr K**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr L**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Dr M**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**Vacant**		**1.00**	0.00	**-1.00**
Specialty Dr	Trust	P	N/A	**Dr M**		**1.00**	1.00	**0.00**
Specialty Dr	Trust	P	N/A	**VACANT**		**0.00**	0.00	**0.00**
S/C/E/F	Trust	FTC		**VACANT**		**0.50**	0.00	**-0.50**
						16.50	13.66	**-2.84**

The workforce skill mix is varied across WVT ED, therefore determining the mean number of patients seen per hour by staff type as detailed below in Table 4 –May 2024 data and the 18month average is presented below; there is little variation from month to month:

Table 4- Productivity by workforce skill mix

Staff Type	Patients Per Hour May 2024	Average over 18 months
Consultant	1.69	1.64
Specialty Dr	0.99	1.15
Resident Doctors	0.94	0.78
ACP	1.08	1.2
UTC GP	1.38	1.49 (3 m average)

The current workforce model across Acute and Emergency is predominantly made up of specialty doctor and resident doctor grade staff many of which require additional support through teaching and professional development provided by our substantive consultant workforce. The productivity of our workforce performs ahead of local EDs and in line with national Royal College of Emergency Medicine (RCEM) productivity guidelines and CQC inspection feedback.

WVT ED consultants support front loading and senior decision making through their work in Pitstop. The current establishment does not provide sufficient senior consultant support to run Pitstop and the general ED more effectively.

Indeed, RCEM indicates Tier 1 clinicians, (the most junior grade of doctor working in the department) or clinicians with enhanced supervision requirements (e.g.) doctors in difficulty, may have minimal or even negative productivity due to the senior input required on cases they see.

The business case proposes that senior input into the service is increased by employing additional consultants, specialty doctors and ACP's.

ENP (Emergency Nurse Practitioner) workforce.

Currently there are 4.67 WTE in post. This comprises of both B6 & B7 staff and also includes one trainee ENP. There is a difference in skill set between the two bands. There is a budget of 4 WTE B7 and 3.02 WTE B6. The plan will be to convert these posts to ACP's when staff retire; this will increase the scope as ACP's review patients with minor illnesses alongside injuries. This will require some additional funding which is included within the preferred option (3).

3. Demand & Case for change

Increase in demand has been observed locally at the Trust, with the National Urgent & Emergency Care Report reflecting the need to refocus and realign capacity to meet the growing demand (Midland UEC Weekly Update Report, October 2023 below.) The Trust is:

- In the Top 10 of providers with the largest percentage growth in overall A&E attendances with a 1.5% increase.
- In the Top 10 of providers with the largest percentage growth in Type 1 Major Attendances with a 7.4% increase.
- In the Top 3 of providers with the largest growth in ambulance arrivals (15.4% increase)

Acute & Emergency care has seen a step change in pressure and deterioration in performance against the 4hr and 12hr ED and Ambulance handover targets since the coronavirus pandemic. This has manifested itself operationally as the following key issues:

- Ambulance delays (deterioration in terms of handover compliance against both the 15min and 60min measures).
- Deterioration in ED 4hr compliance and 12hr waits.
- Disproportionate ED pressures (full unit/lack of assessment space/high volumes to be seen) and an increase in admission volumes.
- Concerns about potential clinical risk as a result of the sustained pressures within the unit.

NHS Benchmarking Network (2018) indicates 12 WTE emergency medicine consultants per 100,000 ED attendances. Therefore, the Trust's ED, although meets national productivity expectations, does not meet the expected workforce establishment for the ED size and senior staffing rotas as Table 1 details the average attendances per annum as circa 73,000.

The RCEM recommends the following staffing levels:

(SDM's = Senior Decision Makers)

Wye Valley Trust have a medium size ED.

Table 5 – Numbers of Consultants and Minimum WTE SDMs

Size of Department (attendances/year)	WTE Consultant numbers	WTE SDMs (minimum)
Medium	18-25	30
Large	25-36	42
Very Large	34-48	60

While a "one size fits all" approach to ED consultant staffing is not possible, RCEM recognises the need for effective staffing to ensure capacity, capability, sustainable working and resilience is upheld as detailed in Figure 2 below.

Figure 2- RCEM Size of Systems and new patient attendances

Table 2 – Size of systems and new patient attendances

Size of ED	New patient attendances
Small ED	less than 60,000 attendances (may be urban)
Remote and Rural ED	typically less than 60,000 attendances (may be much lower attendances, e.g. some EDs in Scotland)
Medium-sized ED	60,000–100,000 attendances per annum
Large ED	greater than 100,000 attendances per annum
Very Large ED	greater than 150,000 attendances
Major Trauma Centre	Usually either a large or very large ED

For the purpose of describing the Trust, this proposal aligns the size of the department to a medium-sized ED receiving 60,000-100,000 attendances per annum. It is therefore recognised that the demand on the ED significantly outweighs capacity.

The department has introduced a number of new initiatives designed to create more efficient streamlining in ED for treatment and care pathways.

It is acknowledged, through the Urgent and Emergency Care Quality Improvement Programme (UEC QIP) that further improvement is required across the service, in particular SDEC and Virtual Ward. The service has committed to the following objectives in relation to improving UEC in WVT:

- All those attending urgent and emergency care settings are there because they need to be and receive care in a timely manner
- Improve integration of urgent and emergency care services (ED, 111/999, UCR, SDEC etc.)
- Increased number of patients on virtual wards
- Reduce pressure on ED
- Improve the flow of inpatients across WVT
- Improve ward-based MDT and inter-specialty communication

During this period, the middle grade and resident doctor contractual changes have been stretched further, increasing the gap between budgeted resource and our ability to meet the increasing demand in line with quality improvement programmes of work.

The implementation of the UTC as part of the UEC work-streams in March 2024 has demonstrated the following benefits:

- Improved 4 hour performance.
- Reduced over –crowding.
- Improved patient safety and experience.

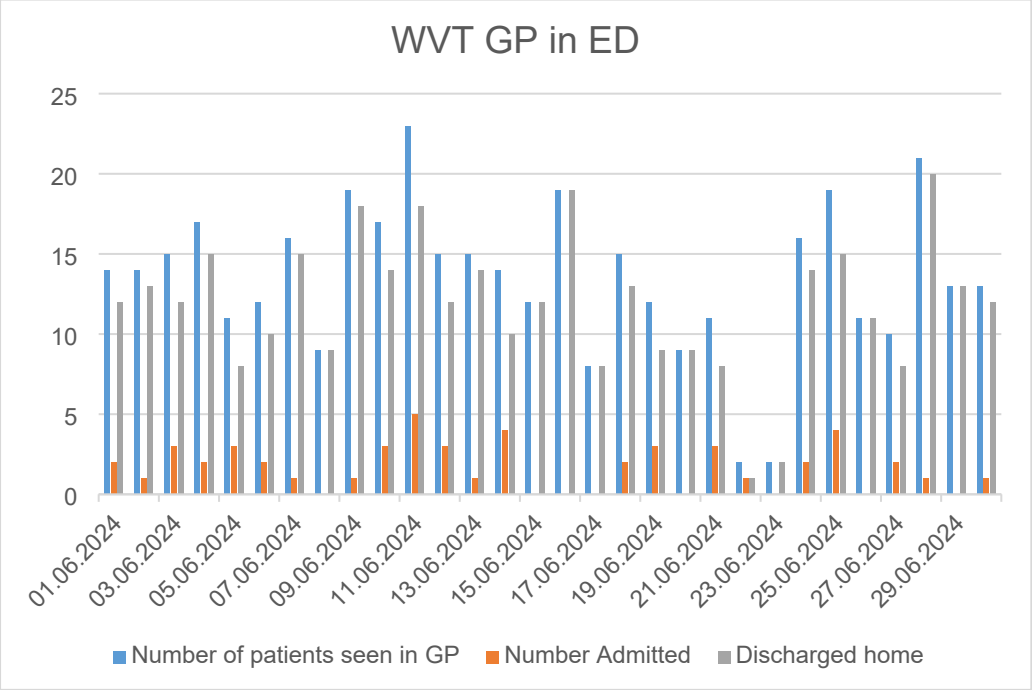


Figure 2 demand and capacity analysis demonstrates the exploration of options presented within this proposal and the impact of the capacity presented for each option and its ability to meet the current demand over a seven-day period based on the known internal productivity of each skilled staff member in ED.

Figure 2 utilises the ECIST and NHSE Capacity & Demand Planning tool to demonstrate the capacity deficit and options presented to meet the demand. However, the original ECIST demand and capacity planning tool shared with WVT following their visit was based on assumptions and did not display accurate data based on the current workforce establishment and associated productivity data. Therefore, the Directorate has used demand from March 2023 –July 2024 to refresh the use of this tool. The demand is derived from an 80th percentile 12-month rolling average demand based on historic demand data in order to evidence the demand trend.

Thorough analysis of the current capacity and demand, lack of systemic flow and, mandated contractual changes has been undertaken, which has highlighted a number of issues that this case seeks to address in a more sustainable way.

The forecasted demand in Figure 2 below highlights the need for future investment now that the service understands the growing demand, the capacity gained from this investment and the disparity in the current resource and actual requirement.

It is important to note that the demand in Figure 2 does not include the significant daily backlog of ED outliers accrued due to lack of flow across the department and challenges with high bed occupancy, length of stay and acuity within acute inpatients. Daily, there are consistently above twenty patients that require review and intervention for the Emergency Physician of the Day (EPoD), which results in medical SDEC staff being utilised to support these patients thereby impacting capacity for ED and flow. This is addressed within the Medical Division Urgent and Emergency Care Quality Improvement plans.

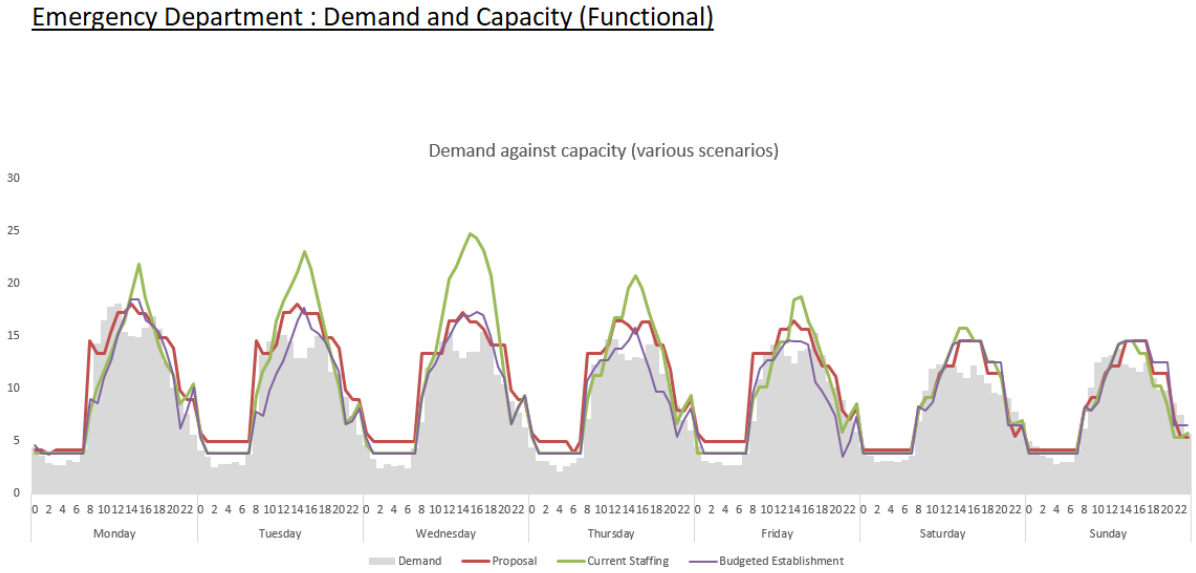


Figure 2- Forecasted Demand and Capacity Analysis

To demonstrate the impact of additional Consultant, specialty doctor and ACP staffing presented within Option 3 (see below), the demand and capacity position has been forecasted based on the following assumptions:

- In-house capacity based on demand, activity and productivity (incl. ED Consultant 7:3 job plan)
- CESR posts (2) are built into the capacity plan to accommodate secondments and impact on deliverable capacity accounted for.
- Skill mix planning: ENP/ACP workforce considered within demand and capacity planning for an ENP/ACP minor injuries-led service.

The level of acuity within the department is increasing (Figure 3) with an increase in those patients requiring immediate medical review.

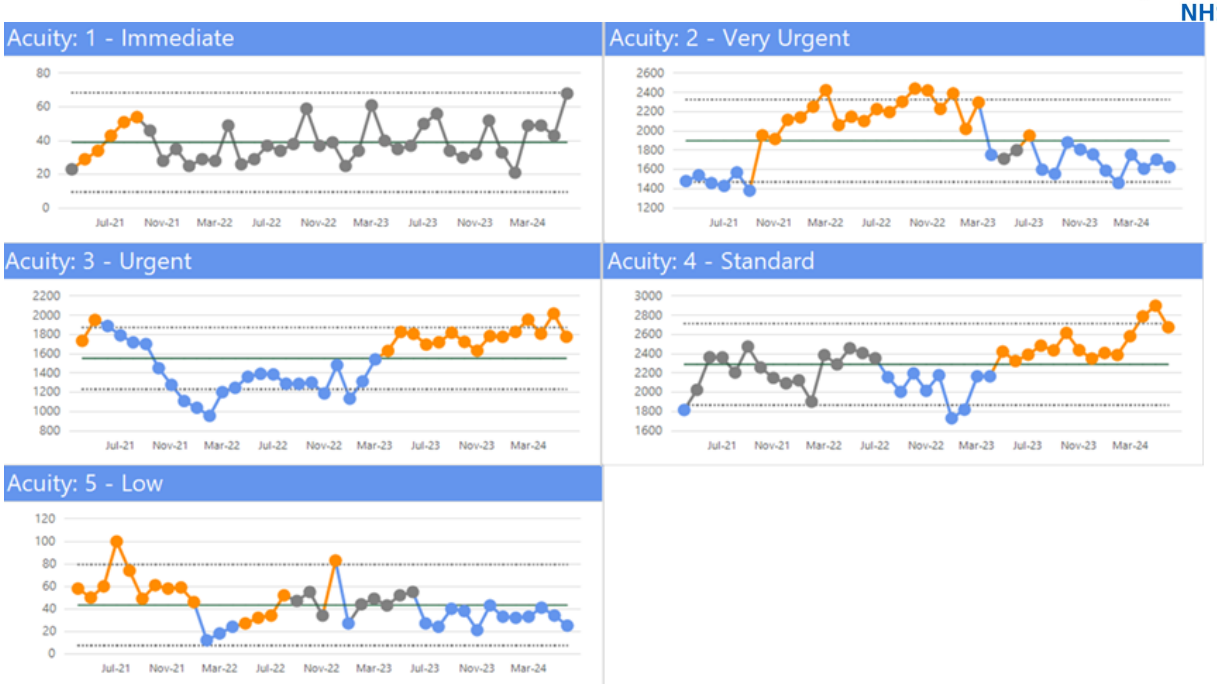


Figure 3 Level of acuity of EC patients 21-24

The proposal ensures that the medical workforce is appropriately staffed substantively to manage the increasing number of patients who present with immediate life threatening conditions. This cohort of patients is increasing.

Consultant Rota

ED has been and continues to be under significant pressure. This has placed a significant burden on ED staff that has led to burnout and a retention crisis – dating back a decade. Working in Emergency Medicine can, by its very nature, be a high pressure and stressful job. This left WVT ED with only two consultants in previous years due to poor retention and recruitment as the increase in ED demand outpaced the growth in the number of Emergency Medicine consultants. Winter 2019/20 was the worst winter on record in terms of ED performance, with a record high number of attendances and admissions that subsequently led to doing things differently and making the role more attractive and recruit-able through the offer of 'hard to recruit' PA bonus and revised job plans to increase PA time.

Therefore, the previously advertised job plan for ED consultants provides six Direct clinical care (DCC) sessions per week/per consultant. This has proven to be an attractive proposal as the Trust has recently been able to recruit high quality staff to this role, which has previously been very difficult. However, ED consultants are currently working a 1:6 on call rota, which is below the RCEM minimum recommended intensity of 1:8. Indeed, the recent CQC visit highlighted the need for improvement as they reported there were insufficient medical staff at consultant level and some nursing staff to care for patients and keep them safe without using high numbers of bank, agency, and locum staff. The consultant numbers were significantly below the recommendations of the RCEM and there was no paediatric emergency consultant, in line with the requirements of the Royal College of Paediatric and Child Health; this paper therefore proposes the recruitment of 4.0 WTE EM Consultant plus 1.0 WTE PEM Consultant.

The recent RCEM survey on consultant working patterns (2023) reported the average split is 7 programmed activities to DCC: 3 (Programmed activity to Supporting Professional Activities (SPA) sessions (these include continuing professional development and other requested tasks eg Governance lead) and WVT ED consultants currently have 6 DCC: 4 PA. However, the average ED partaking in the RCEM survey has 12 consultants compared to WVT 5 ED consultants. Therefore, administrative (SPA) duties are spread out between fewer colleagues resulting in more than the usual share of SPA work- in addition to making the job plan more attractive- to support recruitment and retention, following historical recruitment and retention challenges.

Recruiting an additional five consultants (10.2 WTE) would provide a total of 3,024 DCCs per year on a consultant 7:3 job plan. This recruitment would allow for additional and adjusted shift times so that there is consultant presence on the shop floor until 22:00 (providing 14hrs of onsite cover per day, rather than 11hrs as at present). Bank/locum requirement in this instance would only be required for the weekend 08:00-17:00 hr shifts. This recruitment to full establishment (10.2 WTE) would increase clinical capacity, provide senior cover in ED and provide 3,024 DCCs per year compared to the current 6:4 job plan.

Without a fully established 10.2 WTE ED consultant workforce, the service is at risk of being unable to sustain the volume of SPA related work required to improve the safety of ED following CQC recommendations. In addition, WVT ED consultants have 36 clinicians requiring supervision. An ED leadership portfolio is being developed akin to Southampton NHS Trust (Appendix 4) that will formally detail the lead roles for governance, complaints, education, quality improvement, safeguarding and major trauma to name a few to ensure accountability. Job planning is to be undertaken annually in line with WVT policy.

5.2 WTE WVT ED consultants on a 6:4 job plan provide limited support of SPA roles (owing to capacity and operational pressures), which include the following listed in the table below. These will continue to be covered on a 7:3 job plan, with a slightly increased SPA capacity within the team once recruited to 10.2 WTE consultants:

Clinical Lead	Recruitment	Service Improvement	Intranet Lead
Clinical Governance Lead	Mortality Lead	Complaints - Adult	Complaints – Paeds
Specialty Dr Lead	CESR Lead	Junior Dr Lead	ACP Lead
Undergrad Education	ACP Education	SpDr Education	Junior Education
ES/CS Roles	Paeds Lead	Paeds Safeguarding Lead	Resus Committee
Mental Health Lead	Frequent Attender Lead	Radiology Lead	Surgery Lead
Trauma Lead	O & G Lead	QI/Audit Lead	EPRR Lead

Some key roles are not listed in the table for example:

- Review of policies/guidelines ensuring they are kept updated.
- Frailty lead.
- Ultrasound lead.
- Sepsis lead

It is important to note that there is a variation in the amount of SPA allocated to any of the above roles from 0.25 SPA upwards. The outputs of the roles are regularly reviewed and rotated within the team.

To properly utilise the PA capacity, The Trust would need to implement a fully annualised rota (cost to be absorbed within budget). This is recommended by RCEM and allows shifts to be filled against each Consultant's PA allocation. This would mean that there is the potential to cover all leave rather than with a rolling rota which then needs leave requesting from it, resulting in the need for bank/locum cover. However, this would require the use of specialised software following job planning. A system for use has been identified which has a cost of 3k p.a for 10 WTE consultants (initial set up cost of 1.2 k.) The current Allocate system which is used by the Trust for job planning is not able to support detailed weekly and monthly rostering which this system would deliver.

In order to meet the standards of safety, consistent quality in emergency care and sustainable working practices for consultants working in these intense environments, a 6:4 job plan is the preferred option. However, in light of WVT job planning requirements, ED job planning discussions will reach consensus for a 7:3 job plan split that will require a well-planned for incremental recruitment and implementation plan to reduce the risk of a lack of sustainable ED senior workforce (detailed in the risk assessment and appendix 3 Any new consultant posts agreed as part of this business case will be advertised with a 7:3 job plan split with an additional 1 PA for recruitment and retention for a period of 12 months.

It is also proposed that the one PA for recruitment and retention is given for a period of 12 months maximum – any posts approved will be advertised in this way.

The current recruitment and retention PA within the consultant workforce will be changed to SPA roles as part of a management of change process. This will require senior Human Resources support.

Specialty doctor rota

The specialty doctors posts within this case are 11 PA's rather than 10 PA'S. This is due to there being out of hours shifts within the job plan including weekends and nights. Previously specialty doctor posts have been advertised with a 1 PA recruitment and retention bonus – more recently vacant posts have been advertised without this bonus with recruitment being successful.

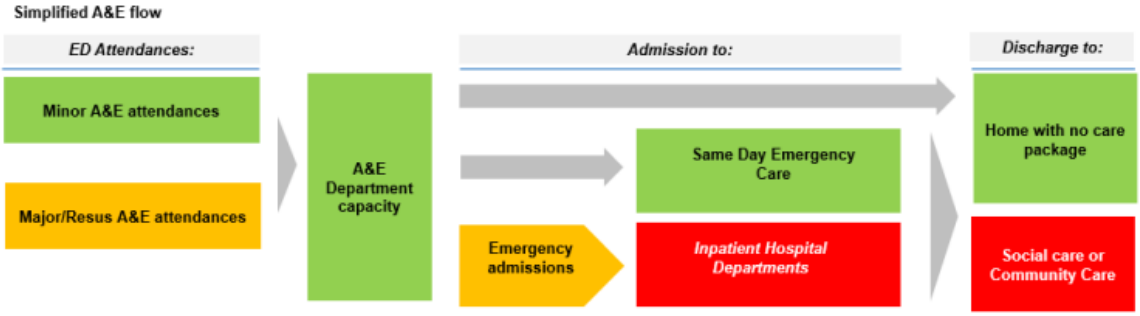
It is proposed that from September 2024 a management of change process will be implemented to change the recruitment and retention bonus within the current specialty doctor job plans with the PA being either converted to clinical work, a management role or removed.

The national and local strategies that underpin this investment include:

- Trust Strategic Objective 2024/25: Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners
- Trust Strategic Objective 2024/25: Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants

- Trust Strategic Objective 2024/25: Productivity; reducing waiting times for patients attending ED
- Delivery of care against ED Internal Professional Standards
- This proposal aligns with NHS England Department of Health & Social Care “Delivery plan for recovering urgent and emergency care services” (January 2023) to increase capacity , grow the workforce and help people access the right care first time.
- National target to ensure78% of patients are treated within 4 hours by March 2025

The figure below provides a simplified picture of A&E patient flow, highlighting the current constraints in hospital:



As set out in the diagram, the key driver for performance is high occupancy, with difficulty discharging patients (in particular to social or community settings) resulting in increased length of stay and knock-on difficulties admitting people as inpatients to hospital departments. High bed occupancy is a key driver of worsening ED performance, which in turn has a direct impact on ambulance ‘handover’ and response times. This is because when hospitals are fuller it is harder to find free beds for patients that need to be admitted from the ED, which means it is harder to bring new patients into the ED (Department of Health & Social Care, 2023).

4. Project Objectives

The proposal is to increase staffing resource required in order for the ED to reduce the departmental delays and improve patient waits, ensure minimal patient harm/risk and improve performance care quality indicators.

One of key aims of this case is to deliver a workforce model which is more financially viable than the current run rate which is below:

Emergency Department - Medical Staffing

Option - Baseline Current Expenditure Trend

Pay

Description	FTE	YTD £'000	Forecast £'000
Month 4 2024-Run Rate		2,249	**6,747**

5. Option Appraisal and Selection of the Short List

This section describes the options considered by the Directorate and the assessment of the benefits provided.

Development of Options
Options have been explored to increase capacity within the service. Whilst this improves the forecasted position it is essential that this is reviewed on a yearly basis to ensure the workforce can meet the future demands of the service. The next review will take place as part of the Trust wide business planning in December 2024.

The Acute and Emergency Care Directorate outline three options detailing the use of additional recurrent investment for 2024/25. These include:

- Option 1: Budgeted establishment
- Option 2: Current workforce model
- Option 3: Do Minimum: Essential uplift of Consultant, Specialty Doctor and ACP workforce to better meet the demand and acuity of patients.

OPTION 1: Budgeted establishment

The current level of staffing does not allow the ED to run to best practice models around flow of the department, this leads to reduced patient flow through the department, leading to extended times for decision making and onward transit from the department.

Option 1 delivers poor quality of care, lack of senior presence in the ED and insufficient capacity to meet the demand. It is therefore not recommended.

Emergency Department - Medical Staffing

Option 1 : Current Recurrent Budget

Pay

Ledger Description	Summary Description	FTE	£'000
MS - A & E CONSULTANTS	Consultant	5.0	890
MS - A & E SPEC DOC NEW CO	Middle Grade Doctor	16.0	1,737
MS - A & E Senior Clinic Educ Fellow	Middle Grade Doctor	0.5	34
MS - A & E FY2	Junior Doctor	1.0	59
MS - A & E GPST	Junior Doctor	3.0	234
MS - A & E FY2-Non Trust	Junior Doctor	2.0	174
MS - A & E Clinical Education Fellow	Junior Doctor	1.0	70
MS - A & E FY2	Junior Doctor	2.0	139
MS - A & E Clinical Fellows - Junior	Junior Doctor	6.3	366
A&E ACP Nurse Band 8a	ACP	3.8	263
A & E - ENP's NURSE BAND 6	ENP	3.0	154
A & E - ENP's NURSE BAND 7	ENP	4.0	268
Total		**47.6**	**4,388**

NB Junior doctor = Resident Doctor

OPTION 2: – Current workforce model

This workforce model continues with the current budgeted establishment outlined in the table above in option 1 and the continued use of agency and bank at current rates; the costs to this are demonstrated through the current run rate which at M4 is forecast at £6.747m

As a consequence of the lack of a substantive workforce to meet the demands of the service a high level of agency/bank doctors are used monthly. Whilst the high use of a temporary workforce does support with the delivery of key performance and quality indicators it does create the following risks within the ED which have an impact on patients and staff:

a. Dependence on agency doctors to staff key shifts within ED which creates instability.
b. Risks associated with using agency doctors including an increase in complaints and incidents leading on occasion to agency doctors being removed from shifts due to patient safety concerns.
c. Increased workload for multiple teams including the temporary staffing and medical rota team.
d. Cover for leave is dependent upon booking agency and bank doctors resulting in rota gaps occurring.
e. Extremely high costs of using bank and agency doctors; the medical staffing budget is the most over-spent in the directorate.
f. Substantive workforce covering rota gaps can be a contributory factor to ‘burn out’ and sickness within the medical team.

g. The use of agency and bank doctors without training such as ATLS can create pressure for substantive staff and create risk for patients.

The use of agency/bank doctors within the department is outlined below as WTE (junior doctor =resident doctor):

		April	May	June	July	August	Average
Data on worked, filled and requested shifts	Bank Consultant	231.00	236.00	207.00	289.00	254.00	
	Agency Consultant	135.00	120.00	178.00	241.00	290.00	
	Total Cosnsultant (WTE)	3.73	3.63	3.93	5.41	5.55	4.45
	Total Consultant (HOURS)	**366.00**	**356.00**	**385.00**	**530.00**	**544.00**	
	Bank Middle Grade	652.00	589.00	558.00	484.00	328.00	
	Agency Middle Grade	547.00	1052.00	766.00	1083.00	813.00	
	Total Middle Grade (WTE)	9.52	13.02	10.51	12.44	9.06	10.91
	Total Middle Grade (HOURS)	**1199.00**	**1641.00**	**1324.00**	**1567.00**	**1141.00**	
	Bank Junior	813.00	986.00	1309.00	1097.00	165.00	
	Agency Junior	28.00	0.00	0.00	44.00		
	Total Junior (WTE)	6.01	7.04	9.35	8.15	1.18	6.35
	Total Junior (HOURS)	**841.00**	**986.00**	**1309.00**	**1141.00**	**165.00**	
	ACP Total	**0**					

The use of this workforce model delivers the following benefits:

a. Incremental improvement in the performance and quality KPI's. There has been a steady improvement in KPI's since March 2024.
b. A level of staffing that supports and enables the delivery of a safer service.
c. An improvement in safety and quality over seven days, specifically: Time to Be Seen, Ambulance offload challenges (including the requirement to regularly monitor those patients unable to be offloaded), & average Length of Stay;
d. Facilitates the commitment to CESR for the Specialty Doctors (two may be on the CESR programme) by enabling release from the department.
e. Continuation of the UEC workstreams namely the GP/specialty doctor in the UTC. During July the GP in the UTC saw 369 patients with the service running 08:00-18:00 Monday to Friday.
f. Ensures staff can attend mandatory training improving safety and enabling development of the workforce.

Whilst improving performance in the Department, Option 2 is not clinically or financially sustainable and is therefore not recommended.

OPTION 3: Do Minimum – RECOMMENDED. Essential uplift of Consultant and Specialty Doctor workforce to better meet the demand.

Investment for Option 3 in 2024/25 will enable an uplift of the following additional posts in addition to the current establishment:

- 5 WTE Consultants to improve RCEM national compliance (4.0 WTE EM Consultant + 1.0 WTE PEM Consultant) 10 PA posts.
- 8 WTE Specialty Doctors (11 PA post).
- There is a potential to change specialty doctor posts into training posts which attract HEE funding; this will reduce the costs of this option.
- 2 WTE Advanced Clinical Practitioner
- GP /Specialty Doctor UTC 08:00 -18:00 Monday to Friday.
- It is important to note that doctors in training should be mostly supernumerary

This option would:

a. Improve RCEM compliance; an increase in the Consultant establishment in line with RCEM New Patient ED attendances per 1 WTE Consultant that defines the ratio should be 1 WTE Consultant to between 3,600-4,000 new attendances;
b. Improved senior consultant supervision of patient and staff safety within the department until 23:00 seven days per week.
c. Meet RCEM on call recommendation and provide a 1:8 on call rota;
d. Sufficient staff to support UEC QIP actions for improvement to further optimising of virtual ward, SDEC and hot clinics with more senior staffing to support timely decision making seven days per week to reduce ED crowding and exit block. Virtual ward and SDEC can safely be led by senior decision makers to improve flow throughput.
e. Review of UEC March performance evaluation are built into the service delivery model and funded as part of ED establishment in future.
f. Quality improvement with consultant uplift will result in ACCS Junior level training and HST registrar training accreditation and recognition as a training centre. This will support the potential to change some specialty doctor posts to training posts which are partly funded by HEE.
g. A significant improvement in safety and quality during the week, specifically: Time to Be Seen, Ambulance offload challenges (including the requirement to regularly monitor those patients unable to be offloaded), & average Length of Stay;
h. Facilitating the commitment to CESR for the Specialty Doctors would no longer be challenging and potentially impact morale and our retention efforts positively to allow the CESR pathway more frequently;
i. Quality will improve throughout the week and weekends, the financial risk of remaining within budget while managing all items that contribute to the time out funding requirement would be challenged;
j. Best impact in delivering Cost improvement plans (CIP) – in this case, a reduction of agency / bank.

k. Ensure that the workforce can manage both the demand and acuity of patients presenting at our ED.
l. Significantly reduce the use of agency and bank doctors.

In order to meet the recurrent demand and capacity gap, it is proposed that Option 3 is implemented; uplifting Tier 2 (specialty doctor) and Tier 3 (consultant) staffing to improve compliance with RCEM recommendations, create a more senior workforce and enable the service to better meet the demand in the medium term.

6. Assessment of Benefits

There are a number of Care Quality Indicators that the ED is held to account on and each can be impacted by a number of factors. By using the demand and capacity analysis tool to calculate the appropriate staffing levels, an assessment of benefits can be made despite the workload (both quantity and type) can knowingly vary on any given day:

- Improving the timely assessment and treatment of patients within the ED at WVT focused on ensuring senior decision making input in Emergency Medicine, with improved capacity and processes for the early assessment and treatment of medical patients.
- Within the context of overall ED performance and compliance, improving the Minors Stream resilience and changing care models to deliver sustainable ENP cover, improving compliance with key performance targets including ambulance offloads, time to triage, length of time in the department and the four hour target.
- Across 40 hospitals that have utilised the tool, ECIST have seen a 3-5% reduction in admissions from departments who have well-matched capacity to demand.
- The value to the Trust is significant when considering the bed base against elective recovery challenges. It is therefore fair to assume that dependent on investment, circa 2 patients fewer per day would be admitted – this is not an insignificant marginal gain. This can be monitored internally.

The RECOMMENDED Option 3 proposal, will deliver the following expected benefits against the Trust Objectives:

Quality Improvement:

- Improved patient experience through reduction in
    - Time to be seen
    - Time to triage
    - Time to clinically ready to proceed
    - Ambulance offload delays
    - 4 and 12 hour breaches

- Reduced incidents and complaints
- More appropriate staff levels to manage attendance increases and also conveyed patients that are unable to be offloaded – especially at the weekend;
- Trained available substantive staff for all critical shifts;
- A substantive workforce who can manage the acuity of patients who attend ED.
- Improved patient safety through increased data quality due to appropriate clinical resource to manage patient demand. Patients seen earlier in their journey will have better outcomes as potentially significant/life threatening pathology will be picked up earlier;
- Improved value for money by reducing bank and agency spend
- The option hugely reduces the use of agency and bank doctors and moves away from a staffing model that is dependent on temporary staffing.
- A substantively funded UTC.
- The option increases the level of senior decision making in the department.

Workforce and Leadership:

- *Closer alignment to the RCEM standards: '*There is clearly a difficulty in ensuring adequate Senior Decision-Maker (SDM) cover at weekends without making the frequency of weekend working unsustainable in terms of recruitment and retention. Trusts (England) and other employers will need to consider on a local basis how to provide the additional SDM cover at weekends. This might involve the use of voluntary bank/locum shifts for those seniors willing to work additional weekends, or local job planning arrangements to agree a higher frequency of weekends under locally negotiated terms, and with attention to sustainability. For permanently employed SDMs a baseline weekend working frequency would be reasonably set at 1 in 8, prior to the implementation of local agreements as described…' *Our current WTEs work varyingly 1 in 4 or 5 weekends – this aspect will be addressed through the implementation of this case.*
- *Funded ability to recruit and train / invest in our own people thereby improving efficiency and patient quality;*
- *Reduced staff turnover and sickness through burnout;*
- *Improved morale / staff well-being and therefore retention;*
- *Demonstrable action to address the Staff Survey 'Lowlights' against 'We Are Safe & Healthy' with comments: '*…Unrealistic time pressures and not enough time to do your role, Staff are burnout, Unwell as a result of work related stress, Morale and There isn't enough staff…*'*

Sustainability:

- Appropriate staffing levels to maintain ED patient specific throughput contributing to shorter 'Length of Stay' with subsequent release of resource – especially at weekends;
- Increased senior decision-making for increased referrals to GP (note: there is no contracted provision OOH).
- Invest in expansion of the ACP workforce within ED.

Integration:

Improved patient safety through increased data quality due to appropriate clinical resource to manage patient demand which in turn will provide more robust data to the emerging Population Health Management Tool (Health inequalities).

7. Financial Analysis

This proposal will require revenue investment for the substantive recruitment but will significantly reduce the use of variable pay and save the associated premium cost. The current run rate is forecast to outturn at £6.7M which offers a baseline of a do nothing option.

As noted earlier, Option 2: Current baseline budget (£4.38M) is not feasible due to the inability to meet clinical workloads and as demonstrated in current run-rates will require significant top-up of Medical Bank and Agency circa £2.35 M (based on current run rates).

Option 3 represents a long term move to stabilising staffing the service to better meet the recurrent demand by uplifting the number of specialty doctors, consultants and ACP's.

As this will require transition period the workforce plan will be reviewed on a weekly basis and the financial impact monitored and tracked in line with the divisional forecast and recovery plans.

Option 3

This proposal will require revenue investment for the substantive recruitment but will significantly reduce the use of variable pay and save the associated premium cost. Based on forecast run-rate outturn the agency/bank premium will outturn at £6.74M which is £2.36M above current recurrent budget baseline.

Over a period of transition Option 3 proposes recurrent baseline investment of £1.79m in order to meet a substantive stable workforce reflective of demand, acuity and appropriate skill-mix across the service. This will generate a notional saving of £561k compare to a do-nothing option.

To move towards a steady state will require a minimum of 2 year transition. The workforce plan will be reviewed on a weekly basis and the financial impact monitored and tracked in line with the divisional forecast and recovery plans.

As recognised elsewhere in the case the request is based on current activity and acuity with some increase in demand built in. Ongoing demand and capacity (based on ECIST recommendations) will be reviewed as part of Operational Planning.

This option based on recruiting to a substantive workforce is below the Month 4 outturn run rate for 24/25 by **£561k**.

Summary Options:

		Annual		
		FTE	**Outturn £'000**	**Difference £'000**
Option 1:	Current Run Rate- M4		6,747	
Option 2:	Current Budget	47.62	4,388	-2,359
Option 3:	Proposed Model	57.65	6,186	-561

Medical Establishment
Additional Requirements

- 5.0 WTE Consultants (4.0 WTE EM Consultant + 1.0 WTE PEM Consultant)
- 8.0 WTE Specialty Doctors
- 1.6 WTE Specialty Doctors –UTC
- 4.0 WTE Advanced Clinical Practitioner (2 of these posts will replace ENP's)

It is anticipated that through a management of change process, the recruitment and retention PA currently given to specialty doctors will be removed or changed to non-clinical roles for 2 specialty doctors within the team through a competitive process.

The consultant posts have been costed at 11 PA's however the posts will initially be advertised as 10 PA's with an additional PA for recruitment and retention offered non-recurrently in year 1. If new consultants are appointed to 10 PA posts this will enable further savings to be made.

The Specialty doctor time out allowance has not been funded previously. With the proposed model of 24 WTE Middle grade doctors this will allow 3 to 4 to be on leave at any time with the rota being covered.

There will be a phased transition removing the 6.3 FTE resident doctors (non training posts) from the baseline budget and replacing with 8 FTE Middle Grade doctors (11 PA's). Consideration will be given to the resident doctors being developed into the middle grade posts through the use of the competency framework and personal development plans. Recruitment to the middle grade posts will only take place when there is released budget from resident doctors leaving the department or development into the vacant posts.

Total additional posts required to implement this workforce model is 10.3 WTE.

Medical Temporary Staffing (MTS) Analysis

In order to evaluate the value and benefits of the requested workforce uplift, an analysis of the current 2023/24 medical temporary staffing (MTS) position has been considered in order to understand what we are using now and how this compares to the requested uplift. This ensures clarity that the requested workforce uplift is in line with expectations and enables a forward planning trajectory for the movement from medical temporary staffing to a substantive workforce.

There will be a requirement to continue with some use of MTS from August 2024 although this will reduce as staff are recruited to the department with prospective cover in place for leave.

Due to the way medical rotas are constructed ensuring they remain compliant results in a lack of cover at the weekends. It is more cost effective to cover these shifts through bank and agency rather than increase the numbers of substantive doctors. If this approach was taken then there would be an excess of doctors working Monday –Friday due to the number required.

Emergency Department - Medical Staffing

Option 3- Full Coverage

Pay

					Year 1 Non Recurrent						Year 2 Recurrent					
					Additional Establishement Year 1				Establishement Year 1		Additional Proposed Establishement Year 2 onwards				Proposed Establishement	
Ledger Description	**Summary Description**	**PAS**	**FTE**	**£'000**	**PAS**	**FTE**	**£'000**	**£'000**	**FTE**	**£'000**	**PAS**	**FTE**	**£'000**	**£'000**	**FTE**	**£'000**
MS - A & E CONSULTANTS	Consultant	11	5.0	890	11	5	166	829	10.0	1,719	10	5	151	753	10.0	1,644
MS - A & E SPEC DOC NEW CO	Middle Grade Docti	12	16.0	1,737	11	8	98	787	24.0	2,524	11	8	98	787	24.0	2,524
	Middle Grade Doctor- Reduce PA				*-10*		*-89*	*89*	-	- 89	*-10*		*-89*	*89*	-	- *89*
MS - A & E Senior Clinic Educ Fellow	Middle Grade Doctor		0.5	34					0.5	34				-	0.50	34
MS - A & E FY2	Junior Doctor		1.0	59					1.0	59				-	1.0	59
MS - A & E GPST	Junior Doctor		3.0	234					3.0	234				-	3.0	234
MS - A & E FY2-Non Trust	Junior Doctor		2.0	174					2.0	174				-	2.0	174
MS - A & E Clinical Education Fellow	Junior Doctor		1.0	70					1.0	70				-	1.0	70
MS - A & E FY2	Junior Doctor		2.0	139					2.0	139				-	2.0	139
MS - A & E Clinical Fellows - Junior	Junior Doctor		6.3	366		-6.3	58	- 366	-	-		-6.3	58	- 366	-	-
A&E ACP Nurse Band 8a	ACP		3.8	263		4	67	269	7.8	532		4	67	269	7.8	532
A & E - ENP's NURSE BAND 6	ENP		3.0	154					3.0	154				-	3.0	154
A & E - ENP's NURSE BAND 7	ENP		4.0	268		-2	63	- 125	2.0	143		-2	63	- 125	2.0	143
Specialty Doctor-UTC					11	1.61	98	158.33	1.6	158	11	1.61	98	158	1.61	158
Total Budgeted Establishment			**47.6**	**4,388**		**10.31**	**461**	**1,462**	**56.3**	**5,850**		**10.31**		**1,387**	**57.9**	**5,775**
Additional Weekend Medical Coverage																
Consultant								86		86				86		86
Middle Grade								200		200				200		200
Junior								109		109				109		109
Total Weekend Medical Expenditure								**395**		**395**				**395**		**395**
Total Pay Cost- Option 3 Full Coverage								**1,857**		**6,245**				**1,782**		**6,170**
Non Pay																
IT- Laptops per consultant								8		8				0		0
Study Leave allowance								13		13				13		13
Rota Software								1.2		1				3		3
Relocation Expenses								64		64				0		0
Recruitment Finder Fees- assume 50%								40		40				0		0
Total Non Pay Costs								**126**		**126**				**16**		**16**
Total Costs								**1,983**		**6,371**				**1,798**		**6,186**

Finance Manager Recommendation

In order to deliver improved capacity as recommended by RCEM, Option 3 would need to be supported, whilst the department will ensure bank and agency usage is reduced there may be a short-term requirement to continue if there are delays in recruitment. In steady state the proposal will save £561k compared to current run-rate.

The Trust is requested to fund the preferred option in full.

Non Pay Impact: [See Table Option 3]

- IT/Office Space – laptops per consultant – total £6,000
- Study leave allowance £1,000 per doctor total £13,000
- Relocation expenses (Up to £8,000 per consultant and £3,000 per Specialty Dr – up to a total of £64,000) Based on 5 Additional Consultants and 8 Specialty Doctors
- Service changes made through the UEC March 2024 performance evaluation have been built into the service delivery model and funded as part of ED establishment in future. The funding received for the test of change in March allowed us to demonstrate some of the benefits of the investment requested in this Business Case. See section 2 for detail on improvements demonstrated.
- Recruitment Finder expenses based on 50% of new Specialty Doctor positions being found through external agency - £40,000.
- To support the implementation of annualised working/prospective cover for specialty doctors and consultants purchase of rota software (set up costs £1,200 and ongoing yearly costs of £3,000)- there will a separate business justification presented for this following confirmation as to whether this can be delivered by the allocate system.
- There is no requirement for extra admin as the numbers of patients seen is not increasing, nor is there a requirement for extra office space the team currently hot desk in a shared office.

  .

Capital

There are no capital costs associated with this business case.

Savings

Based on current run-rate there is reduction in forecast outturn position by £561k where Option 3 is at steady state.

Included within the above option are premium costs of covering the weekend capacity shifts. Unfortunately, due to the flexibility needed at weekends, there would be limited further savings opportunities within this premium funding. i.e. needed on a recurrent basis as part of staffing model and has been accounted for in Option 3.

Activity

Additional activity is expected as part of this business case, in order to better meet the increasing demand within the ED. 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 bank and agency premium of all options has been calculated based on a fill rate of 75% bank and 25% agency. There is a risk that we will not be able to get cover on these splits, which could mean a higher reliance on agency and more premium higher cost cover required.
- If there is an increase in staff turnover as a result of changes made, the underlying position will worsen due to a higher reliance on bank and agency.
- There is scope for some double running costs during the transition period and hence will require very close project management in order to move to the steady state position in a controlled manner.
- The Trust is currently operating above the ICS agency cap level, there is a risk that this will only worsen following implementation of increased rates of pay regionally and nationally who are offering more money to our locum workforce, which we are unable to compete with.

8. Critical Assumptions, Risk Assessment, Quality Impact Assessment and Equality Impact Assessment

Critical Assumptions
The proposal assumes that:

- The NHSE planning tool is broadly accurate and relevant for Wye Valley Trust demographics;
- The productivity average of patients per hour used reflects the increased acuity balance of patients with internally collated data.
- Integrated urgent care pathways for Herefordshire are effective and enable streaming a proportion of the demand.

Critical Success Factors

The proposal is to increase the staffing resource required in order for the ED to achieve the following:

- reduce the departmental delays.
- improve patient waiting times.
- ensure minimal patient harm and reduce risk.
- improve performance care quality indicators.

Quality Impact Assessment (QIA)

The scheme proposed in this business case expand and improve on existing Trust clinical services. 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.

Equality Impact Assessment (EIA)

The EIA is at Appendix 2.

Risk Assessment
The proposal seeks to mitigate the unbudgeted capacity deficits and requirements to meet recurrent demand. Risks associated with not funding this proposal are summarised below (captured in detail in Appendix 3):

- Ability to recruit clinicians to 7:3 job plan with a recruitment and retention PA for a time limited period of 12 months.
- Ability to deliver CQC recommendations for robust leadership and governance with insufficient SPA time

- A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in a timely way, impacting on the safety of care and the wellbeing for our patients.
- Resource and workforce challenges due to national and local workforce shortages, workforce availability of staff with required skills/knowledge, increased pressure on staffing capacity winter/COVID.
- The attendances continue to increase beyond this uplift's ability to meet the increased demand prior to business planning and the next FY. This will be picked up as part of Operational Planning and review of demand and capacity using the ECIST tool.
- The Trust does not support the preferred option resulting in the cost pressure continuing or unsafe levels of staffing matched against demand;
- If the Trust does not support the preferred option this would result in an inability to deliver against the Urgent and Emergency Care Recovery ambitions, including:
- Ambulances getting to patients quicker: with improved ambulance response
- times for Category 2 incidents to 30 minutes on average over 2023/24, with
- further improvement in 2024/25 towards pre-pandemic levels.
- Achieve national target of 78% Four Hour performance by March 2025
- Increase ED specific training compliance to 85%
- Reduce sickness rates by 2%
- Reduce agency spend in 2024/25
- Allow each team to have a team development & training day every three months
- Improve compliance RCEM staffing standards by April 2024
- Continued high use of agency and bank staff.

9. 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 against a current workload, therefore for this specifically, impact on other services cannot be fully articulated. However, this work does need to occur as since the pandemic, with business planning rounds having been interrupted, detailed analysis on service use (e.g. Radiology and specific response time achievement) post departmental changes has not occurred. Meetings with Pharmacy and Radiology to be aligned with Business Planning and broader Acute Floor review.
An increase in pathology is not anticipated due to increase in senior support in ED that should reduce the number of referrals.

10.Implementation Timeline

Implementation of the recommended option 3 is outlined below:
Timelines and Key Milestone for Completion

Milestone Activity	Date
Design consultant rota (1:8 on call)	September 2024
BC submission to TMB	September 2024
TMB Approve BC	September 2024
Advertise consultant, middle grade & ACP vacancies	October 2024
Recruited into ACP, SpDr and Consultant tiers (typically takes six months from advertising for medical staff) and commence in post	April 2025 onwards

In addition, the directorate recruited four clinical education fellows from August 2024 - 2025.These doctors are on 12 month posts to August and do 50% education and 50% EM and can be removed in August 2025 at the end of their contract. However, the recruitment of SpDrs and Consultants will take some time, and we know that training posts are frequently not filled - providing flexibility over the recruitment period.

A detailed recruitment plan will be completed and monitored weekly. There will be a phased approach to recruiting specialty doctor posts as resident doctors (non –training posts) leave the department or are developed into the specialty doctor posts.

This approach is fully supported by the Associated Chief Medical Officer for Medical Education.

Recruitment and Training Timeline

Description	Estimated time start to finish	Variables	Risks
Recruitment Process - Upload to TRAC - Scrutiny Panel - Advert - Shortlist - Interview - Notice Period - Start & Enrol	Up to 6 months for medical staff	Funding approval Scrutiny delays Variable notice periods	Numbers being recruited National recruitment challenges Lack of suitable applicants Non appointable applicant New job plan is not attractive; poor recruitment and lack of applications
Start in post & supernumerary period	3 weeks		Non starters
Supervised practice until sign off	3 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- 9 Months		

11.Leadership and Workforce

The proposal seeks to address a number of workforce issues, including senior leadership 24/7 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.

While recruitment present challenges, the reputation of the department has already increased through the implementation of the compliant rotas and has directly been responsible for a very talented long-term ‘Bank’ Consultant and Specialty Doctor requesting a permanent contract, which was successful at interview. In addition to this, the department has and will continue to utilise headhunting recruitment agencies, who have successfully recruited Consultants and middle grades for other comparable EDs.

Additional workforce requirements					
Staff Group	**Position/Title**	**Permanent/ Fixed Term/ etc.**	**New post/skill-mix change/ etc.**	**Band**	**WTE**
Medical & Dental	Consultant Emergency Medicine	Permanent	New position		5
Medical & Dental	Specialty Doctor	Permanent	New position		8
Agenda for change	ACP	Permanent	New position		4
Medical & Dental	Specialty Doctor UTC	Permanent	New position		1.6
Medical Dental	Resident doctors –non training				-6.3
Agenda for change	ENP				-2
				Total	**10.3 wte**

12. Conclusions and Recommendations

Recommendation: It is assessed that **Option 3** delivers a workforce model which is essential to the delivery of a safer and more efficient ED environment and approval is sought in order to mitigate the risks of continuing with the existing workforce model. It is proposed that this investment will meet the recurrent demand by increasing clinical capacity, providing additional senior decision makers in ED to support timely access to treatment, safer care decongesting the department and improving flow across the ED footprint by providing adequate staffing levels to properly staff rapid assessment, triage and SDEC in order to limit delays completing assessments and diagnostics that in turn lead to congestion alongside improving RCEM compliance in line with RCEM recommendations. Service changes made through the UEC March performance evaluation will be built into the service delivery model and funded as part of ED establishment in future.

WVT is asked to support this proposal outlining the use of additional investment for 2024/25.

The workforce model will be reviewed regularly through the Trust wide business planning process.

13. Post-Implementation Evaluation Plan

The project will be evaluated through the following routes:

Weekly review of the ED rotas and management of change processes.

Annual business planning process in December 2024.

Monthly monitoring of performance data eg 4 hour performance.

Monthly monitoring of quality metrics.

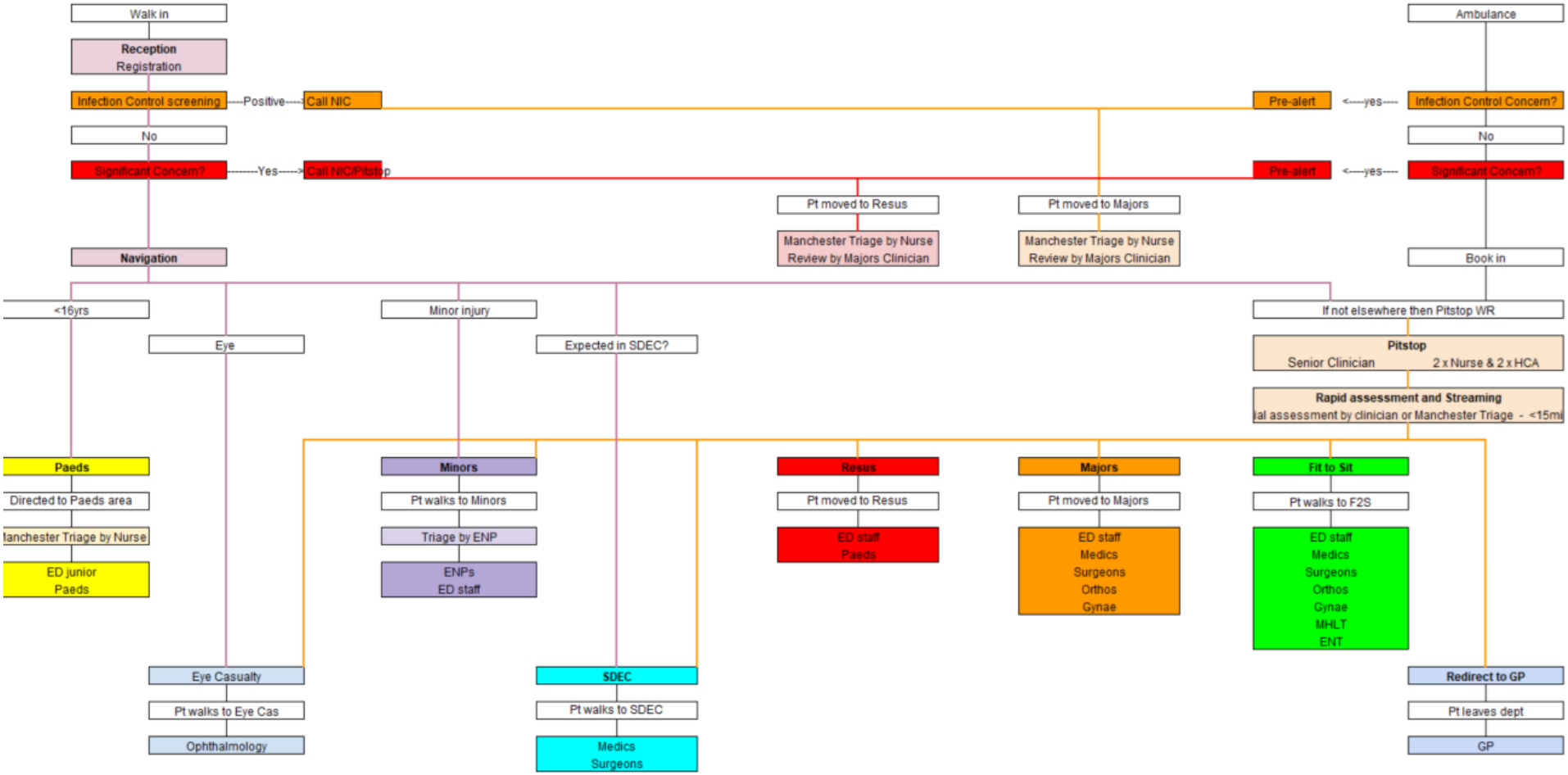
Monthly review of recruitment and turnover.

Monthly review of management of change processes.

Post business case evaluation at Trust Management Board through quarterly reporting.

NHS
Wye Valley
NHS Trust

Appendix 1
Current A&E Model



Appendix 2

EQUALITY IMPACT ASSESSMENT (EIA) FORM

Please read EIA guidelines when completing this form

Section 1

Name of Lead for Activity:	**Kate O'Shea**
Job Title:	Interim General Manager, Acute & Emergency Directorate

	Name	**Job Title**	**Email Contact**
Details of individuals completing this assessment	Shannon Bakan	General Manager, Acute & Emergency Directorate	**Shannon.Bakan@wvt.nhs.uk**
Date assessment completed	**13 November 2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** WVT ED Clinical Staffing Business case				
What is the aim, purpose and/or intended outcomes of this Activity?	This Business Case seeks to increase the clinical budget for the ED (ED) as impacted by the following: - Increased demand for ED services including senior leadership availability at the weekend; - Mandated Resident Doctor (RD) contractual changes requiring time out to be budgeted; - Mandated Specialty Doctor (SD) contractual changes requiring time out to be budgeted.				
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. For example, one of the impacts driving the requirement for larger budget is that the doctors now must work less regularly at weekends.
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 Medical capacity following mandated contractual 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.
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.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
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
- MTS analysis
- Financial analysis
- Job planning (annual)
- Effective rota management via Medical Rotas team (weekly 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:	SBAKAN
Date signed:	09.02.24
Comments:	
Signature of Lead for this activity:	Jo Clutterbuck
Date signed:	3/6/24
Comments:	

Appendix 3 – Risks

Risk	Consequence	Mitigating Action(s)	Risk Score
A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in a timely way, impacting on the safety of care and the wellbeing for our patients.	Resource and workforce challenges due to national and local workforce shortages, workforce availability of staff with required skills/knowledge, increased pressure on staffing capacity winter/Covid. Not able to provide activity and capacity to meet the demand. Risk to patient life; delayed ambulance offloads; delayed patient care; deterioration of 4hr performance Substantive staff burnout; increased sickness. Inability to deliver WVT UEC QIP anticipated actions and outcomes relating to reducing ED crowding and exit block, placing further strain on the workforce and delivery of effective and safe patient care. No 'ready' staff and applicants largely requiring training. Will decrease ability to provide activity and capacity to meet the demand temporarily & delay patient care.	Business case to be considered by TMB. Employing to full consultant establishment in 2022/23; reducing bank/agency for consultant cover through use of head hunting agencies and recruitment and retention strategy led by medical education. WVT Workforce Plan: workforce and risk assessment action plan.	20
No additional investment identified for the department post 2023.	Not able to provide activity and capacity to meet the demand. Risk to patient life; delayed ambulance offloads; delayed patient care; deterioration of 4hr performance	Business case to be considered by TMB.	15

Ability to recruit clinicians to 7:3 job plan	Historical EM Consultant recruitment challenges that has taken c.10 years to recruit to full establishment; unattractive job plan due to rural nature of hospital; Not able to provide activity and capacity to meet the demand. Risk to patient life; delayed ambulance offloads; deterioration of ED CQIs; Substantive staff burnout; increased sickness.	7:3 job plan national recommendation for EM Consultants; Employing to full consultant establishment in 2022/23; reducing bank/agency for consultant cover through use of head hunting agencies and recruitment and retention strategy led by medical education.	12
Ability to deliver CQC recommendations for robust leadership and governance with insufficient SPA time	Risk of inadequate CQC rating in future inspection; Not able to provide activity and capacity to meet the demand. Risk to deterioration of quality & safety in ED; patient life; delayed ambulance offloads; deterioration of ED CQIs; Substantive staff burnout; increased sickness.	Annualised job planning; review annually; continuous monitoring and engagement with CMO/ACMO;	12
Ability to deliver UEC QIP	Inability to deliver WVT UEC QIP anticipated actions and outcomes relating to reducing ED crowding and exit block, placing further strain on the workforce and delivery of effective and safe patient care.	Ward standards implemented; ED IPS implemented; Complex discharge pathways shared for review and adaptation; new ward based flow & discharge coordinator role agreed; UEC QIP prioritisation tool utilised to agree high and medium impact actions; new data dashboards implemented; development and implementation of new ways of working (SDEC, VW).	9
Physical space in the department and offices	No room for people to work from or see patients.	Use of remote working for staff. CPEC bid approved for ED reception and further CPEC bids under discussion.	9
Remote base of clinicians	Clinicians are unable to access patient information via systems and use of email will increase chances of information governance breaches.	Provide hardware to new and established clinicians. Improved Broadband, server and IT links. Provide productivity software for staff working off-site.	9

COVID-19 response and recovery	Staff impacted by sickness, redeployment etc. therefore clinical utilisation deteriorates and waiting time is impacted.	ED staffing 'key' staff prioritised for front line working. Remote working for staff.	4
Junior workforce requiring high levels of supervision and training	Supervised practice/supernumerary until sign off. Nationally, workforce shortages had led to recruitment challenges with no 'ready' staff and applicants largely requiring training. Will decrease ability to provide activity and capacity to meet the demand temporarily; delayed patient care; deterioration of ED CQIs.	Co-planning of capacity, training, clinical supervision, and agreement of roles and responsibilities. Regular review and performance management. Managed clinical network to support.	9
Suboptimal patient care due to inadequate staffing levels in ED and AMU	Not able to provide activity and capacity to meet the demand. Risk to patient life; delayed ambulance offloads; deterioration of ED CQIs; Substantive staff burnout; increased sickness.	Business case to be considered by TMB. Recruitment drives Ongoing recruitment UEC QIP	12
Lack of resource to fund ED outliers	Unfunded; high volumes of ED patients with a DTA unable to move to inpatient bed due to lack of capacity; currently staffed with SDEC & ePOD team to see ED outliers; insufficient ED workforce to meet the increasing demand; Workforce gaps due to leavers and ongoing recruitment challenges; substantive staff burnout and poor morale;	Business case to be considered by TMB to increase workforce.	9

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Bed Reconfiguration for Winter 2024
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Trust Management Board
Lead Executive Director:	**Chief Operating Officer**
Author:	Jo Clutterbuck, ACOO Medical Division
Documents covered by this report:	Business Case - Bed Reconfiguration for Winter 2024 - v7 Public Board.docx

1. Purpose of the report

This report sets out the background to the recent ward moves that have taken place.

It describes the drivers for the change sets out options for continuing with the recently changed bed base or reverting the previous bed base.

With the opening of the New Day Surgical Unit (DSU) in July, and the transfer of activity and staffing to support high volume Theatre lists, this has created a 12 bedded unit that can be utilised to support additional inpatient bed capacity ahead of Winter 2024.

This case is unusual in that the change set out within has already been temporarily implemented for the pragmatic reasons described below but the Trust is seeking to formalise the arrangement from the current temporary one.

It sets out the cost for continuing with the recently changed bed base.

Update from Non-Executive Review Meeting 03/09/2024 and the 24/09/2024

1. Whether there was commissioner support for the scheme and the need for a review of the baseline non-elective activity
2. That the paper should go to Trust Board for approval
3. Included in the paper is a summary of financial implications of the use of the old Day Surgery Unit area is there was unplanned operational requirement to open this capacity as an inpatient area. The impact of an “unplanned” opening would also have an impact on quality within this temporary inpatient area.
4. The ability to recruit to the roles
5. Summary of the initial improvements in flow key Perfomance indicators

Early indications are the changes made are have a positive impact on patient flow:

- The number of medical outlier patients have reduced from a daily average of 9.1 patients per day to 5.8 patients per day
- Length of stay of medical patients on Redbrook ward has reduced to 8.5 days when compared with 10.5 days when these patients were on Gilwern ward
- We have also seen a reduction in the number of patients ward moves compared with 2023, an indication that there is an improvement in the right patient in the right bed:

	Jul-23	Aug-23	Jul-24	Aug-24
Average Ward Moves	1.44	1.46	1.43	1.41
1 Or No Ward Moves	91.6%	90.3%	92.8%	92.8%
2 Or More Ward Moves	8.4%	9.7%	7.2%	7.2%

6. Recommendation(s)

To approve the option for continuing with the recently changed bed base.

7. Executive Director Opinion[1]

The Trust regularly has medical outliers on surgical wards and the opening of the new Surgical Hub has allowed a cross divisional review on how we use the bed base. The agreement was that we increase the medical bed base on Redbrook ward. An opportunity was taken to do this when our Daycase ward was emptied on 15th July. This has resulted in a reduction of our medical outliers and I support the funding for the increased bed base be made permanent.

8. 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.

Wye Valley NHS Trust

BUSINESS CASE

Title:	Bed Reconfiguration for Winter 2024
Ref. No.	WVTBC0138
Author:	Jo Clutterbuck – Associate Chief Operating Office – Medical Division
Division:	Medicine and Surgery
Finance Manager:	Asaf Hussain – Finance Manager
Executive Sponsor:	Andy Parker – Chief Operating Officer
Date:	25/09/2024

1. Introduction and Background Information

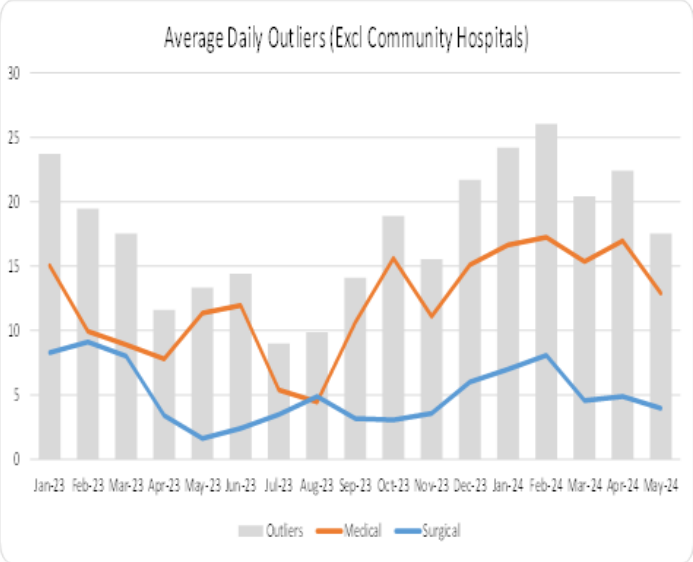
The bed base at the County Hospital until 15/7/24 is shown in table 1 and demonstrates that Medicine had 192 beds and 86 were allocated to Surgery as defined in the New Wards Business Case.

Table 1 – bed based prior to 18/7/24

Medicine			Surgery		
Ward	**Purpose**	**Bed No.'s**	**Ward**	**Purpose**	**Bed No.'s**
AMU	Admissions	24	Frome	Acute Surgery	30
Wye	Stroke	26	Primrose	Elective Surgery	11
Lugg	Cardiology/Gastro	30	Redbrook	Trauma	18
Arrow	Respiratory/Gen Med	24	Teme	Elective Orthopaedics	20
Gilwern	Outliers	16	WHW	Gynaecology	7
Ashgrove	Frailty	24			
Garway	Frailty	24			
Dinmore	Frailty	24			
Total		**192**			**86**

Gilwern ward was built as a Frailty ward prior to the opening of our Frailty block. With the opening of that block, the plan was to mothball the ward to allow it to be used as an escalation space. However due to ongoing bed pressures this has never been possible and the ward has been used first as a clean surgical ward during COVID and then as extra medical bed capacity. The funding for the ward was initially temporary and staff recruited on this basis. The baseline budget for nursing and non-pay has now been made permanent and recently substantive medical staff for Gilwern ward and Medical outliers was agreed (TMB 15th March 2024). However there has never been a business case to identify the full extent of the staff needed on a permanent basis.

Despite the ongoing use of Gilwern ward, modelling of the bed base showed that during 2023/24 there were on average 17 outliers per day - 12 medicine and four surgical (see graph 1) over and above the Gilwern beds. These outliers were a combination of medical patients on surgical wards and surgical inpatients on Daycase. On top of this across 2023/24 there were on average ten escalation beds open per day; for April and May 2024 this has increased to 15. Since October 2023 there have been on average 21 boarding patients per day, 17 of those medical patients.



Graph 1 – numbers of outliers Jan 2023 – May 2024

With the opening of the Day Surgical Unit (DSU) and the transfer of activity and staffing to support high volume Theatre lists, this has created a 12 bedded unit that can be utilised to support additional inpatient bed capacity ahead of Winter 2024.

This case is unusual in that the change set out within has already been temporarily implemented for the pragmatic reasons described below but the Trust is seeking to formalise the arrangement from the current temporary one.

2. Drivers for Change

Due to the number of medical outliers on surgical wards as shown above there is consensus in the Trust that there is a need to permanently increase the medical bed base. The opening of the DSU and move of day case work into the new building gave the Trust an opportunity to review how the existing daycase space is allocated and used. Several options (see Appendix 1) were put to a meeting of executive, divisional and clinical representatives, where Option C was agreed as the best option.

The original plan was to start the move when the existing Daycase Unit became permanently available in October 2024 (following its use as a decant space for various planned estates work). However the Daycase Unit was available for seven weeks over the summer 2024 and it was clear a plan needed to be made as to how to use the beds on the Daycase Unit to avoid the space being used in a sub-optimal way for patients. Following discussions between the Surgery and Medicine Divisions it was agreed to bring forward a modified version of the agreed Option C plan, moving Medicine into Redbrook and using Daycase for Elective surgery and this was implemented on 15th July – see table 2 below.

Table 2 – current bed base post 15/7 change

Medicine			Surgery		
Ward	**Purpose**	**Bed No.'s**	**Ward**	**Purpose**	**Bed No.'s**
AMU	Admissions	24	Frome	Acute Surgery	35
Wye	Stroke	26	DCU/ New Primrose	Elective Surgery	12
Lugg	Cardiology/Gastro	30	Gilwern	Trauma	16
Arrow	Respiratory/Gen Med	24	Teme	Elective Orthopaedics	20
Redbrook	Gen med/frailty	24	WHW	Gynaecology	7
Ashgrove	Frailty	24			
Garway	Frailty	24			
Dinmore	Frailty	24			
Total		**200**			**90**

The moves saw medicine move to Redbrook, which changed its boundaries back to a 24 bed ward, thus reducing the size of the surgical Frome Ward, which gained 12 beds on the vacated Daycase Unit. The net increase is 12 beds (due to the use of the Daycase Unit), with 8 additional beds in Medicine and 4 in Surgery.

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

3.1. Project Objectives

The purpose of this case is to put forward a proposal for re-allocating the bed base with the aim of reducing the number of medical outliers.

3.2. Critical Success Factors (CSFs)

The Critical Success Factors for this project are

- Reduced number of medical outliers in non-medical wards
- Reducing the number of ward moves for patients and the impact this has on Length of Stay (LOS)
- Reduction in LOS for patients on Redbrook Ward compared with previous medical patients on Gilwern ward and outlier patients

3.3. Benefits

Category	Description of Benefit	How benefit will be measured
Quality	Improved care for patients by ensuring consistency of care both medical and nursing Previously - patients on outlying wards were more likely to be moved and therefore have inconsistent nursing and medical care - Initial proposal for a substantive consultant to manage the ward with the aim of reducing LOS amongst this group	Reduced LOS Reduction in incidents
Operational	Substantive workforce particularly amongst medical staff improving continuity for patients Clear operational plan to utilise all potential available bed capacity space for winter 24. Reducing the need for "ad hoc" emergency contingency of escalation beds.	
Financial	Substantive workforce reducing need for bank/agency	Reduction in bank and agency spend

4. Options Appraisal

This proposal includes 2 options:

Option 1 – continue with the current bed base i.e. utilising Redbrook ward for medicine (table 2).

- Benefits
    - See section 3.3
    - No further ward moves
- Difficulties
    - Likely still to require medical patients to outlie at some points in the year

Option 2 – return to bed base described in Table 1

- Benefits
    - No reduction in surgical bed base
- Difficulties
    - Return to previous numbers of outliers with reduced quality of care and increased LOS.

The preferred option is Option 1 - continue with the current bed base i.e. utilising Redbrook Ward for medicine

In discussion with clinical colleagues and a review of the case mix on Gilwern, the Medical Division is proposing that the increased beds on Redbrook be used as a combination of General Medical and Frailty beds. The focus on the ward will be the efficient management of patients and reducing LOS as modelling has shown that the LOS on Gilwern and particularly medical outliers is longer than expected.

5. Staffing requirements

Medical staffing

Adequate medical staffing for this scheme was already in the budget.

Nursing

The nurse staffing requirement of the 12 bed increase are as follows:

	Staffing requirement		Uplift
	Long day	**Night Shift**	
Gilwern 16 beds – current staffing in budget	3 RNs/2 HCAs	2 RNs/2 HCAs	
Redbrook 24 beds	4 RNs/4HCAs	3 RNs/3 HCAs	5.19 WTE Band 5 7.79 WTE Band 2
	0.6 WTE increase in hybrid Housekeeper/ward clerk role		

The Surgical Division nurse staffing over ward areas described in Table 2 balances out with the ability to transfer the costs of 2 WTE HCAs across to the Medical Division.

6. Financial Analysis

The principle used in managing this ward reconfiguration is that the staff move with the patients. This creates a number of efficiencies and therefore the only additional funding required are for a proportion of the additional beds. The staffing for the 16 beds on Gilwern ward is permanently funded and in the budget and the Medical staffing was agreed at TMB on 15th March 2024.

Finance is therefore required to uplift 16 beds from the Gilwern budget to incorporate the additional eight beds on Redbrook. The costs are demonstrated in the table below.

Pay	Workforce	FTE	**Mid point [£]	Total [£]	Assumptions
Nursing	Band 5	5.19	50,013	259,812	1 Additional - 24/7- inc enhancements
Nursing	Band 2	7.79	39,315	306,357	2 Additional - Long Day & 1 - Nights
Healthcare Assistant	Band 2	0.6	£28,908	17,345	
Nursing - Existing transfer	Band 2			- 79,497	Assumes budget transfer for 1 FTE Band 2 HCA
Total Pay				**504,017**	

****FTE = Full Time Equivalent in above table

By way of comparator, if the beds were filled in an unplanned way with a mix of Agency/Bank staff the cost is shown below;

Pay	Workforce	FTE	Bank Hours (75%)	Agency Hours (25%)	Bank - £/PH	Agency - £/PH	£ Total	Assumptions
Nursing	Band 5	4.48	9,828	3,276	30.54	31.63	403,708	1 Additional - 24/7
Nursing	Band 2	6.72	6,552	2,184	22.50	24.06	199,981	2 Additional - Long Day & 1 - Nights
Housekeeper- Ward Clerk	Band 2	0.60	1,170		17.51		20,488	
Nursing - Existing transfer	Band 2						- 79,497	Assumes budget transfer for 1 FTE Band 2 HCA
Total Pay							**544,681**	

****FTE is lower as that is because no timeout is required for this option

7. Critical Assumptions and Risk Assessment

7.1. Critical Assumptions

Assumption from review completed is that there is an increased requirement for Medical Beds

7.2. Risk Assessment

The Quality Impact Assessment [QIA] (Appendix 2) identified that the main risks to the move were related to the proposal to change the use of the old Day Case Unit to a short stay Surgical Ward. The unit was not designed for in-patients but with the mitigations included in the QIA it was felt that the benefits of utilising the space for short stay inpatient beds and maintaining our elective activity outweighed the risks identified.

The specific risks identified were:

- The air changes per hour in old day case unit are 4, under HTN03-01 general ward areas should be served with a minimum of 6 air changes per hour. Mitigation - the old day surgery unit has been used for a mixture of day surgery and in-patients for a number of years. The plan to place clean elective surgery in this area is the lowest risk group of patients that could be identified.
- There is no natural light in the old day surgery unit. Mitigation - consider the installation of daylight LED panels
- Toilet and shower facilities are adjacent to one another and there is no natural light. Mitigation – this is similar to the facilities in Gilwern Ward. A costing for swapping the dirty utility and a shower/toilet facility would address the proximity/privacy and dignity issue. A CN will be raised to identify a cost

The Surgical Division will continue to monitor the environment and any incidents/complaints received and where possible put changes in place to improve the environment.

8. Impact Assessments

8.1. Equality Impact Assessment

See Appendix 2

8.2. Quality Impact Assessment

QIA completed + present to TMB 19/7/2024. See risk assessment for further narrative on QIA

8.3. Sustainability Impact Assessment

N/A

8.4. Data Protection Impact Assessment

N/A

9. 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	☐	AHP	☒
ICT Support – Application and/or infrastructure support	☐	No material impact	☐

AHP and Pharmacy requirement

Following discussion of the case; it was recognised that changes such as these have an impact on support services. The AHP team are currently undertaking a demand and capacity review and will include this move in that. It was suggested that the Pharmacy team undertake a similar review.

Estates

There were no additional costs for the ward moves.

10. Implementation Timeline

Option 1 was put into place on 15/7/2024.

If Option 2 is agreed implementing the move back could be completed relatively quickly (one day)

11. Leadership and Project Management

The move has already been undertaken and has been managed by the Medical Division.

12. Workforce Plan

Section 5 above sets out the staffing requirements. The posts are filled or are in the recruitment process.

13. Conclusions and Recommendations

In conclusion, there was agreement at meeting of executive, clinical and divisional representatives that there needed to be an increase in the medical bed base (Option 1). This occurred on 15/07/2024 with an increase of eight beds for medicine. This case is to retrospectively agree the permanent staffing requirement.

14. Post-Implementation Evaluation Plan

A post bed move evaluation to be undertaken at the end of September and again post winter 2024/25

15. Appendix 1 – Bed base options

Option A

Medicine			Surgery		
Ward	**Purpose**	**Bed No.'s**	**Ward**	**Purpose**	**Bed No.'s**
AMU	Admissions	24	Redbrook	General Surgery	24
Wye	Stroke	26	DCU	Elective Surgery	12
Lugg	Cardiology/Gastro	30	Gilwern	Trauma	16
Arrow	Respiratory/Gen Med	24	Teme	Elective Orthopaedics	20
Frome/ Primrose	TBC	35	WHW	Gynaecology	7
Ashgrove	Frailty	24			
Garway	Frailty	24			
Dinmore	Frailty	24			
Total		**211**			**79**

Option B

Medicine			Surgery		
Ward	**Purpose**	**Bed No.'s**	**Ward**	**Purpose**	**Bed No.'s**
AMU	Admissions	24	Frome	General Surgery	30
Wye	Stroke	26	DCU	Elective Surgery	12
Lugg	Cardiology/Gastro	30	Gilwern	Trauma	16
Arrow	Respiratory/Gen Med	24	Redbrook	Elective Orthopaedics	18
Teme/ Primrose	TBC	31	WHW	Gynaecology	7
Ashgrove	Frailty	24			
Garway	Frailty	24			
Dinmore	Frailty	24			
Total		**207**			**83**

Option C

Medicine			Surgery		
Ward	**Purpose**	**Bed No.'s**	**Ward**	**Purpose**	**Bed No.'s**
AMU	Admissions	24	Frome	Acute Surgery	29
Wye	Stroke	26	DCU	Elective Surgery	12
Lugg	Cardiology/Gastro	30	Gilwern	Trauma	16
Arrow	Respiratory/Gen Med	24	Teme	Elective Orthopaedics	20
Redbrook	Gen med/frailty	30	WHW	Gynaecology	7
Ashgrove	Frailty	24			
Garway	Frailty	24			
Dinmore	Frailty	24			
Total		**206**			**84**

16. Appendix 2 - Equality Impact Assessment

Name	**Surgical Ward Reconfiguration**	**Clinician/Practitioner Completing QIA**	Lynne Kedward
Overview	This QIA supports plans to reconfigure the bed base following the opening of new day case theatres which results in the old day surgery unit without an identified specialty function. The planned reconfiguration is for the winter and will be reviewed in March 2025 and includes: - GAU becoming a 16 bedded Trauma Unit - Primrose and short stay (no more than 72 hrs) electives move to old day surgery unit (12 beds) - Frome moving into the vacated Primrose beds and relinquishing 6 beds back to Redbrook (35 bedded Surgical Ward with 6 beds allocated for longer stay elective work) - Redbrook expanding to 24 beds and becoming General Medicine Further changes are planned in October when the annual maintenance cycle has concluded	**KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)**	Patient experience/feedback, complaints, incidents,

	Details	Consequence	Likelihood	Score	Mitigation actions controls	Residual Score	Escalate to Division/ Trust risk register?	Quality indicators
Patient Safety	Medical patients currently outlie in all surgical areas There are occasions when these patients are inappropriate to outlie due to complex medical conditions These patients are often nursed by surgical nurses who do not have the experience to manage medical patients. The medical staff struggle to review these patients in a timely fashion due to the spread and number of medical outliers across the surgical bed base. Patients are often moved out of hours when there are reduced staffing levels. Previous inappropriate placement of patients	4	4	16	This proposal sees an increase in the medical bed base resulting in patients being cared for by appropriately skilled nursing and medical teams. The plan is that short stay elective patients will be cared for in the old day surgery unit which is adjacent to theatres and improves elective surgical flow. The changes will be closely monitored throughout July with a planned review in August ahead of further potential changes in October.	8	Review after reconfiguration, potential risk if this issue persists	Patient Feedback Complaints Incidents

	has resulted in serious incidents.							
Clinical Effectiveness	**Details**	**Consequence**	**Likelihood**	**Score**	**Mitigation actions controls**	**Residual Score**	**Escalate to SU / Trust risk register?**	**Quality indicators**
	The medical staff struggle to review outlying patients in a timely fashion due to the spread and number of medical outliers across the surgical bed base. Medical staff are often locums, continuity is also an issue. Length of stay often increases in outlying patients due to lack of continuity of care.	4	4	16	Increased medical bed capacity (8 additional beds) allows for patients to be co-located in one area with appropriately skilled regular nursing and medical staff.	4	Review after reconfiguration, potential risk if this issue persists	Patient Feedback Complaints Incidents
Patient Experience	**Details**	**Consequence**	**Likelihood**	**Score**	**Mitigation actions controls**	**Residual Score**	**Escalate to SU / Trust risk register?**	**Quality indicators**

	Medical patients are currently moved into outlying surgical beds due to bed capacity issues. They are informed of the reason for the move and some patients experience multiple moves. Some of these outlying patients find themselves in the Day Surgery Unit where there are no windows, space is limited and the environment is not designed for in-patients - bathroom and toileting facilities are not of the same provision as ward areas, these patients can often stay in the unit for a week or more, already having had a multi-day stay in other wards. Nurse staffing and skill mix is not always appropriate for the management of medical patients.	3	5	15	This proposal reduces the number of medical patients experiencing outlying into surgical beds and surgical day surgery unit. The plan to move primrose into Day Surgery Unit for short stay patients - up to 72hrs, allows the Trust to ensure that patient experience in the old day surgery unit is relatively	9	Review after reconfiguration, potential risk if this issue persists	Patient Feedback Complaints

						short. Longer stay elective surgical patients will be cared for in a 6 bedded area within Frome Ward. The nursing team will be skilled to care for the patients and the adjacency to theatres ensures that surgical flow and patient experience is maximised. There are male and female shower rooms with			

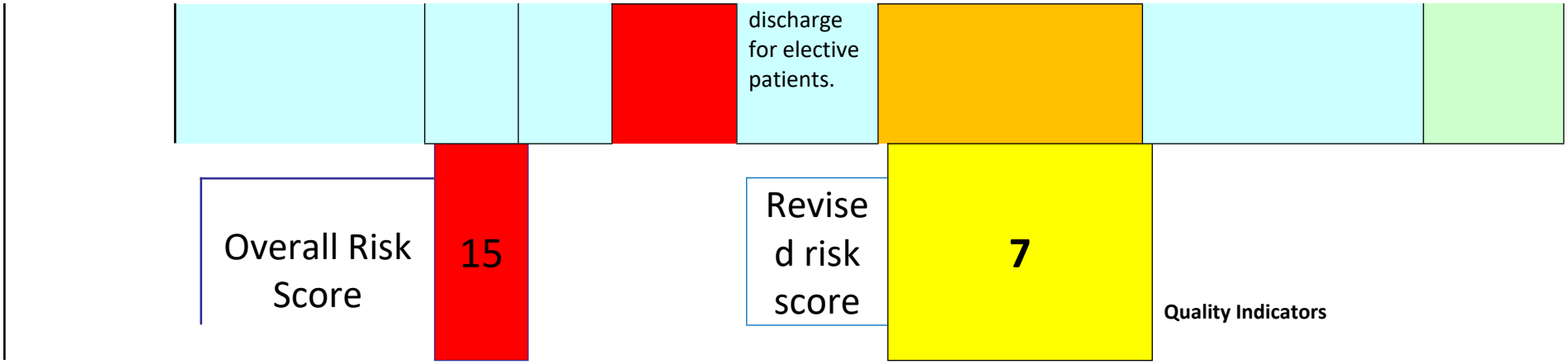
				separate toilets although these are adjacent to each other (split by a single toilet). In terms of availability they are similar to Gilwern Ward provision. The male and female sides of the unit are segregated but patients use the same corridor to access washing and toileting facilities.				

Staff Experience		Consequence	Likelihood	Score	Mitigation actions controls	Residual Score	Escalate to SU / Trust risk register?	Quality indicators
	Surgical staff are currently caring for medical patients, this has a detrimental effect on retention in some surgical areas. Nurse staffing levels in Medicine will need to be subject review and investment to ensure that there is not an over reliance on agency staff. The proposed changes should reduce this, however the process of reconfiguration will impact on some staff within the surgical wards as some staff will need to move to different wards	4	4	16	Full staff consultation has taken place and teams of staff will be kept together. Matrons are supporting teams and working through induction and orientation processes for staff who are moving.	8	Review after reconfiguration, potential risk if this issue persists	Staff Satisfaction Survey/Exit interviews Recruitment and Retention Sickness Absence

	associated with the proposed changes.							

Inequalities	Details	Consequence	Likelihood	Score	Mitigation actions controls	Residual Score	Escalate to SU / Trust risk register?	Quality indicators
	Medical patients do not get reviewed in a timely way in surgical areas whereas surgical patients do. Medical patients in medical wards receive care from medically experienced nurses.	3	4	12	The planned reconfiguration will minimise outlying medical patients and assist with continuity of care, reducing inequalities.	6	Review after reconfiguration, potential risk if this issue persists	Incidents Length of stay for medical outlying patients

Targets / Performance	Details	Consequence	Likelihood	Score	Mitigation actions controls	Residual Score	Escalate to SU / Trust risk register?	Quality indicators
	Length of stay for outlying medical patients is often extended due to lack of continuity. Outlying patients slows down patient flow and impacts on ED performance.	4	4	16	This proposal should improve length of stay for some medical patients. Improved management of outliers will have a positive impact on ED performance. The surgical specialties will continue to focus on improvements in length of stay and nurse led	8	Review after reconfiguration, potential risk if this issue persists	Length of stay for medical and surgical patients Reduced delays in ED for medical beds Reduction in medical outliers


discharge for elective patients.
Overall Risk Score
15
Revise d risk score
7
Quality Indicators

17. Appendix 3 - Equality Impact Assessment

Equality Impact Assessment

Please read EIA Guidance when completing this form.

Section 1

Name of Lead for Activity:	Jo Clutterbuck
Job Title:	ACOO Medical Division

	Name	**Job Title**	**Email Contact**
Details of individuals completing this assessment	Jo Clutterbuck	ACOO Medical Division	Joanna.clutterbuck@wvt.nhs.uk
Date assessment completed	15/8/24		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Proposal to re-allocate bed base to increase medical bed base and reduce outliers			
What is the aim, purpose and/or intended outcomes of this Activity?	Aim of project is to increase the medical bed base by moving 16 medical beds on Gilwern to 24 medical beds on Redbrook.			
Who will be affected by the development & implementation of this activity?	❑ ✓ ✓	Service User Patient Carers Visitors	✓ ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑ 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.)	Due to the number of medical outliers on surgical wards there is consensus in the Trust that there is a need to permanently increase the medical bed base.
Summary of engagement or consultation undertaken (e.g. who, and how, have you engaged with, or why do you believe this is not required)	Meeting with members of the Executive team + operational and clinical representatives from Medicine and Surgery.
Summary of relevant findings	Agreed to increase move of medical bed base

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 <u>positive</u> impact**	**Potential <u>neutral</u> impact**	**Potential <u>negative</u> impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Age		✓		Overall this move will have minimal impact as the plan will change the location of beds rather than overall capacity or change in ability to access beds. Overall it should have a positive impact on quality of care but no specific impact on any groups.
Disability		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status		✓		

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

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**

How will you monitor these actions?

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)

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:	Jo Clutterbuck
Date signed:	15/8/24
Comments:	
Signature of Lead for this activity:	Jo Clutterbuck

Date signed:	15/8/24
Comments:	

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	**Proposed Board and Committee dates for 2025**
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon (Company Secretary)
Documents covered by this report:	Proposed Board and Committee dates for 2025
1. Purpose of the report	
To provide the Board with the opportunity to review and agree the proposed Board and Committee dates for 2025.	
2. Recommendation(s)	
To note and agree the Board and Committee dates for 2025.	
3. Executive Director Opinion[1]	
These dates have been discussed and agreed with respective committee chairs.	
4. Please tick box for the Trust's 2024/25 Objectives the report relates to:	

[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.

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***

WVT Board & Committee Dates 2025																		
2025	NED's Pre-meet with		Board Workshop		Board of Directors		Executive Risk		Charity Trustee		Audit		RemCo		Trust Management Board		Quality Committee	
January	16th	12.30pm - 1pm			16th	1pm- 4.00pm	21st	1pm-2.30pm							10th/24th	1pm-2.30pm/12.00-2.00	30th	1.00pm-4.00pm
February - FG BOARD	***5th***	***8.30am - 9.30am***	***5th***	***9.30am-12pm***	***5th***	***1.30pm- 4.45 pm***	18th	1pm-2.30pm							7th/21st	1pm-3.00pm	27th	1.00pm-4.00pm
March	6th	9.00am - 9.30am	6th	9.30am-12pm	6th	1pm- 4.00pm	18th	1pm-2.30pm	13th	1pm-2.00pm	13th	9.30am-12pm	13th	2pm-3.00pm	7th/21st	1pm-3.00pm	27th	1.00pm-4.00pm
April	3rd	8.30am-9.00am	3rd	9.00am-11.30pm	3rd	1pm- 4.00pm	15th	1pm-2.30pm							4th only	1pm-3.00pm	24th	1.00pm-4.00pm
May - FG BOARD	***7th***	***8.30am - 9.30am***	***7th***	***9.30am-12pm***	***7th***	***1.30pm- 4.45pm***	20th	1pm-2.30pm							2nd/16th	1pm-3.00pm	29th	1.00pm-4.00pm
June	5th	9.00am - 9.30am	5th	9.30 - 12pm	5th	1pm - 4.00pm	17th	1pm-2.30pm	12th	1pm-2.00pm	12th	9.30am-12pm	12th	2pm-3.00pm	6th/20th	1pm-3.00pm	26th	1.00pm-4.00pm
July EOY Board	3rd	8.30am - 9.00am	3rd	9.00am-11.30am	3rd	1pm- 4.00pm	15th	1pm-2.30pm			24 June EOY MEETING	9.30am-12pm			4th/18th	1pm-3.00pm	31st	1.00pm-4.00pm
August - FG BOARD	***6th***	***8.30am - 9.30am***	***6th***	***9.30am-12pm***	***6th***	***1.30pm- 4.45pm***	19th	1pm-2.30pm							1st/15th	1pm-3.00pm	28th	1.00pm-4.00pm
September	4th	9.00am - 9.30am	4th	9.30am-12pm	4th	1pm- 4.00pm	16th	1pm-2.30pm	18th	1pm-2.00pm	18th	9.30am-12pm	18th	2pm-3.00pm	5th/19th	1pm-3.00pm	25th	1.00pm-4.00pm
October	2nd	8.30am-9.00am	2nd	9.00am-11.30am	2nd	1pm- 4.00pm	21st	1pm-2.30pm							3rd/17th	1pm-3.00pm	30th	1.00pm-4.00pm
November - FG BOARD	***5th***	***8.30am - 9.30am***	***5th***	***9.30am-12pm***	***5th***	***1.30pm- 4.45pm***	18th	1pm-2.30pm							7th/21st	1pm-3.00pm	27th	1.00pm-4.00pm
December	4th	9am - 9.30am	4th	9.30am-12pm	4th	1pm- 4.00pm	16th	1pm-2.30pm	11th	1pm-2.00pm	11th	9.30am-12pm			5th/19th	1pm-3.00pm	18th	1.00pm-4.00pm

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Sustainable Development Management Plan (SDMP) update
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Sustainability Group, Trust Management Board
Lead Executive Director:	**Chief Strategy Officer**
Author:	Nick Exon, Christian Homersley, Lee Stockton
Documents covered by this report:	SDMP progress update.docx

1. Purpose of the report

The report provides an update on progress made against the Trust's Sustainable Development Management Plan 2020-2025 (SDMP) which was approved by the Board in the summer of 2020.

The SDMP outlines projects and activities which will address sustainability throughout the Trust, covering areas such as staff awareness and engagement, through to technical schemes aimed at reducing carbon emissions produced from the Trust's activity.

The SDMP was developed using the Sustainable Development Assessment Tool (SDAT) the national bench marking system designed by the then Public Health England and NHS England. The Trust SDMP describes the "Top 3 things we need to do" and other "We will" commitments against each of the 10 modules of the SDAT tool.

The report summarises the progress against these commitments. The Trust has made good progress against the SDMP where overall two thirds of the commitments have been delivered, one third are still in progress with none undelivered. Two commitments were undeliverable.

The report also presents progress against some of the key metrics (Energy and water usage, waste and mileage)

2. Recommendation(s)

TMB are recommended to note the progress against the SDMP.

3. Executive Director Opinion[1]

The SDMP or 'Greener Plan' has been in place for some time and will need to be refreshed this year. This report clearly shows progress against the plan we committed to, in some ways helped and hindered by the Covid pandemic. I would draw member's attention to the indicators used in the appendix, which does tell a positive story. It has been immensely difficult to find any objective way of demonstrating progress in this field, which is surprising given the national focus on sustainability in the NHS.

[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

Sustainable Development Management Plan (SDMP) update

2024

Document Properties:

Authors:	Nick Exon, Christian Homersley, Lee Stockton
Executive Sponsor:	Alan Dawson
Date:	03/09/2024
Version	1.0

Table of Contents

1. Introduction

This report provides an update on progress made against the Trust's Sustainable Development Management Plan 2020-2025 (SDMP) which was approved by the Board in the summer of 2020.

2. The SDMP

The SDMP outlines projects and activities which will address sustainability throughout the Trust, covering areas such as staff awareness and engagement, through to technical schemes aimed at reducing carbon emissions produced from the Trust's activity.

The plan is the blueprint for co-ordinating our response to the challenges of sustainability and is aligned with the UN's 17 Sustainable Development Goals (SDG) (2015/30), an ambitious collection of global aims intended to encourage countries to end all forms of poverty, fight inequalities and climate change, whilst ensuring that no one is left behind.

This is also set against the backdrop of the NHS Green Plan aiming to achieve net zero carbon emissions by 2040.

The SDMP was developed using the Sustainable Development Assessment Tool (SDAT) the national bench marking system designed by the then Public Health England and NHS England. The tool is designed to help the NHS and other health and care organisations understand their work, measure progress and help create the focus of and action plans for their sustainable development management plans.

The SDAT is made up of ten modules which are all assessed against four themes; governance and policy, core responsibilities, procurement and supply chain, and working with staff. The ten modules are:

Corporate Approach	Asset Management & Utilities	Travel & Logistics	Adaptation	Capital Projects
Greenspace & Biodiversity	Sustainable Care Models	Our People	Sustainable Use of Resources	Carbon / GHGs

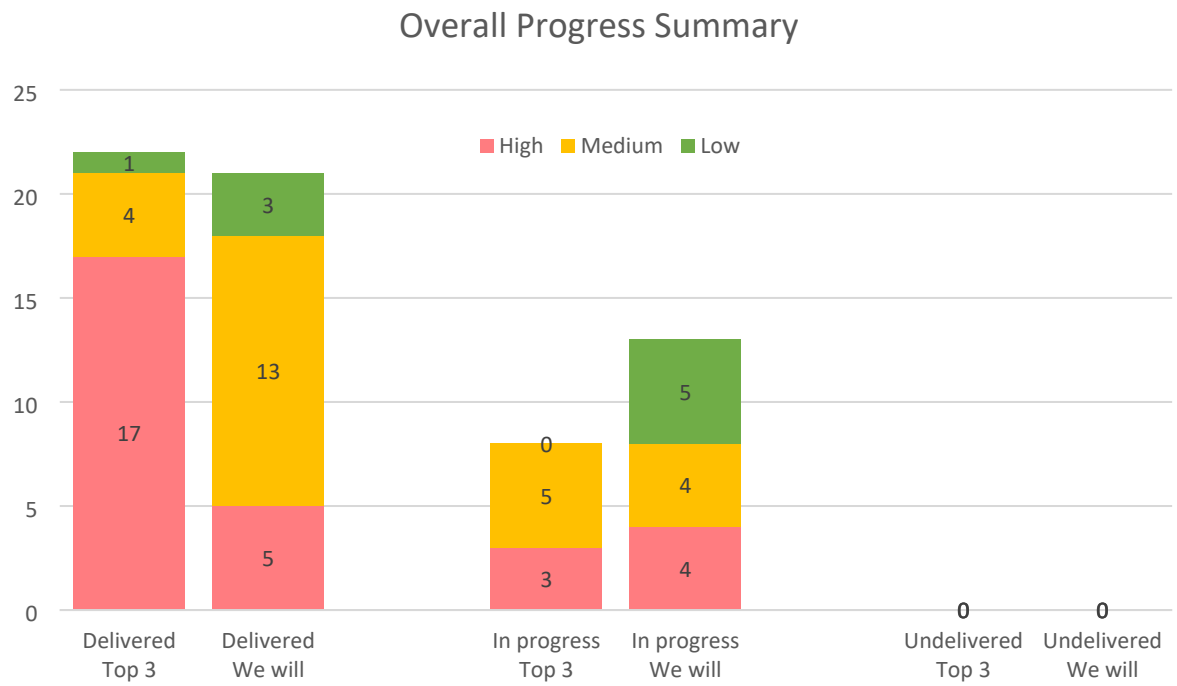
The Trust SDMP describes the "Top 3 things we need to do" and other "We will" commitments against each of the modules. This report summarises the progress against these commitments.

3. Progress against the SDMP

Each commitment was prioritised as either “High”, “Medium” or “Low” and the status rated as either “Delivered”, “In progress”, “Undelivered” or “Undeliverable”.

Overall Progress Summary

		Status				Status	
	Priority	Delivered	In progress	Undelivered	Total	Undeliverable	Total
Top 3	High	17	3	0	***20***	0	***20***
	Medium	4	5	0	***9***	0	***9***
	Low	1	0	0	***1***	0	***1***
		22	***8***	***0***	**30**	***0***	**30**
		73%	***27%***	***0%***			
We Will	High	5	4	0	***9***	0	***9***
	Medium	13	4	0	***17***	0	***17***
	Low	3	5	0	***8***	2	***10***
		21	***13***	***0***	**34**	***2***	**36**
		62%	***38%***	***0%***			
Total		**43**	**21**	**0**	**64**	**2**	**66**
%		**67%**	**33%**	**0%**			



Overall two thirds of the commitments have been delivered, one third are still in progress with none undelivered. Two commitments were undeliverable.

High-level progress against each module

	Corporate approach	Asset Manage-ment & Utilities	Travel & Logistics	Adaptation	Capital Projects	Green Space and Bio-diversity	Sus-tainable Care Models	Our People	Sus-tainable Use of Resources	Carbon / GHG's	Total
Delivered	3	5	7	3	4	0	3	10	4	4	**43**
In progress	4	1	1	1	0	7	4	0	3	0	**21**
Undelivered	0	0	0	0	0	0	0	0	0	0	**0**
Undeliverable	0	1	0	0	0	1	0	0	0	0	**2**
											66

Each of the sections below provide a narrative against each of the modules.

Corporate approach

The Trust has developed robust plans to reduce carbon which are being delivered through the Integrated Energy Solutions (IES) project:

- Phase 1 - drilling of a ground array of 46 boreholes, installation of ground source heat pumps, air source heat pumps, solar photovoltaic panels and LED lights, along with the upgrade of air conditioning and lighting controls.
- Phase 2 - construction of a new Integrated Energy Centre (IEC) to provide heat from air-source heat pumps removing the reliance on the existing gas/oil fired steam boilers providing a reduction in CO2 which will almost completely decarbonise the County Hospital site. Phase 2 is underway and is due to complete December 2025.

The Sustainability Group is further embedded in the Trust with increased engagement across the organisation including the introduction of the Green Champions initiative.

Sustainability Impact Assessments (SIAs) are now included in a combined Impact Assessment template to be submitted with business cases.

Key sustainability performance indicators are being developed.

Asset Management & Utilities

The Trust has a clear policy and process for our Estates Strategy which is currently being refreshed that clearly demonstrates our commitment to sustainability.

The Trust is reducing energy demand, improving energy efficiency and increasing on-site energy generation from renewable sources through the IES project.

The commitment to work with our Council partners on the creation of a heat network for Herefordshire was explored but not taken forward so was deemed to be undeliverable.

Travel & Logistics

The Trust Travel Plan was reviewed and updated and taken to TMB in April 2024.

Active travel and public transport facilities across the Trust's sites have been improved through the Beryl bike hire scheme, introduction of the City Zipper bus service, incentivizing car sharing and promoting the "park and share" scheme.

Grey Fleet mileage has been reduced mainly by the move to online meetings but also by incentivising alternative, more sustainable, travel methods such as the Cycle to work scheme and the Contract Hire and Salary Sacrifice Schemes which are available to new and existing employees of the Trust who do Business Miles, Private Miles or a combination of both.

The Trust has worked with the Council to promote the "Choose how you move" campaign including intranet pages and car parking communications to staff.

Adaptation

The Climate Adaptation Plan was approved by TMB on 16/02/204 and the Trust Board on 07/03/2024. The plan will support the whole organization to prepare to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures.

The Trust has embedded the effects of climate change into the organisation's risk register with the following entry:

Risk Number	1711
Risk Type	Emergency Planning
Risk Title	Effects of Climate Change
Risk Detail	There is a risk of harm, loss of life and environmental catastrophes due to climate change, which has the potential to impact the NHS service delivery, resources and infrastructure
Initial Risk Rating	16 (Extreme) = (Likelihood 4, Consequence 4)
Current (2024) Risk Rating	12 (High) = (Likelihood 3, Consequence 4)
Target Risk Rating	8 (High) = (Likelihood 2, Consequence 4)

Capital Projects

All new build and major refurbishments are now specified to achieve the Building Research Establishment Environmental Assessment Methodology (BREEAM) excellent standard. This has included the Elective Surgical Hub (ESH), Community Diagnostic Centre (CDC) and the future Education Centre.

Contractors are now assessed against sustainability as part of the tender process for capital projects through including sustainability criteria as part of the Procure 23 (P23) procurement methodology used for large capital schemes.

Sustainability Impact Assessments (SIAs) are now included in a combined Impact Assessment template to be submitted with business cases.

Green Space and Biodiversity

This domain will be a focus this year where one of the Trust's 2024/25 Objectives is "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"

A planting plan and commitment to maintain the area around the new Ward block has been developed. Work on this frailty garden is underway and the Bereavement garden will follow later in the year.

There was a commitment to investigate the use of roof space and walls with a focus on improving our biodiversity. This has been investigated but although desirable there are a number of issues that potentially make this impractical as it is unlikely that any of the existing roofs were designed as green roofs. This commitment was therefore deemed undeliverable.

Sustainable Care Model

In 2022-23 the Trust launched the Valuing Patients Time programme board which seeks to empower patients to know what their plan of care is, when they should expect to be discharged to their preferred place of care and what happens after discharge. Each division contributes a bespoke improvement plan to the programme which is monitored centrally by the Trust Transformation team.

The Digital Strategy for 2024-2027 has been approved by the Board and has been built around 4 main tenets:

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

A number of "perfect week/fortnight" initiatives have been undertaken including Theatre Utilisation, ED, SDEC, T&O and "focus on flow" in order to redesign care pathways to drive out any unnecessary stages. Other initiatives include providing more outpatient activity closer to home through the use of virtual clinic appointments and group clinics, use of advice and guidance and patient initiated follow up to avoid unnecessary appointments.

To support staff with these initiatives the Trust uses the Quality Service Improvement and Redesign (QSIR) methodology to enhance Quality Improvement knowledge and skills across the workforce.

The Trust does not use the anaesthetic gases (such as Desflurane) that produce the highest emissions associated with areas of high impact and are working on ways to reduce

emissions from Nitrous Oxide. The Trust is using best evidence and practice to ensure that the most efficient and effective medicine choices are made.

Our People

All commitments for this domain have been delivered.

The Trust directly employs more nurses and clinical staff and is working hard to reduce its reliance on Agency staff.

The Trust uses a "Grow our own" workforce approach to recruit and train people into the key professional roles from entry level to senior clinician.

To improve the security of staff at work the Trust has implemented the guidance from NHS Protect where the Trust Security and Logistics Manager has been trained as an accredited Local Security Management Specialists (LSMS). In addition a security service is now provided 24/7 on the County Hospital site and a number of the Sodexo porters are Security Industry Authorised (SIA) licenced.

The Trust encourages appropriate staff behaviours through the Leadership Charter and listens and takes action through staff annual engagement exercises including Staff Engagement Sessions, NHS Survey results and Staff Friends & Family Test.

To support staff wellbeing outside spaces have been set up in the courtyard by ED, and tables and chairs have been set up by the Old Chapel and Union Walk entrance. The Trust has also worked with Sodexo to make the Spires restaurant available to staff 24/7 and created a staff rest room.

The Trust has increased access to counselling for staff by teaming up with Health Assured to provide an Employee Assistance Programme (EAP) which is accessible 24/7 and can be accessed when you staff away from the office through the myWVT app.

The Trust have teamed up with the Point of Care Foundation to offer both Schwartz Rounds and Team Time (a virtual version of Schwartz Rounds). Schwartz Rounds are held every other month, each one focusing on a different topic, but interested in exploring our very human experiences of working in healthcare. Staff who have attended Schwartz Rounds report improvements in their ability to attend to the emotional aspects of care, their experience of team working and relationships with colleagues, and a reduction in stress and isolation.

Exit interviews are undertaken as part of the leaver's procedure. To encourage actions on what is said exit Survey data is analysed and fed back to managers and a monthly reported is provided to the Chief People Officer.

Suitable Use of Resources

WVT is now part of the Foundation Group Procurement Shared Service. Key deliverables include:

- Adhere to the requirements of the NHS Sustainable Suppler Framework.

- Ensure tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts from April 2022 and 2023 respectively.
- Work with NHS Supply Chain to address Modern Slavery and domestic and international supply chain environmental, and human rights risks, including those linked to PPE.
- Work to identify impactful future supply chain emissions reductions opportunities and links to climate adaptation and other Green Plan commitments in procurement specifications and through contract delivery

Supporting the principles of the 5 R's of zero waste approximately 31% of Community waste is recycled (24% at the County). Extra bins have been put in place to improve take up. There is no landfill from the non-clinical waste streams and not routinely from the clinical waste streams. Recycling schemes have been launched at the Trust community sites and is being trialled at the County site.

To ensure facilities management contracts include sustainability within the specification and as part of the tender process the Trust follows the new NHS Procurement rules and standards.

Carbon / GHG's

The Trust has developed plans to reduce our carbon emissions in line with the NHS Sustainable Development Strategy, the Climate Change Act (2008) and the new target of zero emissions by 2050.

The commitments of this domain are mainly being addressed through the Integrated Energy Solutions (IES) project.

Vehicle mileage reduction is being achieved through the digital strategy (Virtual working).

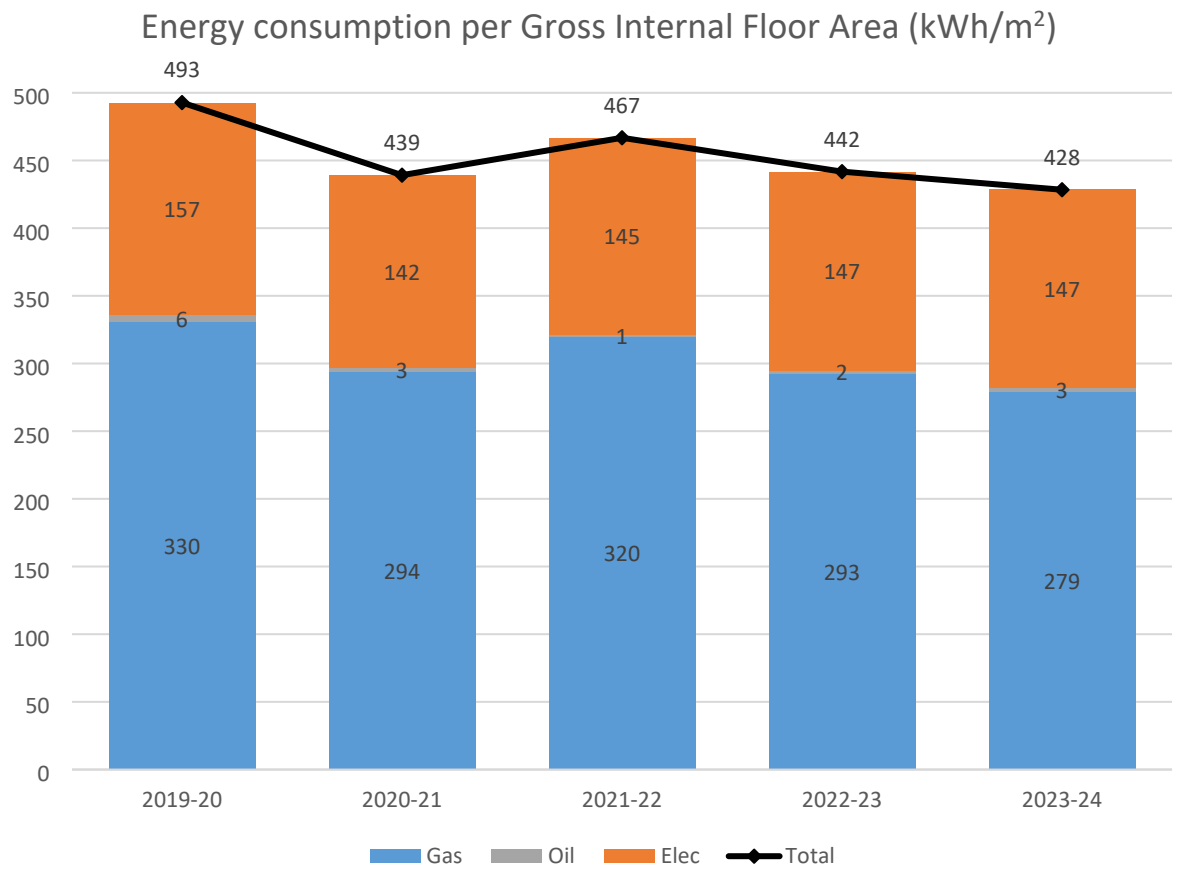
4. Conclusions

The Trust has made good progress against the SDMP where overall two thirds of the commitments have been delivered, one third are still in progress with none undelivered.

5. Appendix A - Metrics

Where possible metrics have been converted to Kg of CO_2 equivalent ($KgCO_2e$)

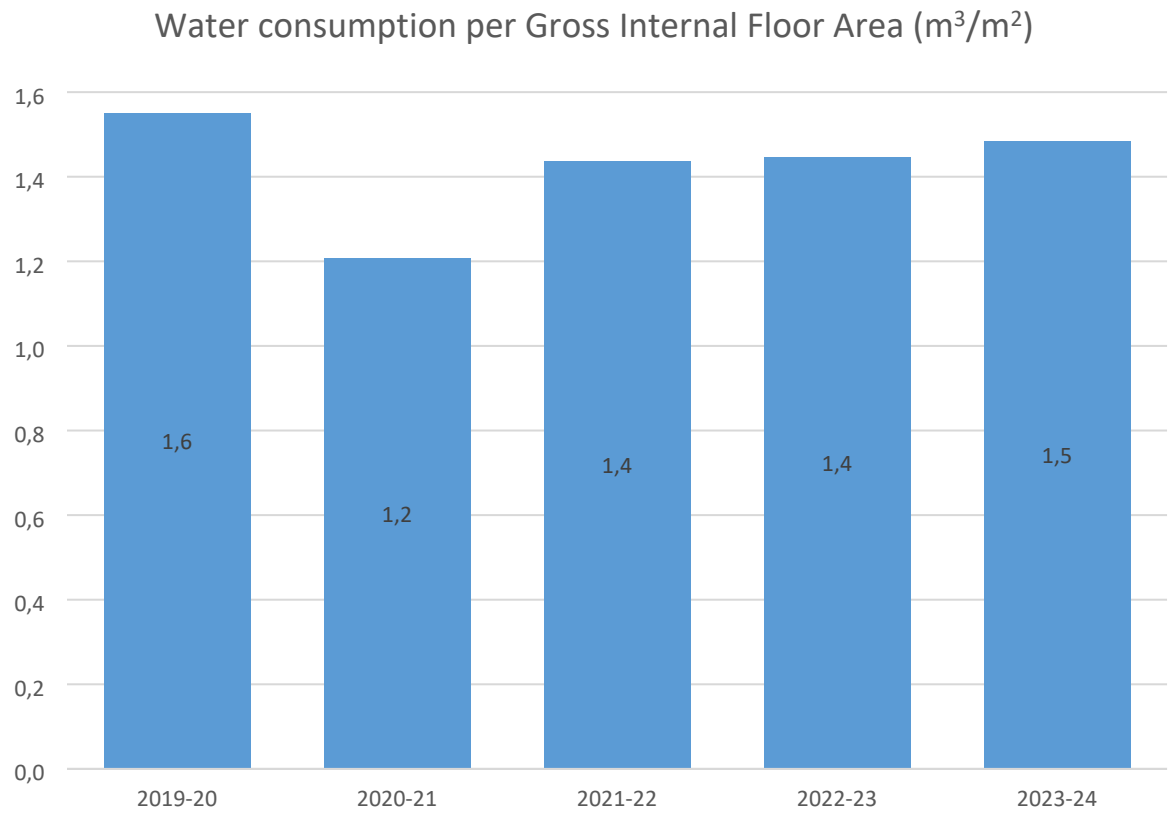
Energy consumption



Narrative:

- The overall energy consumption has fallen, mainly driven by a reduction in gas consumption
- Comparing 2023/24 to 2019/20 there has been a reduction of 12.3 $KgCO_2e$ per m^2 of Gross Internal Floor area

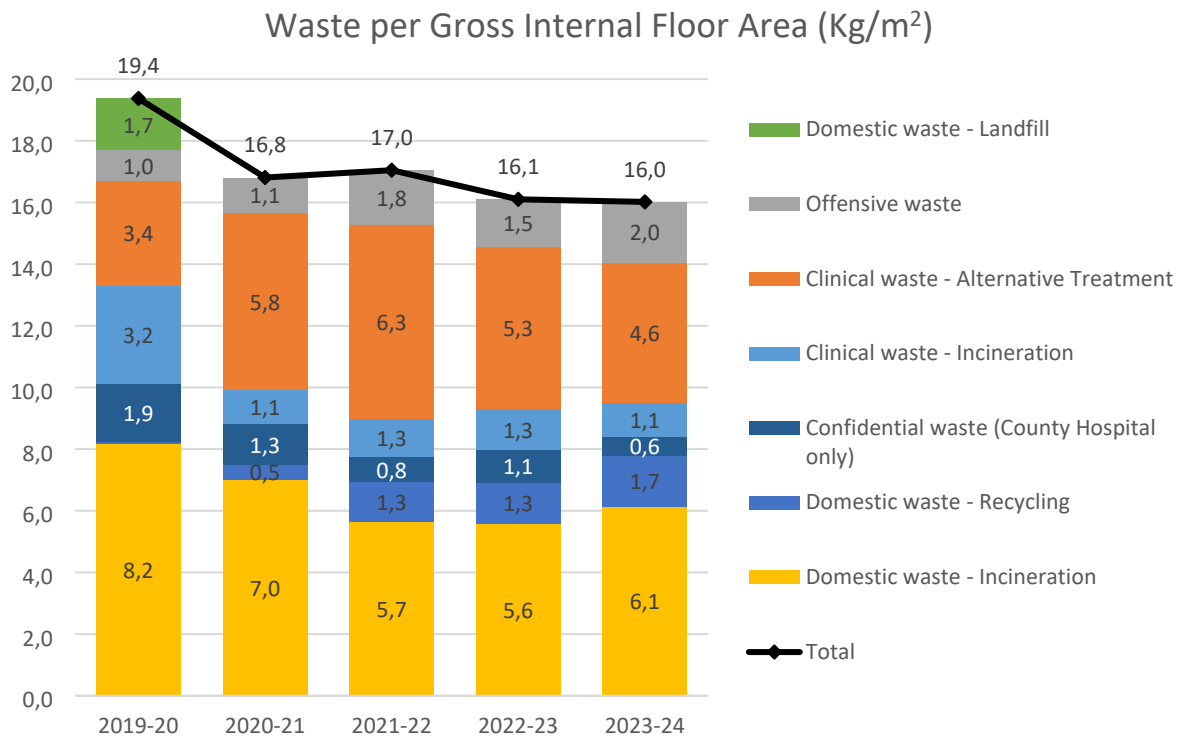
Water



Narrative:

- Water consumption has remained broadly static

Waste

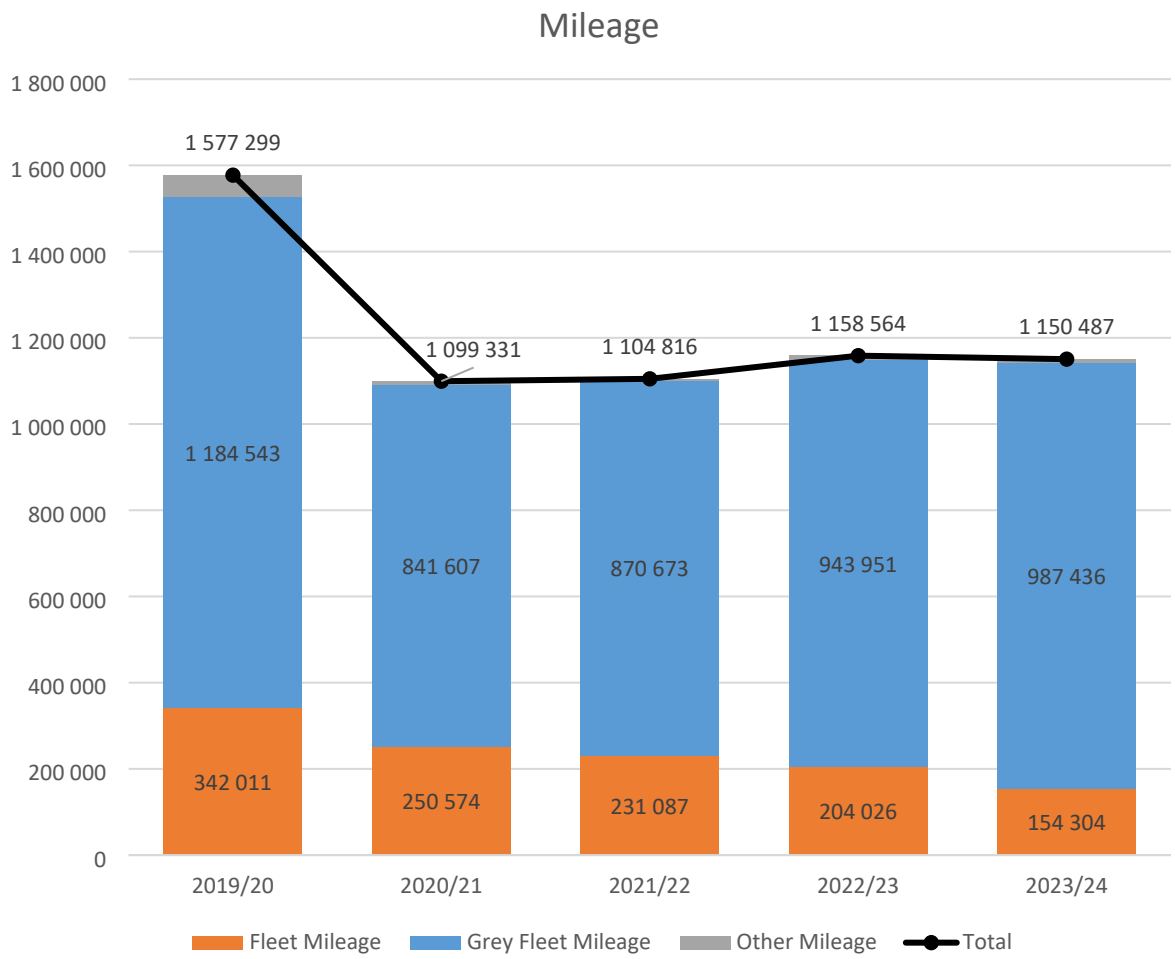


Narrative:

- Overall waste has reduced
- Waste to landfill has been eliminated
- Domestic waste for incineration has reduced
- Recycling has increased
- Clinical waste (incineration + alternative + offensive) has remained broadly the same
- Confidential waste has reduced

Note – Excludes food waste as the data was incomplete

Mileage



Narrative:

- Large reduction in mileage compared to pre-covid
- Steady reduction in (Trust owned vehicle) fleet mileage
- Grey fleet mileage (i.e. staff travel mileage claimed via expenses) has increased since covid but not up to pre-covid levels
- Overall mileage has reduced between 2022/23 and 2023/24
- The reduced mileage between 2023/24 to 2019/20 is equivalent to 112,593 $KgCO_2e$ (based on an average petrol car)

Report to:	**Public Board**
Date of Meeting:	**3rd October 2024**
Title of Report:	Perinatal Safety Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Perinatal Dashboard

1. Purpose of the report

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

2. Recommendation(s)

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

3. Executive Director Opinion[1]

This report was discussed and given due scrutiny at quality committee with no requirement to escalate any matters for Board attention.

Quality Committee also received an update on progress and improvements made in response to the 2023 CQC inspection. Good progress has been made in all areas. Quality Committee did discuss the revised plan in relation to the second obstetric theatre and the risk assessment to mitigate the risk was presented and noted.

[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***

Perinatal Services Safety Report – September 2024

1. INTRODUCTION

1.1 Since 2016 the spotlight has been on maternity services to work towards achieving a national target of reducing stillbirths, neonatal deaths and intrapartum brain injuries by 50% by 2025. The Perinatal 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 data from August 2024, and will be shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board.

2. PERFORMANCE

2.1 **Activity**

There were 122 births in August, the lowest we have seen this past quarter.

Midwife to birth ratio (<1:24)	1:21

2.2 **Red flags**

Red flags are outlined within CNST standards and are all subject to an incident report and MDT review. The red flags in August are recorded as:

	August
Delay in Induction >2hrs	0
Delay in Category 1 C-Section >30mins	2
Delay in administering medication	1
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	3
Any movement of midwifery staff from any area to provide midwifery cover	0
Delayed recognition of and action on abnormal vital signs	0
DSC lost - supernumerary status	0
Full clinical examination not carried out when presenting in labour	0
Delay of more than 30 minutes in providing pain relief	0

There were 2 out of a total 8 cases in August where a Category 1 delivery took longer than 30 minutes. The cases have been reviewed. In both cases the decision to delivery was 37 minutes, the first delay there was no documented reason for delay however the baby was born with Apgar's of 9 and 9 and no maternal compromise. In the second case it was documented that there was difficulty inserting the spinal however the CTG was normal so it was decided by the MDT to continue with the spinal, the baby was born with Apgar's of 9 and 9 and there was no maternal compromise. Communication has been sent out to the Doctors to remind them to document why there are delays from the time a cat 1 caesarean decision is made to the birth of the baby.

2.3 **RCOG Obstetric attendance**

CNST requires compliance with the RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. Our performance in August 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	1	100%	The Consultant was present 20 minutes after being called in from home.
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	1	100%	Consultant present within two minutes of MOH call going out.

There was one case where a woman had an eclamptic seizure following birth, a Consultant was in attendance within 20 minutes of being notified (RCOG standard is within 30 minute). The Consultant had documented that the eclampsia pathway was already being followed and they were able to provide a helicopter view of the situation. The mother made a full recovery and remained on delivery suite on the enhanced care pathway.

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 Minimum Data Set incident summary:

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

3.2 **Concerns and Complaints**

	Concerns	Complaints
August	1	0

4. WORKFORCE

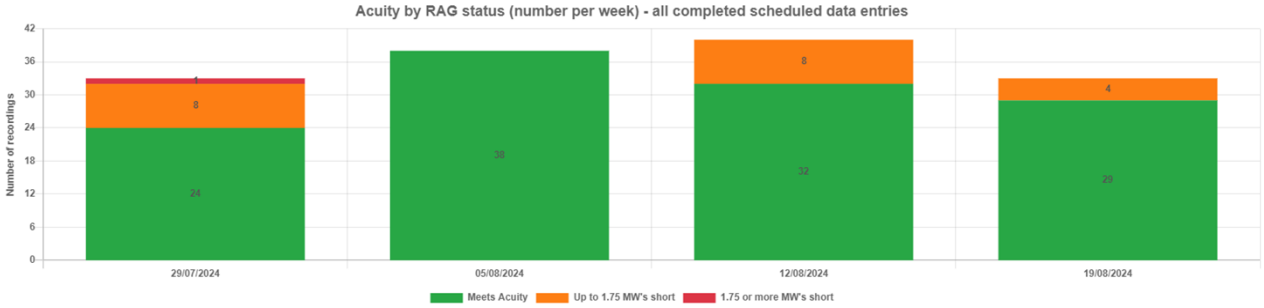
4.1 **Safe Staffing - Midwifery**

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

- Completion of Birthrate plus acuity tool
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags, also monitored for CNST compliance

- Shift fill data
- Daily SitRep reporting
- Sickness absence, vacancy and turnover rate

4.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 85.7% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 85% of the time. For 14% of the time the service was 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 the previous month.



4.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 26 instances of staff being redeployed internally to cover acuity, for example from another clinical area to Delivery Suite. This is a decrease on 47 instances in July. In a small service, this is reasonable as it demonstrates flexibility within the service to meet acuity needs. There were 3 occasions where community were redeployed to support Delivery Suite acuity. There were 4 occasions where specialist midwives supported clinical acuity and this is a positive practice, they all participate in a standby rota which supports them to retain clinical skill whilst meeting the needs of the service. There were 11 occasions where acuity was escalated to the manager on call for support.

Number & % of Management Actions Taken

From 01/08/2024 to 29/08/2024

MA1	Redeploy staff internally	26	54%
MA2	Redeploy from community	3	6%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	4%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	4	8%
MA7	Manager/Matron working clinically	1	2%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	11	23%
MA11	Maternity Unit on Divert	1	2%
	Total	48	

4.1.3 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November. The workforce remains mainly static for the month of August apart from long term sickness within Maternity Triage which would account for the increase in the midwife extra hours in this area. There are four newly qualified midwives who commence employment at WVT from the 2nd September. They will follow a six week supernumerary programme prior to being rostered into the numbers. There are also six maternity support workers recruited who will also join the Trust between September and December.

	Fill Rate %					
	MW contracted	**MW extra hrs**	**MW bank only**	**MSW contracted**	**MSW extra hrs**	**MSW bank only**
AN clinic/DAU	85.71%	1.19%	0%	85.71%	7.14%	7.14%
Community	80.49%	4.17%	0%	75.71%	1.43%	0%
Delivery Suite	90.93%	6.74%	0%	93.55%	1.61%	31.61%
Maternity Ward	92.74%	3.23%	1.12%	46.77%	0.81%	0.81%
Triage	67.74%	20.5%	4.84%	19.35%	22.58%	33.87%
DS Co-ordinators	96.77%	3.23%	0%	-	-	-

4.2 **Obstetric workforce**

4.2.1 The obstetric rotas have been covered throughout July and August as outlined below. July was not included in last month's report due to sickness within the administrative team. The Obstetric workforce is in a positive place as a new Obstetric Consultant is joining the team in September and will take them to full complement.

July

	Substantive fill	Substantive fill rate%	Substantive extra fill	Sub. extra fill rate %	Locum fill	Locum fill rate%
Consultant: hot week	230/230hrs	100%	0/230hrs	0%	0/230hrs	0%
Consultant: on call	423/537hrs	79%	114/537hrs	21%	0/537hrs	0%
Consultant: cold week	104/112hrs	93%	8/112hrs	7%	0/112hrs	0%
Consultant: antenatal clinic	67.5/81hrs	83%	13.5/81hrs	17%	0/81hrs	0%
Middle Grade: delivery suite	207/207hrs	100%	0/207hrs	0%	0/207hrs	0%
Middle Grade: antenatal clinic	139.5/229.5hrs	61%	90/229.5hrs	39%	0/229.5hrs	0%

August

	Substantive fill	Substantive fill rate%	Substantive extra fill	Sub. extra fill rate %	Locum fill	Locum fill rate%
Consultant: hot week	130/210hrs	62%	80/210hrs	38%	0/210hrs	0%
Consultant: on call	399/570hrs	70%	171/570hrs	30%	0/570hrs	0%
Consultant: cold week	72/104hrs	69%	32/104hrs	31%	0/104hrs	0%
Consultant: antenatal clinic	54/67.5hrs	80%	13.5/67.5hrs	20%	0/67.5hrs	0%
Middle Grade: delivery suite	189/189hrs	100%	0/189hrs	0%	0/189hrs	0%
Middle Grade: antenatal clinic	162/238.5hrs	68%	76.5/238.5hrs	32%	0/238.5hrs	0%

4.3 Anaesthetic workforce

The anaesthetic rotas have been covered throughout August as outlined below. The rota gaps were filled by existing members of staff with cover provided 100% of the time.

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	30	96%	9	29%
Anaesthetist extra days	1	4%	22	71%

4.4 MDT ward rounds

	08:30	20:30
Anaesthetist	97%	80%
Obstetric Consultant	97%	97%
Ward round completed	100%	100%

MDT ward rounds take place at 08:30 and 20:30 daily. Medical staff attendance is expected 100% of the time, however due to high acuity for example, this may not always be possible. The Anaesthetist attending ward round during August has improved at the 08:30 ward round from 93% to 97% however the attendance has dropped on the evening ward round from 87% to 80%. There are improvements from the attendance of the Obstetric Consultants at both ward rounds, both at 97% which sees an increase of 10% on the 0830 handover from last month. Attendance has been escalated further to the CL for anaesthetics. It is believed that this may be due to the rotation of new doctors, however communications have been shared with them all so we expect to see improvements. They have been asked to provide assurance more closely on a monthly basis, with an action plan for improvement.

4.5 Neonatal Nursing

The Neonatal Nursing workforce is outlined as:

Nursing position	Budgeted	Contracted	Maternity leave	Long term sickness
	WTE	WTE		
Band 7	2	2	0	0
Band 6	5.2	5	0	0
Band 5	10.5	9.1	0.92	0
Outreach	1.26	1.21	0	0

% Qualified In Speciality - expected standard minimum 70% of registered workforce.	% Qualified in Speciality available to work	% of shifts with mimimum 1 x QIS on duty
48.40%	46.40%	100%

*All shifts during June had at least 1 member of staff with neonatal qualification – therefore 100% compliance for all shifts.

5. COMPLIANCE

5.1 Training

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

Maternity Support Workers were not initially required to be a part of the CNST Standards, therefore the speciality has been added to the training agenda from 2023 onwards. Further to this an increase in turnover and new staff number has also impacted statistics. 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.

	August
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	62%
Annual NLS update compliance: Paediatric Consultants	100%
Annual NLS update compliance: Paediatric Middle Grades	80%
Annual NLS update compliance: Paediatric Juniors	90%
Annual NLS update compliance: Midwives	93%
Annual NLS update compliance: Neonatal Nurses	100%
Fetal Wellbeing update day: Obstetrics	95%
Fetal Wellbeing update day: Midwives	95%
Midwifery update day (Core Competency): Midwives	98%
Midwifery update day (Core Competency): Support Staff	77%

5.2 Saving Babies Lives

Saving Babies Lives v3 was launched in March 2023 with an update to the previous 5 elements and introduction of a 6th element to cover maternal diabetes. Under CNST standards, Trusts are required to demonstrate compliance with the use of the nationally approved toolkit, which WVT are fully compliant with. The trust progress is also quality assurance checked by the LMNS on a quarterly basis. The latest quarterly review for Q1 took place in August covering April-June and the current progress is reported as:

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	40%	Partially implemented	40%	CNST Not Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	81%	Partially implemented	81%	CNST Met

The service has action plans to address each of the key areas. CNST year 6 requires full implementation by March 2024, however where this has not been met compliance can still be achieved if the ICB confirms it is assured best endeavours and sufficient progress has been made. Element 4 compliance has fallen under 50% for quarter 1 this is due to medical staff returning from long term sick therefore the training compliance dropped to 89% just below the target of 90%.

Further this is due to a reduced compliance in 'Fresh Eye' reviews of CTGs. Safety Champions have asked the service to work with the LMNS and partners at WAHT to determine a system based approach and this work is underway. An improvement plan is in place to address the other areas of this element to ensure compliance improves. The LMNS have confirmed that they are satisfied with efforts and progress to date but do require an increase in trajectory in element 4 in order to be compliant with CNST.

5.3 **CNST MIS Year 6**

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

Whilst the service starts to pull evidence for each of the relevant sections it is not possible to share progress in a visual format as almost all actions are 'in progress' status. The NHS Futures Platform offers a tracking tool this year and the team are currently working to embed this into their governance, performance is shared with the LMNS and regular service level reviews ensure positive trajectories are maintained.

5.4 **SAFETY CHAMPIONS**

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

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

A safety walk round took place on the 3rd September with the Non-Executive Director present. The walk round visited Maternity Ward, Delivery Suite and Triage. The theme of the month was noted as Major Obstetric haemorrhage.

During the visit discussions took place there were several IPC items raised. The first being concern around the use of knitted breasts, the staff use these as teaching aids for breastfeeding women. It was agreed amongst the safety champions that this risk is low and to enable us to continue to use these teaching aids a risk assessment has been completed. The maternity department have had their new hand gel dispensers installed and it has been noted that the splashbacks are not fixed to the wall, this has been escalated to the ICP team.

When visiting delivery suite it was explained to the safety champions present that to enable the department to move forward with fully digitalised CTG's there are connectivity issues which will require further investigation. A further conversation took place around 'fresh eye' compliance. Saving babies lives is a national tool however there is no standardised audit tool for monitoring purposes, it was discussed about the variation across the LMNS in auditing this element and the Board champions suggested the LMNS develop a standardised audit tool so that comparisons can be made at LMNS level.

The Maternity Inpatient Matron celebrated the maternity housekeepers and their dedication and commitment to the department. Each one takes pride in their workplace striving to maintain high cleanliness standards.

No safety concerns were identified.

APPENDIX 1 – PQSM Dashboard

Indicator Description	April	May	June	July	August
Total bookings	143	132	139	154	122
Women who were booked before 12 + 6 weeks	135	124	126	147	116
% Women who were booked before 12 + 6 weeks (target 90%)	94.4%	93.9%	90.6%	95.5%	95.1%
Women who were booked after 12 + 6 weeks	8	8	13	7	6
% Women who were booked after 12 + 6 weeks	5.6%	6.1%	9.4%	4.5%	4.9%
Midwife led care at booking	18	19	16	27	24
% Midwife led care at booking	12.6%	14.4%	11.5%	17.5%	19.7%
Women with BMI of 30 and over at booking	39	41	39	40	40
% Women with BMI of 30 and over at booking	27.3%	31.1%	28.1%	26.0%	32.8%
% Antenatal Personalised Care Plan completed	99.2%	97.6%	95.9%	97.1%	100.0%
% Intrapartum Personalised Care Plan completed	50.7%	63.2%	61.5%	61.0%	68.5%
% Portal Access Consent	100.0%	99.2%	100.0%	100.0%	98.4%
% Portal Access - Women who registered and logged in	80.4%	88.5%	83.5%	82.5%	80.8%
% Contacts were place of birth suitability was recorded	14.9%	13.7%	65.3%	65.4%	65.3%
% High risk women assigned a named Consultant - within 7 days	35.0%	50.7%	56.6%	62.7%	58.40%
% High risk women assigned a named Consultant - at any time	74.4%	79.7%	83.5%	86.0%	88.5%
% Antenatal contacts with a reviewed / authorised risk assessment	29.6%	30.7%	56.3%	77.1%	72.9%
% Antenatal contacts with a risk assessment form completed	96.2%	92.9%	94.3%	91.1%	91.7%
Recorded Smoking Status at Booking - Yes	16	7	14	10	5
Recorded Smoking Status at Booking - No	127	125	125	144	117
Recorded Smoking Status at Booking - Unknown	0	0	0	0	0
% of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%	100.0%	100.0%
Women who were current smokers at booking	16	7	14	10	5
% Women who were current smokers at booking	11.2%	5.3%	10.1%	6.5%	4.1%
Smokers who were referred to smoking cessation services	14	7	14	9	5
% Smokers who were referred to smoking cessation services	87.5%	100.0%	100.0%	90.0%	100.0%
Smokers who accepted CO screening at booking	16	7	14	10	5
% Smokers who accepted CO screening at booking	100.0%	100.0%	100.0%	100.0%	100.0%
Women who were screened for CO at booking	141	126	133	149	113
% Women who were screened for CO at booking (of total bookings)	98.6%	95.5%	95.7%	91.4%	92.6%
Women with CO reading of 4 ppm or more at booking	12	9	14	6	5
% Women with CO reading of 4 ppm or more at booking (of total bookings)	8.4%	6.8%	10.1%	3.9%	4.1%
Indicator Description	**April**	**May**	**June**	**July**	**August**
Total births (deliveries)	124	135	148	128	125
Home Births	1	2	3	0	0
BBA's	2	0	1	0	1
Vaginal births (deliveries)	45	62	68	47	43
% Vaginal births (deliveries)	36.3%	45.9%	45.9%	36.7%	34.4%
Ventouse & forceps births (deliveries)	18	22	16	17	13
% Ventouse & forceps births (deliveries)	14.5%	16.3%	10.8%	13.3%	10.4%
RG*1 having a caesarean section with no previous births	2	3	5	2	2
RG*1 Deliveries	13	26	22	17	15
RG*1 % C-section deliveries	15.4%	11.5%	22.7%	11.8%	13.3%
RG*2 having a caesarean section with no previous births	20	15	16	20	25
RG*2 Deliveries	35	36	30	36	31
RG*2 % C-section deliveries	57.1%	41.7%	53.3%	55.6%	80.6%
RG*5 having a caesarean section with at least one previous birth	20	19	17	18	21
RG*5 Deliveries	25	20	21	19	23
RG*5 % C-section deliveries	80.0%	95.0%	81.0%	94.7%	91.3%
Total Elective C-Sections	30	23	19	27	22
Total Emergency C-Sections	31	28	45	36	46
Total Caesarean births (deliveries)	61	51	64	63	68
% Total Caesarean births (deliveries)	49.2%	37.8%	43.2%	49.2%	54.4%
% Grade 1 C-Sections within 30 minutes	77.8%	71.4%	62.5%	75.0%	75.0%
% Grade 2 C-Sections within 75 minutes	90.5%	80.9%	84.8%	84.6%	100.0%
Midwife led (low risk care) births	24	33	31	29	29
% Midwife led (low risk care) births	19.4%	24.4%	20.9%	22.7%	23.2%
Home births (deliveries) - midwife led only	1	0	2	0	0
% Home births (deliveries)	0.0%	0.0%	1.4%	0.0%	0.0%
Total number of babies born	125	136	150	131	128
Babies born preterm (singletons born 36+6 or less)	11	9	10	17	11
% Babies born preterm (singletons born 36+6 or less)	8.94%	6.62%	6.67%	13.0%	8.6%
Singleton babies born 26+6 or less	0	1	0	0	1
% Singleton babies born 26+6 or less	0%	1%	0%	0.00%	0.83%
Babies (multiples) born 27+6 or less	0	0	0	0	0
% Babies (multiples) born 27+6 or less	0%	0%	0%	0.00%	0.00%
Stillbirths	0	1	0	2	2
% Stillbirths	0.0%	0.7%	0.0%	1.5%	1.6%
Stillbirths rate per 1,000	0	0.136	0	0.3	0.3

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Live births where breastfeeding initiated (first feed = breastmilk)	100	114	119	102	105
% Live births where breastfeeding initiated (first feed = breastmilk)	80.6%	85.7%	80.4%	81.0%	86.1%
Women who were current smokers at booking (delivered mothers)	6	9	16	7	11
% Women who were current smokers at booking (delivered mothers)	4.8%	6.7%	10.8%	5.5%	8.8%
Women who were current smokers at birth (delivery)	9	7	13	8	12
% Women who were current smokers at birth (delivery)	7.3%	5.2%	8.8%	6.4%	9.6%
% Women with CO measured at 36 weeks	100.0%	98.4%	99.3%	100.0%	100.0%
% CO >= 4ppm at booking and below 4 ppm at 36 weeks	60.0%	7.3%	10.4%	2.7%	7.2%
Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0	0	0
% (as a % of all singleton births)			0.00%		
% Detection rate for FGR (below 3rd centile)	13%	15%	13%	10%	20.0%
Women who had a PPH of 1,500ml or more	6	11	8	6	5
% Women who had a PPH of 1,500ml or more	4.8%	8.1%	5.4%	4.7%	4.0%
Women who sustained a 3rd or 4th degree tear	1	1	2	1	0
% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.6%	1.2%	2.4%	1.5%	0.00%
% Induction of labour rate (of all births)	33.9%	34.8%	36.5%	34.4%	39.2%
Routine Enquiry Domestic Violence - Asked	90	87	92	84	78
Routine Enquiry Domestic Violence - Unable to ask	33	45	54	43	47
Routine Enquiry Domestic Violence - Unknown	1	3	2	1	0
% routine enquiry domestic violence	99.2%	97.8%	98.6%	99.2%	100.0%
Midwife to birth ratio	1:23	1:25	1:26	1:22	1:21
Delay in Induction >2hrs	0	0	8	0	0
Delay in Catagory 1 C-Section >30mins	0	1	3	0	2
Delay in administering medication	1	0	0	0	1
Delay in starting syntocinon/ARM >30mins	0	0	2	0	0
Delay in Suturing >60mins	0	0	0	0	0
Unable to provide 1:1 care in labour	0	0	0	0	0
Delay in Triage >30mins	0	0	0	0	0
Community midwives on call covering maternity unit	0	0	8	0	3
Any movement of midwifery staff from any area to provide midwifery cover	2	0	2	1	0
Delayed recognition of and action on abnormal vital signs	0	0	1	0	0
DSC lost - supernumerary status	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	*	*	*	0	0
Delay of more than 30 minutes in providing pain relief	*	*	*	0	0
Number of women presenting to service with reduced fetal movements	158	174	199	220	199
Number of women presenting with RFM who are recorded as having a CTG	158	172	197	218	197
% of women presenting with RFM who received CTG	100.0%	98.9%	99.0%	99.1%	99.0%
Indicator Description	**April**	**May**	**June**	**July**	**August**
Total admissions to neonatal care	17	5	13	12	6
Unexpected admissions of full-term babies to neonatal care	7	1	7	3	2
% Unexpected admissions of full-term babies to neonatal care	6.1%	0.8%	5.0%	2.7%	1.7%
Eligible Babies	2	2	3	1	0
% taken within hour	50.0%	50.0%	100.0%	100.0%	n/a
Adm temp <36.5 degrees	0	0	0	0	0
Eligible Babies	19	9	17	22	12
% taken within hour	89.5%	89.0%	82.3%	86.3%	75.0%
Adm temp <36.5 degrees	1	0	0	3	1
Babies born with an APGAR score between 0 and 6 (at 5 minutes)	0	3	3	3	3
Neonatal deaths	0	0	0	0	1
% Neonatal deaths	n/a	n/a	n/a	0.0%	0.8%
Neonatal mortality per 1,000 births	0	0	0	0	0.128
Neonatal transfers for therapeutic hypothermia	0	0	0	0	0
% Neonatal transfers for therapeutic hypothermia	0%	n/a	n/a	n/a	n/a
Neonatal brain injuries	0	0	0	0	0
% Neonatal brain injuries	n/a	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	1
Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	2	3	3	2	2
% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	100.0%	66.7%	100.0%	50.0%	50.0%
Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0	0
Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0	0	0
% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a	n/a	n/a

Indicator Description	April	May	June	July	August
Obstetrics admissions to ITU	0	0	0	1	0
Maternal deaths	0	0	0	0	0
% Postnatal Personalised Care Plan completed	95.7%	97.0%	97.7%	98.4%	97.7%
Postnatal readmissions within 28 days (mothers)	14	9	4	10	13
Postnatal readmissions within 28 days (babies)	7	6	7	5	7
Number of times Maternity Services Suspended per month	0	0	1	0	1
Number of hrs Maternity Services suspended	0	0	8	0	9
Number of times Home Birth services suspended per month	0	0	0	0	0
Number of hrs Home Birth services suspended	0	0	0	0	0
Number of times SCBU suspended per month	0	0	0	0	0
Number of hrs SCBU suspended per month	0	0	0	0	0
Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0	0	0	0
New HSIB SI referrals accepted	0	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	0
Coroner Reg 28 made directly to Trust	0		0	0	0
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	160	0	0	0
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	4	150	4.5	0	0
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	4	0	0	0
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	6	0	4	3	2
Vacancy rate for midwives (black = over establishment, red = under establishment	6.2	4.8	0.06wte	0.06wte	2.4wte
Inphase related to workforce (service provision/staffing)	3	0	11	0	3
MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%	100.00%	1000.00%
Service User feedback: Number of Compliments (formal)	13	0	4	7	5
Service User feedback: Number of Complaints (formal)	1	0	4	1	0
Staff feedback from frontline champions and walk-abouts (number of themes)	1	2	0	0	0
Progress in achievement of CNST /10	10	On Track	On Track	On Track	On Track
Training compliance in PROMPT: Midwives	95%	96%	98%	93%	93%
Training compliance in PROMPT: Obstetric Consultants	100%	100%	100%	100%	100%
Training compliance in PROMPT: Obstetric Middle Grades	81%	93%	87%	93%	93%
Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%	100%	100%	100%
Training compliance PROMPT: Maternity Support Workers	60%	67%	67%	65%	62%
Annual NLS update compliance: Paediatric Consultants	100%	100%	100%	100%	100%
Annual NLS update compliance: Paediatric Middle Grades	100%	100%	100%	100%	80%
Annual NLS update compliance: Paediatric Juniors	*	*	90%	91%	90%
Annual NLS update compliance: Midwives	95%	96%	98%	93%	93%
Annual NLS update compliance: Neonatal Nurses	90%	94%	98%	100%	100%
Fetal Wellbeing update day: Obstetrics	100%	100%	89%	89%	95%
Fetal Wellbeing update day: Midwives	99%	98%	98%	94%	95%
Midwifery update day (Core Competency): Midwives	93%	97%	97%	98%	98%
Midwifery update day (Core Competency): Support Staff	76%	88%	88%	79%	77%

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Board Assurance Framework (BAF) and Divisional Very High Risk Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Associate Director of Corporate Governance / Company Secretary
Documents covered by this report:	1) BAF as at 6th September 2024 2) Very High Risks, 15 and above as at 6th September 2024

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WVT's Strategic Objectives for 2024/25 and a review of the current operational Very High Risks (rated 15 and above).

2. Recommendation(s)

The WVT Trust Board is invited to note:

- The risks to delivery of WVT's strategic objectives 2024/25; and,
- The operational Very High risks (rated 15 and above) being carried by divisions within the Trust.

3. Executive Director Opinion[1]

The BAF is a live document which currently details the risks of achieving the Trust's 2024/25 strategic objectives utilising the Incident and Risk Management system, InPhase. This document is continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives.

As requested by the Board, the BAF now also reflects the direction of travel: the consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.
Since the last review the following changes can be seen:-

- 1 new BAF risk has been put on the framework since the last review around Cyber Security (1945)
- 1 BAF risk score has increased since the last review (1688) - Academic Programme increased from 6 to 8 due to additional 3 staff vacancies
- 2 BAF risk scores have decreased since the last review
    - 0059 – Digital Strategy – decreased to 12 due to funding for 2024/25 now on track
    - 0756 – Histopathology – decreased to 8 due to increased staffing levels.

The Board Assurance Framework is aligned to the Trust's strategic objectives for 2024/25 and are now presented to the Board for review on a quarterly basis.

The Trust's very high risks are also provided and are reviewed bi-monthly by the Executive Risk Committee, with a deep dive of each divisions' risk registers taking place on a rotational basis.

Also included in this Board overview is a heat map of the current BAF risks against our risk matrix.

[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.

Heat Map

The below denotes a graphical representation of the current principle BAF risks and provides a visual and concise summary of the scores obtained through the risk matrix. This has been included in line with a suggestion from our recent Board Assurance Framework audit. The views of the Board are welcome to identify if this is felt to be a useful representation of the risks.

CONSEQUENCE					
LIKELIHOOD	**1: Rare**	**2: Unlikely**	**3: Possible**	**4: Likely**	**5: Almost Certain**
5: Catastrophic					
4: Major		**1688**	**0056 / 1933**	**0054**	
3: Moderate			**0002 / 0827 / 1931 / 1932**	**0058 / 0059 / 1934**	**0066/1945**
2: Minor			**1687**	**0756**	**0423**
1: Negligible					

Risk Level	Frequency of Review
Very High 15-25	Monthly
High 8-12	1-2 months
Moderate 4-6	3 monthly
Low 1-3	6 monthly

Version 1 April 2024

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***

Risk Title	Risk detail	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
0054 - **BAF 2024/25** Ability of system to manage flow across the urgent and emergency care pathway	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.	Andy Parker	20	4	4	16	8	•Trust Capacity meetings allowing visibility of the issues and escalation. •Investment in additional ward discharge coordinator capacity. •Escalation and Surge Plans in place •System wide silver meetings • Winter Plan 2023/24 - Discharge to Assess Board - Valuing Patient Time Board - ICS Urgent and Emergency Care Board	•Ability for out of area partners to respond to the repatriation of patients. •Gaps in Homefirst provision and Discharge to Assess settings. •Shortfalls in staffing at ward level creating delays in discharge planning. • Additional financial burden as a result of inability to mitigate additional activity at the 'front door'. • Inability for Powys to respond to discharge pressures in a timely manner - Continued use of Boarding on acute wards to maintain flow	03-Sep-24	•System wide silver and gold calls. •Finance and performance executive reporting •Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board. Standardization of discharge processes and planning of admission across patient settings. Ward Based Dashboards Better Care Fund oversight by both One Herefordshire Partnership and Integrated Care Executive. Winter Plan and capacity bridge analysis.	System oversight of discharge delays and capacity.	
0066 - **BAF 2024/25** Risks to productivity and operational capacity plans and delivery	There is a risk that the Trust will not be able to achieve its productivity and activity plans as a result of factors due to: vacancies; pace of productivity improvements; access to outsourced capacity; and, sub-optimal urgent care pathway. This may severely impact on the delivery of productivity and operational capacity plans that deliver safe and timely elective, emergency and urgent care. All factors, either individually or collectively, could significantly decrease the level of available capacity and productivity.	Andy Parker	25	5	3	15	10	•Recovery and Restoration plan (under regular review) •Escalation and surge plan •Ringfenced elective pathways •Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. •Group and system-wide mutual aid •Activity plans. •Clearly documented value for money assessment of additional flexible capacity options as part of business case process. - GIRFT Faster Further 40 programme in place across region.	•Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. •Productivity plans based on GIRFT faster further programme	03-Sep-24	•Daily reporting and escalation. •Monthly division check and challenge reviews. •ICS restoration and recovery oversight group •Productivity Board •Finance and Performance Executive reports. •Integrated Performance report to Board. •Local and regional value-weighted activity is above 100% of 2019/20 levels. - GIRFT Further Faster 40 meetings - monthly - Finance Recovery Board - ICS Elective Cancer and Diagnostic Board	None	
1945 - **BAF24/25** Cyber Security	There is a risk that a successful cyber-attack may negatively impact one or more of the Trust's electronic systems compromising the delivery of services and the Trust's strategic objectives.	Katie Osmond	20	5	3	15	10	Identify Alerts from NHS England and Improvement. Email and website filtering is in place and maintained by Hoople. Anti-virus software is in place and maintained by Hoople. Windows updates are applied monthly to all Trust PCs by Hoople. Prevent Information Governance/Health Records policies, procedures, and Standard Operating Procedures. Mandatory annual IG training includes awareness of cyber fraud. Periodic phishing exercises conducted by Hoople under direction of Trust. Information about cyber security is made available to staff on the Trust intranet. Detect Email filtering, AV software and Windows Updates. Hoople network monitoring. ICT Service Desk Respond The Trust has access to cyber security expertise through Hoople, in-house staff and its auditors. All key Trust systems have established business continuity plans which are kept under review by system owners and system managers. Recover stem backups are taken daily and weekly by Hoople with an element of off-site storage. Dual data centre architecture would support off-line recovery of systems and/or failover if only one data centre was affected.	1) Uncertainty of funding 2) Staff consistency of compliance for cyber training 3) Aligning baseline support levels and resources to pace of digital maturity 4) Further improvements to backup technology identified for 2024/25 5) Third-party contracts don't consistently cover cyber and continuity requirements	28-Aug-24	Trust Board, Trust Management Board, Digital Programme Board, Emergency Planning Committee, Executive Risk Committee, WVT Fraud Risk Assessment April 2024	1) Keeping pace of the continually changing landscape of cyber risk 2) frequency of national benchmarking reports 3) Embedding of information asset owners roles and responsibilities	NEW RISK
0056 - **BAF 2024/25** Availability of Capital Funds to meet Trust's Strategic Objectives	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivering of key estates and investment being made on Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to an ability to procure essential equipment resulting in adverse impacts on healthcare delivery.	Alan Dawson	15	3	4	12	9	•Capital planning and prioritisation of key schemes and equipment •Holding contingency funds for adhoc emergency requirements •Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	•Ability to determine emergency capital spend requirements •Approval of capital fund applications •Capital funding provided is not sufficient to meet whole requirement	27-Aug-24	•Project teams and programme board structure in place for major schemes. Capital Planning and Equipment Committee •Trust Management Board •Financial reports to Board Operational Planning Process Capital Programme Board	None	
0058 - **BAF 2024/25** Clinical and support staff recruitment and retention	There is a risk to achieving the Trust's strategic objectives due to staff shortages and being unable to recruit to clinical, nursing and support staff vacancies, resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	Geoffrey Etule	20	4	3	12	8	•Recruitment and retention initiatives: plan for clinical staff; international recruitment; 'golden hello' for hard to recruit role; TRAC recruitment system; flexible working policy; career and pay progression framework. •Allocate Project Plan (which oversees implementation of innovative job planning) to allow adaptive use of existing workforce negating the need for recruitment by making best use of resources •Workforce and OD Strategy and Leadership Development Programme - developing skills and competencies of managers to enable improved recruitment and retention. •'Deep dives' and analysis into areas of high turnover, vacancies, exit interviews and new starter surveys. •Contract management and monitoring data of Master Vendor and Direct Engagement use. including monitoring of agency price cap. •Mutual Aid opportunities within the ICS and/or Group. National NHS workforce to inform WVT 5 year 'grow our own' workforce plan now in place	•Clear medical workforce plan that addresses opportunities within ICS. •Full implementation of e-rostering in clinical areas. •Temporary Staffing engagement and deployment policy. •Enhanced workforce planning and development support for managers. •National shortage of clinical staff both Medics and Registered Nurses. • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes. • Cost of living impact on recruitment and retention.	22-Aug-24	•BR Directors weekly ICS meeting. •R&PE reports •E-rostering project board to deliver against plan. •JNCC and Equalities group receive quarterly update on workforce issues. •Staff recruitment and retention working group. •Integrated Performance Report to Board •MARP and NARP (reinstated in August 2022). •Weekly MD-led vacancy review panel - reviews all non-clinical recruitment. •Health and Wellbeing Group to review and assess effectiveness of health and wellbeing initiatives to support recruitment and retention.	• Limited assurance that the master vendor contract will meet required agency fill rates which leads to use of higher cost tiers within the contract and other agencies - due to ongoing National shortage of clinical staff. • Expediency of ICS-wide initiatives.	
0059 - **BAF 2024/25** Delivery of the Digital Strategy	There is a risk of a delay to the delivery of benefits and the future capital funding of the Digital Strategy due to the scale, number and complexity of individual projects, the change/transition requirements of the workforce and the availability of targeted capital investment from NHSE.	Katie Osmond	16	4	3	12	8	Trust, Foundation Group and ICB Digital Strategies Substantive project team Clinical Systems Governance Board provides clinical acceptance and engagement in any proposed solutions or changes Clinical Systems Group has been established to manage and develop systems in BAU. Benefits Manager is now a substantive role in CSG. Engagement with the national frontline digitisation programme.	Change management training of staff Staff engagement. Work pressures and availability of staff to be released to attend training. Lack of resilience in resource plans. Impact of the introduction of digital strategies across all stakeholders. Uncertainty in national priorities for delivery of digital strategies. Uncertainty in availability of Front-line Digitalisation funding to progress strategy.	28-Aug-24	Capital Planning and Equipment Ctte. Periodic Board update on digital progress. Monthly update to Trust Management Board Internal audit reviews NHS England participation in governance forums Digital programme board with overview of projects to determine critical path, overlap and staff impact. Clinical Systems Group - maintenance and monitoring of BAU. Reporting to the national frontline digitisation programme. Trust membership of ICB Digital Data and Technology Forum (DDAT)	Uncertainty around NHSE Frontline Digitisation funding for existing solutions based on historic Procurement concerns.	
1933 - ** BAF 2024/25 - **Inability to identify resource to 'left shift' and/or maintain financial flow into Herefordshire	There is a risk of inability to move funding sources across providers within Herefordshire due to the funding arrangements across primary and secondary care which could lead to an inability to achieve left shift in all cases	Jon Barnes	12	3	4	12	3	Able to subcontract using standard NHS contracts for some services and maintain income flows, counting activity as Trust based.	Other than subcontracting, no contracting mechanism identified to allow the movement of work and funding without a loss of income to Herefordshire	21-Aug-24	One Herefordshire Partnership	Need to better understand available opportunities	

1934 - ** BAF 2024/25 - **Risk of reputational damage to Wye Valley NHS Trust in relation to the strength of partnership working arrangements in the context of the inadequate rating for local children's services	There is a risk that relationships are insufficiently developed between Health and Social Care partners which could lead to ineffective arrangements for children and young people	Lucy Flanagan	16	4	3	**12**	8	Multi-agency policies relating to children and young people - Local authority improvement plan and associated committee meeting attended by statutory partners.	Inconsistencies in practice of Multi-agency teams working with children and young people	22-Aug-24	Community Paediatrics Performance Review meeting - SEND - children and young people Partnership - Quality committee - One Herefordshire Partnership - children and young people Safeguarding Partnership - Local authority improvement Board	OFSTED report findings - Progress against improvement plan not met expected timescales for delivery - LGA report findings	
0423 - ** BAF 2024/25 - **Fragility of the Haematology service at Wye Valley	There is a risk of not providing clinical care to Haematology patients under the care of WVT due to all substantive consultants leaving the Haematology department. This could lead to increased waiting times for routine and urgent patients, delays in cancer patient pathways, and lack of oversight and clinical leadership to progress lab results. All of which will result in poor patient experience and timely health outcomes.	Chizo Agwu	25	5	2	**10**	5	•2.6 locum consultant secured - still the case 13/08/24 •2 x trainee ACP in post - 1 x band 7 and 1 x band 6 •Lab supporting agreed with Coventry/ Warwick •Out of hours urgent films when on call virtual process agreed with Worcester • Out of hours on call filled • In hours on call filled • Some treatment patients at other trusts, most back at WVT • Insourcing available if needed - being used 13/08/2024 for 6 sessions across August/September • Heam/SACT navigator in post - no longer the case 13/08/2024 - 'Golden Hello' incentive approved to aid recruitment	•Locum contract only requires one week notice •Unsuccessful recruiting to all substantive posts - one applicant for a substantive and being reviewed 13/08/2024 •Competency restraints •Blood bank cover - which impacts surgery, maternity and emergencies, needed named consultant to authorise out of hours - out of hours on call filled •3.6 WTE consultant vacancies and 1 WTE AS long term sickness • All substantive consultants have resigned	13-Aug-24	• Audit of waiting lists • CSD monthly governance meeting • Limited number of incidents relating to risk • Adverts for posts re-advertised • F+PE - CMO/COO meeting with ICB and WAHT - Fortnightly Fragile Services meeting with Worcester Acute	• ICB options not agreed • National shortage of qualified staff	
0002 - ** BAF 2024/25 **Difficulties in delivering on the Equality, Diversity and Inclusion agenda (part of CQC Well Led)	There is a risk of failing to deliver on the Equality, Diversity and Inclusion (EDI) agenda both from a strategic and operational perspective due to lack of dedicated specialist role and resources within the Trust, which will lead to falling further behind in responding to national/leg requirements and results in negatively impacting staff attraction, engagement and morale.	Geoffrey Etule	15	3	3	**9**	6	Limited support through the fixed-term ICS EDI role. Maintaining the staff networks in WVT. Regular communications and updates across the organisation. Workforce Race Equality for WVT Workforce Disability Equality Standards for WVT Equality Delivery System 2 for WVT Cultural Ambassadors. Continuation of engagement with Staff Networks EDI delivery plan Some support on EDI programmes from the SWFT EDI lead Working closely with FTSU Guardian and Staff Side Chair on EDI actions	Funded establishment of WVT EDI role - There is no dedicated resource for the Trust to specifically focus on this work which means that we will not be able to move forward more progressively. Future provision of ICS or Group EDI role.	22-Aug-24	TMB - 6 monthly reports that the Trust is meeting its obligations under WDES, WRES, EDS22 and meeting the delivery plan. CQC Inspection. WVT Equality Diversity and Inclusion Group monitoring the delivery plan. ICS engagement forums on EDI matters. CPO Board reports	Lack of dedicated EDI resource for WVT to pro-actively focus on the agenda.	
0827 - **BAF 2024/25 ** Fragility of Medical cover for Stroke pathway	There is a risk of harm to patients due to the loss of substantive stroke consultants. This could result in no stroke specific consultants at Wye Valley Trust which in turn may result in poor decision making and poor clinical care.	Chizo Agwu	15	3	3	**9**	3	1. Stroke locums extended until October 2024 Update 44 hours p/w + on call. 2. Develop non medical workforce model - now designed and waiting financial approval 3. Locum consultants providing virtual ward rounds at weekends and on-call for thrombolysis Sat & Sun 0900-1700. 4. Trust Registrar appointed 5. ACP appointed Jan '24 6. Contingency paper written for cover; currently with Execs for approval. 7. Fortnightly discussion meetings with Managing Director / Chief Medical Officer / Chief Operating Officer with equivalents at Worcester Acute Hospital to discuss all fragile services 8. Worcester Acute Consultants now providing out of hours thrombolysis cover 9. Clinical Senate review of the future of stroke services to take place September 2024	1. Locum does not stay at WVT. Further recruitment has been successful but turnover is very high 2. unsuccessful recruitment of substantive ICS joint appointment Consultant 3. Non-medical workforce model is not approved or recruitment into posts is unsuccessful 4. Weekend additional rounds are costly and not a sustainable financial model 5. ACP not backfilled from CNS rota. 6. Formal SLA for Thrombolysis cover from Worc Acute awaiting development and sign off	28-Aug-24	SSNAP performance monitoring SQL data and local dashboard ICB Programme Board (monthly) Inphase incidents Harm reviews Operational meeting (Monthly) Transformational meeting (Quarterly)	SSNAP data is retrospective released quarterly Dashboard is monthly pull which can change due to lock down date vs discharge date Lack of clinical lead impacts effectiveness/championing of WVT issues, concerns and mitigation plans	
1931 - ** BAF 2024/25 - **Failure to gain system support for agreed Herefordshire Integrated Care Model	Risk that the procurement process will find a solution that identifies an appropriate out of hours general practice service but one that does not support the agreed integrated urgent care model for Herefordshire.	Jon Barnes	9	3	3	**9**	3	Revision of the blueprint for integrated urgent care by One Herefordshire Partnership	No current formal agreement across the ICS to support the integrated urgent care model for Herefordshire	21-Aug-24	One Herefordshire Partnership Trust Board	No current formal agreement across the ICS to support the integrated urgent care model for Herefordshire	
1932 - ** BAF 2024/25 - **Inability to fund the required resource to achieve maximum functionality of EMIS	There is a risk that we will be unable to make the required improvements to both EMIS Community and EMIS GP due to lack of financial resource and the complexity of the underlying problems. Which would prevent the required improvements in functionality and intra-operability. Resulting in missed opportunity to improve support to community and general practice teams.	Jon Barnes	9	3	3	**9**	3	Project support identified to scope the potential for improvement and resources required	No dedicated IT support identified	21-Aug-24	One Herefordshire Partnership Trust Board - work programme updates for information	Unclear at present extent of opportunities / issues with EMIS and MAXIMS	
1688 - **BAF 2024/25** Delivery of Academic Programme to improve our Research Profile	There is a risk that WVT may be unable develop an effective academic programme in order to improve our research profile due to a lack of resources including finance, manpower and delivery models required to achieve improvements to patient care.	Chizo Agwu	10	2	4	**8**	4	Project oversight in place: Executive lead; Research and development lead; Associate CMO for Research Narrowed scope in place focusing on the research strategy Research strategy was approved at TMB and Quality Committee - Scope agreed Following workshop in April 2024 - a draft MOU with the 3 Counties has been commenced - awaiting sign off Full time Research Manager post approved at TMB	1) Pause recruitment to some studies due to staff shortages 2) Current SLA with Worcester does not cover the academic programme 3) Awaiting recruitment of the Research Manager role 4) MOU with 3 Counties University awaiting final sign off by the Managing Director	28-Aug-24	Reviewed under normal research meetings Quality Committee Trust Management Board	None	
0756 - **BAF 2024/25 **Fragility of Histopathology Service: Lack of sufficient consultant histopathologists	There is a risk of patient harm due to insufficient local histopathologist which will lead to a lack of 100% MDT cover, some urgent cases having to the outsourced and delays or lack of local 2nd opinions and hence diagnostic delays.	Chizo Agwu	20	4	2	**8**	8	•Locums employed in the department • Suitable work sent to backlogs or bank • Support from Worcester/SWFT/UHCW • 2 WTE Histopathologist's appointed to and due to start 05/08/2024 - all above controls remain in place during training period of 2 new WTE staff members Fortnightly meetings with Managing Director / Chief Medical Officer and Chief Operating Officer with equivalents at Worcester Acute to discuss all current concerns around fragile services - not aware of these June 2024	•Locums not always available • A lot of work is not suitable for sending to backlogs - resections main samples which stay in house also urgent samples	06-Aug-24	Monitoring of staffing levels regularly by management team - Assessment daily within Histology of suitability for sending samples to backlogs/bank - turn round times and cancer escalations monitored regularly	Staff availability for Monitoring - availability of backlog resource	
1687 - **BAF2024/25** One Herefordshire delivery of responsibilities contained within the MOU	There is a risk that One Herefordshire will be unable to make improvements to 'working in a more integrated way' due to an inability to achieve consensus. This includes being unable to realise the potential benefits of the MOU (containing new responsibilities for the Better Care Fund) between the ICB and One Herefordshire.	Jon Barnes	9	3	2	**6**	6	•Terms of Reference for ICE to provide oversight of delivery of the MOU. •Availability of shared data Discharge to Assess Board commenced 2023/24 BCF Operational Group commenced Autumn 2023 Quarterly reporting to Strategic Commissioning Committee at the ICB	•Finalised and signed MOU for 2024/25	21-Aug-24	•Monthly reports to ICE •One Herefordshire agreement of the MOU, enabling consensus. MOU finalised and signed (ICB and 1HP) in place for 2023/24	•Defined reporting mechanism to assure delivery against the MOU.	

Risk Id	Risk Title	Type	Risk detail	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
34	Quality assurance of clinical pre-operative assessment	Clinical Care	There is a risk of patient cancellation on the day of surgery or of an unfit patient proceeding to surgery due to inadequate assessment of fitness to proceed (assessment of functional status, optimisation of comorbidities, nutritional status, psychological preparedness) by the preoperative assessment service leading to potential patient harm. Safety (4) Quality (4) Complaints (2) Statutory (3) Reputation (2) Service (2) Financial (3) Business (1) Environment (1)	Surgical Division	20	4	4	16	4	The controls are 1. POA consultant anaesthetic review. 2. Anaesthetist and surgeon on the day of surgery. 3. 2 pre-operative assessment nurses have undertaken the preoperative training model with the Pre-operative Association. 4. All new appointments need to undertake these training models until they are able to work independently.	1. Human Error in the downstream of the POA triage process. 2. All new appointments need to undertake these training models until they are able to work independently, but this needs funding. 3. Lack of reported system for identifying changes in health between day of pre-operative assessment and day of surgery. Especially for those who are less health literate. 4. No accredited Professional Development Nurse (Education lead in department) to facilitate dissemination of learning 5. Funding Gap for training of Nursing staff 6 nurses have not been able to attend relevant course 6. No matron in directorate to support	1. Incident reporting system on day cancellation of unfit patients and clinical incidents of patient harm if an unfit patient proceeds to surgery. These when submitted are reviewed by preoperative team leads. MAXIMS reporting of reason for on day cancellation	1. Poor adherence to incident reporting system. 2. Lack of flexibility of MAXIMS to pick up POA reasons.
115	Inadequate Allied Health Professional Specialist Support to Critical Care	Workforce	There is a risk of critically ill patients not receiving specialist allied health professional support, due to the lack of funded baseline establishment within the intensive care unit budget. This has the potential to lead to intermittent rehabilitation programs, and results in delays to patient recovery. The unit also becomes unable to provide mandatory NHSE CQUIN data due to the lack of AHP support.	Surgical Division	20	5	3	15	5	1. 0.6 funded critical care pharmacist support, and on call pharmacist 2. Direct referral process to dietetic service 3. Direct referral process to OT service 4. Direct referral process to SLT 5. Direct referral to Physiotherapy, and emergency weekend cover 6. Weekly Rehabilitation MDT meeting for critical care	1. Gap of 0.2 WTE critical care pharmacist support 2. Gap of 0.8 WTE and no dietetic cover at weekends 3. Gap of 1.84 WTE and no OT cover at weekends 4. Gap of 0.8 WTE and no SLT cover at weekends 5. Gap of 2 WTE Physiotherapy, including 24/7 respiratory on call 6. Attendance is reliant on goodwill 7. The current service spec for clinical psychology does not incorporate critical care 8. Delays in weaning pathway 9. No defined training pathway for AHPs working in critical care e.g. lack of specialist knowledge such as implementation and use of speech valves.10. No cover for AL or sickness absence for AHPS 10. Limited understanding of the actual demand 11. in times of staff shortages ICU	Incident reports for gaps in individualised patient care Workforce business planning	Cluster review - corporate that this is aspirational Workforce business planning - consistently rejected. Incident reporting is inconsistent and only demonstrates a failure in controls

Risk Id	Risk Title	Type	Risk detail	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
											patients may not be prioritised from the general pool of therapy support		
255	Decline in function of APEX (including data storage)	ITIT	There is a risk of reduction in function of APEX as the hardware refresh is 4 years overdue which could result in system failure. This has the potential to lead to Trust wide failure in the reporting of pathology samples and could lead to adverse patient outcomes	Clinical Support Division	16	4	4	16	4	- Trust data back up as detailed in description didn't work on breakdown in June 2024, no backup data was available - Internal Trust security systems - Added to business CPEC priorities for Division for 24/25 - no plan for implementation as yet	- Failure of support contract if risk not mitigated. Limited support contract which does not include evenings and weekends - Trust security systems have failed elsewhere and at WVT in June 2024 - Added to Plan B on capital lists so no guarantee it will go ahead this year. - Failure of systems - we would still have a support contract but to fix any hardware problems would be dependent on the ability to source replacement parts	- Apex is working satisfactorily currently with Trust back up - Monitored monthly at Directorate level - Due to high risk score monitored monthly at Divisional level - Inphase incidents reported for any breakdowns and linked to this risk	- Unable to predict breakdowns/loss of function of systems so difficult to plan for this
643	Lack of appropriate Head Injury Pathway	Clinical Care	There is a risk to patients with a head injury who attend WVT due to there being a lack of clinicians who have the specialist training to deal with this type of injury. The impact would be that patients do not receive the appropriate care after admission to hospital. This risk has a greater impact on patients who present with major head injury trauma.	Surgical Division	20	4	4	16	8	1. Use of Network Oncall Referral Service (NORSe) - Electronic based referral solution, managed by Queen Elizabeth Hospital Birmingham. 2. Transfer of unstable major trauma to QE	1. No approved WVT pathway for head injuries 2. Timely transfer of patients to tertiary units 3. Timeliness of response via NORSe can lead to patients having considerable increase in length of stay	Executive risk, Divisional Governance	Head injuries are normally not cared for by T&O surgeons in other district general hospitals. Not currently best practice and not in line with national guidelines.
687	Lack of health psychology for children	Clinical Care	There is currently no provision at all for health psychology for children and young people who have long term health conditions. It is well recognised the impact that a diagnosis of a life limiting condition can have on a young person and currently there is no specialist psychology to support them. This has a significant impact on their well-being in their short term and long term care.	Surgical Division	16	4	4	16	8	NICE Guidance NG61: End of life care for infants, children and young people with life-limiting conditions NG206 Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management	Lack of funding available for service development opportunities There is no Health psychology service currently commissioned. CAMHS will not see these patients as they do not have a mental health condition.	No identified assurance as no service provision Children and Young People Board	No service provision

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788	Long waiting times in gynaecology services	Clinical Care	There is a risk of harm to patients due to the long waiting times for appointments in the gynaecology service New routine patients are currently waiting up to 42 weeks for a 1st appointment Urgent general gynaecology patients are now waiting up to 40 weeks for a first apt. Due to the long wait for these services there is a risk that a patient's condition may worsen and their health may deteriorate and harm therefore may be caused.	Surgical Division	20	4	4	16	8	Additional clinics are being undertaken in colposcopy, general gynae and hysteroscopy. Nurse hysteroscopist/CNS pessary clinic requested in business planning - awaiting approval Nurse and registrar being trained to deliver colposcopy service - takes 18 months Outsourcing hysteroscopies to health harmonie Exploring more robust nursing cover to implement super Saturday's in Oxford Suite.	There is a lack of workforce to manage the current size of the waiting list. The change to the 1:9 rota reduced the amount of elective work from each consultant. 1 consultant vacancy - currently be filled by locum, substantive appointed commence in Sept 2024 1 consultant on long term sick Awaiting agreement of business plan, new consultant included in business planning.	The clinical team are committed to undertaking additional clinics to try and reduce the long waiting times.	The size of the waiting list is such that it is challenging to reduce waiting times without additional workforce
789	Risk of adverse patient events due to long stay within ED resulting in overcrowded department	Clinical Care	There is a risk of long patient stays in ED, due to poor flow within the urgent care pathway, which leads to an overcrowded department. This has, could, will lead to patient harm, (falls, pressure area damage, delirium, poor patient experience, suboptimal care; food, fluids, observations, medication and escalation of the ill patient) and privacy and dignity. It also leads to increased delays in ambulances offloads. Due to the congestion in ED and high levels of boarders on the wards, patients in ED are now being cared for in inappropriate areas forcing staff to work outside of SOPs. This is evidenced by increasing numbers of InPhases showing near misses. Although national evidence links long stays within ED to increased mortality, there is no evidence that this is occurring in WVT currently. Achieving the UEC challenge of minimum 76% on the 4 hour target by March 2024 would markedly lower this risk. 05/07/24 following the	Medical Division	20	4	5	20	4	Colour coded identification on Symphony of patients in department in excess of 6, 12, 18 and 24 hours. 1. Pressure area damage; Risk 1788 Repose mattress toppers on trolleys Ability to utilise hospital beds (space permitting) Anderson tool on Symphony High risk patients highlighted to site team for ward bed transfer Comprehensive nursing handovers within ED Senior nurse checklist completed Howard Wright trolleys introduced within ED, providing 48 hour pressure relief. 2. Delirium / Mental Health / Learning Difficulties Level of frailty determined at triage. Frailty SDEC opened to reduce length of time patients stay in main ED. Autism Care Pathway work led by DGM Plan for sensory room Mental Health Assessment Room Enhanced education for MCAs for	1. ECIST review of SNCT data - Awaited 2. Inconsistent use of existing tools 3. Surgical SDEC; when opened should reduce number of patients waiting within ED 4. Involvement with T&O 5. Virtual ward; under utilisation and lack of surgical input preventing surgical patients to be admitted to virtual ward. 6. Internal professional standards; productive meetings held with medical division & surgical division. 7. Additional ED trolley's with pressure relieving qualities. 8. Lack of workforce plan relating to ED and Acute medicine consultants. 9. Use of acute physician SPA time to manage ED outliers impacts on time to implement improvements. 10. ED Matron pulled operationally impacting on implementation of improvements 11.Overall Demand & Capacity model work up & ECIST feedback	Monthly ED Mortality meetings Directorate Tri Directorate Risk Meeting Tri to Tri Divisional Quality Governance Meeting Quality walkabouts by Divisional Tri F&PE Executive Risk Meeting Quarterly update to Quality Committee; standardised agenda item in medical division report. * All unexpected deaths added onto Inphase and reviewed by Division * All moderate harm and above pressures ulcers reviewed at PUP with engagement from B7 sisters. * Visible leadership from B7 sister * Senior Nursing Review checklist * 6 hourly checks reflective of intentional nurse rounding. * Operational meetings - gaps in staffing * Twice daily ED huddles	1. Resilience within the multidisciplinary workforce. 2. Ward implementation of agreed Ward Standards; promotion of flow and reduce congestion within ED. 3. Professional standards agreed, but inconsistently implemented. 4. Junior nursing workforce and clinical skills. 5. Confirmation from ECIST re; nursing establishment.

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			implementation of the UEC work-streams there have been improvements in KIPs and CQI's , this has consistent over the last 4 months. This will need to be closely monitored due to some of the work-streams being ceased from 06/07/24							ED Nursing and Medical staff. Security team at WVT Multi agency roundtables occurring following moderate harm incidents 3. Sub-optimal care Senior nurse checklist Staff huddles Sodexo catering provided for patients 4+ hours within department 4. SDEC Medical SDEC; working well Surgical SDEC; engagement and initial walk rounds undertaken with surgical division Frailty SDEC; Opened 13/09/23 5. Medical cover of patients awaiting inpatient beds in ED Re-deployment of staff across the division and within the directorate Use of acute physician SPA time to manage ED outliers	review required by Clinical Director + GM A&E. 12.UEC QIP; In process of being written, but not agreed/implemented. 13.12 hour waits in the Emergency Department be tracked as part of monitoring the risk as we are still a national outlier.	* Wisdom Wednesday & Feedback Friday * Engagement from Mental Health colleagues	

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1032	Pharmacist cover to Intensive Care Unit	(Multiple)	There is a risk of medication related errors due to the lack of insufficient pharmacist cover within the intensive care unit which could lead to: 1)medicines omitted without clinical reason with adverse effects 2)wrong drug or dosage administered with adverse effects 3)Expired medication dispensed and administered with adverse effects 4)Medication administered via wrong route with adverse effects 5) Monitoring during drug therapy not undertaken or not taken into consideration with adverse effects And results in the non-compliance of the GPIC standards for intensive care. ICU peer review (June 2024) listed the lack of pharmacist provision in ICU as a serious concern and as non-compliant with GPICS Standards and therefore ...'not meeting professional or societal standards'.	Surgical Division	20	4	4	16	4	Medicine related guidelines that support our activity in ITU and they're accessible to staff via the Intranet. Pharmacist for ITU is the Handler for Medication related incidents, the directorate Weekly Incident Review Panel also review. Staff have access to general pharmacy for advice. Nursing and medical staff would seek advice from the on-call pharmacist in the event of administering unfamiliar medications. Ad-hoc provision for medicines reconciliation and prescription review	1. Only ad-hoc pharmacist availability. No regular cover. 2. No pharmacist on ward rounds 3. Majority of ICU medicine related guidelines out of date and in need of review 4. Currently no ICU dedicated pharmacist to review medicine associated incidents 5. No cover for sickness or absence. A business case is being prepared to address this and the specific criteria (below) which the peer review (pp5-6) highlighted as a serious concern. 2.7a The provider must have a designated advanced level pharmacist for critical care 2.7c A clinical pharmacist* performs medicines reconciliation within 24 hours of critical care admission *(or suitable competent pharmacy technician with appropriate clinical pharmacist supervision) 2.7d A clinical pharmacist performs medicines reconciliation for patients discharged from critical care on the day of discharge 2.7e A clinical pharmacist performs a medicines review for each patient on a daily basis 2.7f A clinical pharmacist attends the multi professional ward round on a daily basis 2.7g Clinical pharmacists sufficiently support the units governance agenda, education and training agenda, and audit/evaluation/research agenda 2.7h Pharmacy services are available 24/7 - e.g. systems are in place to ensure medicines/advice are immediately available when needed	Monitoring via In Phase incidents	Non reporting of incidents

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1317	Risk of patient harm due to Pharmacy Service reduced capacity/staffing	Workforce	There is a risk of harm to patients due to the lack of registered pharmacy staff nationally including agency staff. This is currently resulting in reduced ability to maintain/develop medicines related policies and procedures and maintaining governance processes including audit across the Trust (specifically controlled drug storage audits). Delays in the processing of medicines orders including inpatient, discharge and outpatient supplies. Inefficiencies due to all dispensing taking place within the pharmacy dispensary instead of ward based where possible.	Clinical Support Division	20	4	4	16	4	• Prioritisation of clinical service at ward level and technical services to reduce risk to patients and maintain capacity. • Searching for two locum pharmacists but not appointed yet - update 18/06/2024 both positions now filled, remote locum and bank pharmacist have started. • Flexible working requests considered for all roles.	• Insufficient pharmacist numbers to cover all ward areas and maintain policy and procedure development for Divisions/Directorates • No readily available additional cover (locum or bank). • Medium to long term threat of pharmacy staff shortage due to expansion in services in all sectors.	• Pharmacy staffing reviewed weekly by COO and CMO with Division Lead and CD of Pharmacy. • Incident reports completion for medicines related incidents, complaints and PALs concerns. • Rota indicating all areas are covered adequately if possible. • Completion of medicines reconciliation at ward level, turnaround time KPIs. • Staff overtime records and sickness records and turnover. • Staff concerns and wellbeing issues raised. • Bi monthly report to Patient Safety Committee/Quality Committee on risk status via the Medicines Safety escalation report	None
1473	Single Lead Orthodontics Service has become fragile and unstable.	Clinical Care	There is a risk to delay in patient care to the Orthodontic service due to the current gap in substantive workforce. WVT are currently relying upon insourcing services to maintain the service.	Surgical Division	20	4	4	16	4	1. Contract with insourcing in place until end of September 2024 to ensure capacity plan is achieved. 2. Additional 2 consultants provided by Portland to maximise capacity. 3. Additional capacity for clinics now being offered to ensure patients are seen in a timely manner. 4. Long term Issue being led at ICS level - meetings held fortnightly. 5. Joint clinics have at Worcester to commence in June 2024	No substantive staff currently available. Reliability of insourced consultants. Patient experience - increase in complaints due to clinician attitude Willingness of clinical team to commence new patient pathways Capacity in Worcester for joint clinics - not able to run in July and August ICB meetings not routinely running	Contract with Portland confirmed until end of September 2024. Provision of service being transferred to Worcester from March 2025. Worcester providing joint clinics for more complex patients where capacity aligns with the insourcing company Contract with commissioners has been extended.	No clear plan on service provider from September 24 onwards.

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1704	Delivery of Financial Plan and improving underlying position	(Multiple)	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) required; impact of inflationary pressures; and, risk to achieving the full income target. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and shortfall in cash to meet obligations.	Corporate Division	20	4	5	20	12	CPIP devolved as part of divisional budgets for identification and delivery. CPIP targets agreed by divisions. Established process for identification and monitoring of CPIP delivery. Action plans in place for MARP and NARP. Activity Plan implementation. Enhanced financial controls. Financial Recovery Board established with additional divisional check and challenge face to face sessions monthly Relaunch of the CPIP PMO governance	National inflationary pressures. Process of early identification and capture of full CPIP plan. Trust policies and processes require strengthening to ensure compliance. Lack of recurrent efficiencies within the programme. Lack of medium term financial plan. Deficit plan submitted for 24/25. Adverse variance to plan at M4 24/25.	Productivity Board routine monitoring of activity plan. Monthly F&PEs review of CPIP delivery. MARP and NARP routine review of action plan and compliance with controls. Integrated performance report to Board. CPIP Audit Report ICS Finance Committee - NED-led to oversee system financial performance. System Investment and Expenditure Ctte - Management-led oversees adherence to the enhanced financial controls Finance Recovery Board - NED-led Divisional Check and Challenge sessions	Trust policies and processes require strengthening to ensure regular monitoring and reporting. CPIP plans not fully identified to meet targets. Adverse variance to plan at M4.

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1724	Lack of electronic patient record that is fit for purpose	Clinical Care	The lack of an appropriate EPR for Ophthalmology has many implications as below: 1) Serious incidents and never events that are avoidable with an EPR (e.g. SI 2022/25261 - Under "Section 9: Action Plan for Improved Practice", Point 2 recommends an ophthalmology-specific EPR "OpenEyes" with a proposed completion date of September 2023). We are now far beyond this proposed date. 2) Risks to patient safety (e.g. instances of eye casualty documentation not being scanned onto Maxims, resulting in patients not being triaged for urgent follow-up). 3) Inability to implement service improvement measures that would increase the efficiency, patient flow, cost-effectiveness and effectiveness of care (e.g. virtual clinics). 4) Inability to comply with GIRFT guidelines (e.g. for IVI injections). 5) Non-compliance with NOD and other national audits. NICE guidelines state that commissioners should ensure that "Processes [are in place] to ensure that the UK Minimum Cataract Dataset for National Audit is completed". This also results in a reputational issue for the trust as the audit is listed on the trust quality accounts. 6) Inability to communicate with relevant primary care providers (e.g. optometrists, whose details cannot be stored on Maxims). This results in poor continuity of care.	Surgical Division	2	4	5	20	1	Currently using written notes and Maxims in day-to-day patient care. Increased consultant, doctor, nursing and admin time spent in order to reduce the risk to patient safety. Local Cataract audit outcome data is collected and reported at specialty meetings but a much smaller dataset.	Increased consultant, doctor, nursing and admin time spent in order to reduce the risk to patient safety (which could be put instead towards active patient care). Service improvements seen around the UK cannot be implemented. Smaller audit data set and not participating in national audit.	Lack of assurance	As above

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1762	Replacement of 4 Aseptic Isolators	Compliance with standards	There is a risk of our Technical Services Department not being able to manufacture aseptic products (inc. Chemotherapy) due to the unreliability of the current cabinets. 4 of the cabinets are approximately 15 years old and frequently breakdown requiring an engineer to come out and repair the cabinet. Due to the age of the cabinets, they are beyond full repair and the some of the parts that are required to fix the cabinets are no longer produced by the manufacturer (ENVAIR). The potential impact on the production of aseptic products is catastrophic - particularly affecting cancer services.	Clinical Support Division	20	4	4	16	4	- Regular maintenance - Quarterly external checks - Daily Internal checks including air pressures, air flow, microbiology - Approved procedures in relation to aseptic production - Contingency/capacity plans	- Exceeded life cycle by 8 years resulting in more regular failures - Downtime	- Annual Regional Quality Assurance Inspection (IQAAPS) - Incident Reporting via Inphase	- No gaps
1781	Harm to patient and staff due to lack of appropriate Mental health assessment room	Clinical Care	There is risk of harm to patients and staff due to no suitable assessment room provided in ED majors area (risk assessment and management of patients who are high risk of self-harm or absconding from the Emergency department). There is a risk that patients who are high risk of self-harm/ overdose/ harm to others could abscond from the Emergency Department. This is due to lack of staffing and space to deliver existing processes to manage these situations. This has resulted in a patient absconding from the ED whereupon she overdosed on paracetamol and subsequently died.	Medical Division	16	4	4	16	3	Triage and risk assessment on arrival 1:1 supervision when deemed necessary leaving doors open Panic alarm in the room and fully functional. Policies: Trust wide: MCA/DOLs, Enhanced observation. ED: Post triage metal health triage within symphony that dictates level of supervision. Environment: Mental health space in cubicle 4 and 5 of majors, which is immediately adjacent to nursing base and ED nurse in charge desk locked access to department. Funding approved at CEPEC on 24/06/24 to have the work done to ensure the room complies with all standard. The work will be completed in September 2024 as part of the ED life cycle work.	Ligature and self-harm risks remain in room Room does not have 2 exits Doors allow patients to lock themselves and staff in. Doors do not open outwards Doors do not have window/viewing panels Unnecessary fixtures and fittings No ligature free bathroom (taps, locks, door handles) More than 1 patient requiring safe room at times. Space within crowded department to deliver on the policies Staffing to deliver on policies	Escalated to Matron, DGM, GM	Uncertain timescale

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1803	Serious harm, death or injury due to backlog of maintenance/servicing on medical equipment	Clinical Care	There is a risk of serious harm due to the large number of medical devices which may be overdue maintenance or servicing. Due to lack of access, equipment relocation (e.g. during COVID), data quality, asset management system incompatible with clinical functions (no longer fit for purpose), recent significant turnover and sickness within EBME team, historic low WTE per device ratio, lack established process (SOP) for new equipment registration. If equipment is not up to date with maintenance/servicing there is a potential for patient or staff harm. The harm may be caused by a range of factors including, for example, electrical shock, incorrect medication (dosing), incorrect diagnosis, incorrect readings etc. The results from the failure in medical equipment can be catastrophic for patients. For example a patient not receiving the correct dosage of critical medication or babies with life changing disability through lack of medical gases if resucitaire not working correctly.	Corporate Division	15	5	3	15	5	Risk stratification of devices to focus on areas of greatest concern Training of EBME staff	Poor information Lack of coordination with departmental (non EBME) managed service contracts New equipment not being registered with EBME	No known trends in terms of incident reporting relating to medical equipment Frequency of escalation from Departments if equipment overdue	Lack of Medical Devices Committee clinical input and yet to establish sufficient reporting through Quality Committee Insufficient trained resource to meet quantum of work required

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1808	Increased prevalence of Carbapenemase Producing Enterobacteriaceae (CPE) colonisation being identified in Wye Valley NHS Trust patients.	Infection Control	Due to a high prevalence of patients with CPE colonisation being reported in Wye Valley NHS Trust there is a potential for cross contamination to patients & environment and infection spread resulting in patient harm	Corporate Division	16	4	4	16	8	1. Trust wide policy on CPE management 2. CPE risk assessment undertaken on admission by staff in Emergency department or admitting wards 3. CPE risk and management included in Infection Prevention training 4. 7 day access to in an UKAS accredited laboratory 5. Antibiotic stewardship programme and full management guidelines 6. 25% side room available to support isolation practices 7. Infection Prevention nurse team available 7 days a week to support isolation management in clinical settings 8. Education & training programme including Infection Prevention Champions, Commode & Toileting aid training, Gloves off campaign 9. Infection Prevention & control training included in all clinical staff mandatory training. This includes application of standard infection control precautions. 10. Adequate hand washing facilities; provision in line with national standards 11. Application of National Cleaning Standards 2021 12. Locally developed Clinical Cleaning Code. Red clean is required for all CPE known cases on discharge/ transfer. Amber clean in place during patient residency. 13. Trust isolation policy in line with National Infection Control Manual 2022 guidance. Single side room with en-suite facilities recommended for patient with known CPE 14. Infection Prevention team annual monitoring of CPE assessment completion 15. Management of infectious	1. Staff understanding and application of CPE risk assessment 2. Application of National Cleanliness Standards 2021 at Contract and Clinical levels 3. Staff application of priorisation of side rooms 4. Provision of Infection Prevention Champions study days 5. Lack of antimicrobial pharmacist resource 6. Lack of storage including in Dirty Utility areas 7. Assurance on staff knowledge of the correct method to decontaminate clinical equipment 8. Staff using hand wash basins for the sole purpose of hand decontamination	Infection Prevention Committee	1. Divisional response to Infection Prevention monitoring/ audits action plans etc 2. Clinical demand of side room availability 3. Appropriate use of hand wash basins 4. Clinical staff cleaning practices

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										linen in line with National legislation. 16. Bed spacing as per national guidance 17. PPE in line with National Infection Control Manual 2022. Contact precautions promoted. 18. Isolation door signs updated May 2023 to support National Infection Control Manual 2022 guidance. 19. Tracking inter hospital transfers for outpatients procedures in place on CCU, Arrow, Lugg and Wye ward. 20. Prioritisation of side rooms tool in place to add staff decision making 21. Contacts of patient with known or suspected CPE are isolated in single side rooms or cohorted with other patient from the same exposure group 22. All patients with known CPE are alerted on the Patient clinical records (MAXIMS) to highlight risk to staff. This alert lasts a lifetime. 23. All patient contacts of a known CPE carrier are isolated and screened as per national guidance. Isolation ends on receipt of 3 negative screens. 24. All patients identified as being colonised with CPE are provided with a CPE passport by the Infection Prevention team to support/ prompt communication with all care providers in and outside of Wye Valley NHS Trust 25. Infection Prevention team undertake monitoring of Standard Infection Control precautions following each HCAI 26. Infection prevention team undertaken quarterly hand hygiene and BBE assurance checks in all inpatients areas 27. Infection Prevention team undertake quarterly Commode and toileting aid cleanliness			

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										assurance checks 28. Learning from incidents reviewed in HCAI panel shared Trust wide via Safety Bites 29. Monitoring on cleanliness undertaken by a dedicated Monitoring team as per National Cleanliness Standards 2021 30. Compliance figures for Induction & mandatory infection prevention training monitored. 31. Infection Prevention Improvement plan developed 2022 with NHSE & ICS colleagues. This is monitored quarterly in the Infection Prevention Committee. 32. External reviews with the ICS in place 33. Environmental screening undertaken in clinical settings following two linked patient with positive CPE screen result. This includes Water waste pipes and shower facilities 34. IP team annual audit of hand wash provision and usage 35. Water safety committee meets monthly. CPE results from effected water waste pipes etc shared and discussed. 36. External company provide Red clean service. All Red cleans are recorded aiding auditing of compliancy. 37. All cases of CPE colonisation are reviewed at HCAI review panel. This enables risks and trends in acquisition and management to be monitored.			
1851	Waiting times for colposcopy appointments	Workforce	Current challenges with seeing patients with 14 days for their 2ww appointments, urgent patients who should be seen at 6 weeks are being pushed out further past their see by dates to accommodate the 2ww patients. Alongside delayed follow ups, MDT patients are prioritised pushing follow ups out further past their see by dates.	Surgical Division	16	4	4	16	4	Additional clinics are being undertaken. Review and prioritisation of follow up waiting list is being undertaken by DGM and colposcopy lead Long term training of nurse colposcopist Middle grade doctor training to undertake colposcopy	Do not have full establishment of colposcopists Not able to run sufficient clinics to manage demand due to the following: lack of clinic space. Lack of nursing staff available to run weekend clinics (not in budget).	The 2ww patients have been prioritised due to them being the most urgent cohort of patients.	There needs to be a higher number of additional clinics done to clear the backlog and reduce the waiting time.

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			There has been an increase in referrals - we have had 149 more referrals than the same period last year - the same number of clinics have been delivered. Waiting time for urgent appointments = 5 weeks. The waiting time for urgent patients should be 6 weeks - there is a risk of harm, although no harm has currently been identified.										
1861	Community Paediatric Workforce	Clinical Care	There is a risk of adverse health, emotional and educational outcomes for children due to insufficient clinical workforce, which has led to a wait of more than 52 weeks to see a community paediatrician and significant delays in follow up appointments. This may result in short-term physical harm and long-term disadvantage due to adverse impact on behaviour, emotional and social development and risk of educational disadvantage, disadvantage and reduced life expectancy.	Surgical Division	20	4	4	16	4	Robust triage process and referrals passed on to other services, e.g. behavioural support, AHP at triage to prevent delays. Moving some services to acute paediatrics, e.g. preterm neurodevelopmental follow up, continence issues, epilepsy. Change in referral criteria for Child Protection Health Assessment so only CYP with unmet health needs are seen rather than all patients on a Child Protection Plan. All clinicians providing additional clinics to meet statutory requirements. 'Hot clinics' added to job plans to manage short term demands and meet statutory requirements. Vacant post advertised - interviews on 1st February 24. Expansion of workforce agreed, consultant post advertised July 2023. Plans to appoint a band 7 nurse prescriber to support clinical workload. Expansion of band 4 assistant practitioner role to support clinicians. Clinical validation of new and follow up waiting lists to reduce unnecessary appointments. Use of PIFU to reduce	Clinical validation of waiting lists and additional clinics increased the burden on medical staff, increased risk of sickness and burnout. Increased pressure on AHP and acute paediatrics when picking up additional work - may not be sustainable. Additional recruitment plans on hold whilst awaiting outcome of NHSE workforce/service review.	Weekly PTL meetings. Internal and NHSE process and workforce reviews. Close monitoring of timescales for statutory requirements	EHCP/IHA statutory requirements not visible on PTL

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										unnecessary follow ups. Insourcing company brought in to see long-waiters and specific follow up patients (audiology and risperidone) November - January 24. 6 month locum starting 26th February 2024.			
1894	Reduction in provision of paediatric endocrinology services	Clinical Care	There is a risk of delay in the diagnosis, management and treatment of children and young people with endocrine issues due to the paediatrician with an expertise in endocrinology leaving the department. This will lead to delays in children being seen in clinic and delays in answering parent/professional queries	Surgical Division	20	4	4	16	8	CMO to continue to do 1 clinic per month seeing paediatric endocrinology patients. Discussions with tertiary team regarding need for increased support. Urgent referrals to be seen in general paediatric clinics and discuss with tertiary endocrinology Some follow ups to be put into general paediatric clinics Consultant on call to review parent queries Consultant to sit in on endocrinology clinics with tertiary endocrinologists Locum post out to external agencies Permanent post on NHS jobs	No-one available from external agency. Permanent advert still out for applications	Review of patient waiting for out-patient appt to see if can be seen in a general paediatric clinic. Discussions with tertiary service for extra support. If complex patients referrals redirected to tertiary service	No-one available to triage referrals. Not meeting National guidance if patients with thyroid problems are seen in a general paediatric clinic.
1909	Risk of delay of renal replacement therapies due to unreliability of machines.	Clinical Care	Currently within ICU we have 4 machines which are utilised to deliver renal replacement therapy. However, these machines have become unreliable and have on times been out of action due to faults and failures. Despite a paid annual maintenance and service contract, engineer reviews and repairs have been delayed resulting in using a loan machine which is dependent on availability.	Surgical Division	15	3	5	15	3	1. 4 machines in fleet 2. Paid annual service and maintenance contract 3. Loan machine from contractor dependant on availability 4. Arranged regular contractor involvement in relation to concerns	1. Poor contract service 2. Potential limited availability of loan machine from contractor 3. Potential high patient renal requirement needs >4 machines	1. Incident reporting to monitor controls efficacy 2. Internal audit/log of issues	1. inconsistent incident reports

Risk Id	Risk Title	Type	Risk detail	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
1937	Inability to admit patients with a fractured neck of femur to Dinmore ward within the recommended 4 hours	Clinical Care	There is a risk of increased mortality, increased length of stay and increased complications due to prolonged stay in the Emergency Department for patients with femoral fractures.	Medical Division	20	4	5	20	8	1. Escalated to Division 2. Change in emphasis of ring fenced bed in afternoon bed meetings. 3. Reported at Quality Committee, Divisional Governance Meeting, Clinical Leads, Consultants meetings and 1:1 with CMO. 4. Ownership at ward level in relation to identification of step down patients to create a ring fenced bed on a daily basis. 5. Cross divisional working with Integrated Care in relation to discharge processes and continued use of Discharge Lounge, where appropriate. 6. Patients identified as suitable to move off Dinmore on a daily basis to support ring fenced bed.	1. Lack of capacity to facilitate a ring fenced bed due to hospital congestion. 2. Additional boarders, particularly on frailty wards up to 4 p/day. 3. Protect ring fenced bed for femoral fractures 4. Ensure patients are transferred from ED to Dinmore within 4 hours of admission. 5. Bed modelling done prior to Frailty block opening is no longer accurate due to increased numbers of patients presenting with #NOF. 6. Lack of fast track policy across the Trust.	Executive Risk Committee (ERM) Divisional Risk Meeting Specialty Meeting Quality Committee Divisional Governance Meeting Clinical Leads, Consultant Meetings Learning from Deaths Meeting	1. Bed availability on specialist wards 2. Continued presence of boarders, in high numbers on frailty wards.
1942	Sustainability of Nursing Workforce in ED	Workforce	Historically, recruitment and retention of substantive staff within ED has proved problematic. This has resulted in: 1. Associated cost implications due to a heavy reliance on a temporary workforce, including bank and agency staff. 2. Poor staff morale due to a lack of continuity of staff, high turnover and increased staff sickness. 3. Increase in incidents, complaints and concerns relating values and behaviours. 4. Resulting in reputational harm.	Medical Division	15	3	5	15	6	Workforce: 1. Safe staffing meetings twice daily 2. Capacity meetings 4 x daily 3. Allocate Rosters completed 12 weeks in advance with all vacant shifts escalated. 4. Staffing for escalation areas requested in advance. 5. Increased Senior oversight 7 days p/w 6. Block booking Agency Nurses to ensure continuity and team working. 7. Education Department identified TNA's to backfill registered nurse gaps. 8. Fortnightly challenge boards. 9. Proactive recruitment by B7 with support from centralised recruitment in relation to assignment of overseas OSCE Nurses and HCAs. 10. BC approved at TMB on the 16/8. HR: 10. ED B7 Senior Nurse Forums with CNO and COO	1. Registered Nurse vacancies currently 10.11 WTE (August 24) 2. Nursing Business Case to be presented to TMB (August 24) 3. Establishment uplift to reflect recommendations from CQC and NHSE, captured as cost pressure. 4. Assurance that vacant shifts can be filled, particularly if short notice cancellations and sickness. 5. Inability to reduce staff turnover. 6. WVT ban on off framework agency nurses (Thornbury) as of July '24. 7. Additional staff for escalation areas due to operational pressures. 8. Acute & Emergency Mandatory Training Compliance 82.82% (July'24)	F&PE Executive Meeting (Monthly) Quality Committee (Quarterly) Health & Safety Report (Quarterly) Patient Safety Panel (Weekly) Specialty, Directorate & Divisional Tri meetings Master Vendor Meeting (Quarterly) ID Medical Meeting (Weekly)	ED to be benchmarked against other ED's within the Foundation Group to ascertain if WVT is an outlier Workforce & Development Committee

Risk Id	Risk Title	Type	Risk detail	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
										11. HR KPIs discussed at all Directorate/Divisional meetings to ensure robust sickness management. Safety: 12. B7 Lead Roles for Governance and Education to promote quality and safety in the department and support staff engagement. 13. Safeguarding Lead assigned to ensure PAU is staffed safely with staff trained in PILS and Safeguarding L3. 14. RCN to be provided 24/7 in the PAU.			
1961	The ability to provide appropriate level of patient observation within agreed established staffing levels	Clinical Care	There is a risk of ward staff being unable to provide the appropriate level of observation for patients on the ward due to high levels of patients requiring enhanced observation, or who have high levels of acuity and dependency. Current staffing ratios and patient cohort are not compatible for staff to provide good quality care. This is compounded by a lack of visible bed spaces, bed rooms isolated from the main body of the ward, as well as by open escalation areas which were not designed as patient rooms. Current patient cohort includes around 1/3 of patients who require continuous direct line of sight observation to prevent falls (as per AFLOAT risk assessment and Enhanced Observation policy), as well as multiple confused patients and those with challenging behaviours. The current staffing level makes the correct level observation challenging or impossible and leads to a risk of unwitnessed falls and accidents. Higher staff to patient ratios also increases the risk of medicines errors, hospital acquired	Integrated Care Division	16	4	4	16	12	Daily staffing meetings, weekly sisters meeting, additional staff requested with authorisation of matron, senior nurse checklist, monthly matron audit, Patient Safety Panel, falls panel, budget meetings, divisional quality board	1. Safe Staffing audit data felt to be unreliable, and concurrent sets of data suggestive of uplift has not been acted on 2. Additional factors not included in SNCT audit include layout of ward and unavailability of additional support eg security team/crash team 3. Business Justification not yet presented to TMB - awaiting further audit results 4. Escalation beds not included within establishment and required staffing is recorded as an overspend 5. Assurance in vacant shifts can be filled, particularly if short notice cancellations and sickness-away from main site, staff transfers require transport- lack of uptake from WVT bank staff 5. Inability to reduce staff turnover and sickness, and difficulty in recruitment 6. WVT ban on off framework agency nurses (Thornbury) as of July '24. 7. removal of bank enhancements potentially leading to lower uptake of bank fill	F&PE Executive Meeting (Monthly) Quality Committee (Quarterly) Health & Safety Report (Quarterly) Patient Safety Panel (Weekly) Specialty, Directorate & Divisional Tri meetings Falls Panel Weekly sister's meeting	CH ward layouts are different across all 3 sites, and bring different challenges relating to patient observation and management.

Risk Id	Risk Title	Type	Risk detail	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
			pressure damage, infection outbreaks, poor patient and family communication and poor documentation. There is also a risk of staff burn-out, failures in recruitment and retention, high staff turnover and sickness.										
1992	Risk of harm to patients awaiting discharge to Powys	(Multiple)	There is a risk to patients who live in Powys, being delayed to return home/to discharge pathways from Wye Valley NHS Trust. The risk is related to the likely outcome of patients suffering from Hospital Acquired Functional Decline and having reduced access to their family due to the distances from home.	Integrated Care Division	16	4	4	16	8	Weekly Silver meeting with colleagues across Health and ASC Additional twice weekly urgent meetings Monitoring of delays by Integrated Discharge Team Powys staff work in IDT Mon- Fri as coordinating liaison function	Despite monitoring position, the outcome is not within WVT controls Issues within home care/care home market capacity in Powys Lack of D2A process for Powys patients mean patients are assessed whilst in hospital Delays around social care staff attending WVT to assess patients	Daily handover by IDT Herefordshire Silver meeting (weekly) Divisional Operational and Quality Board Executive Risk Committee (ERM)	

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Audit Committee Summary Report 13 June 2024 and 25 June 2024
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	Select Director
Author:	Nicola Twigg, Chair of Audit Committee/NED
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To brief the Board on the main issues arising from the Audit Committees held on 13 June 2024 and 25 June 2024.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

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.

Wye Valley NHS Trust
Trust Board Meeting – 3 Oct 2024
Summary of Audit Committee (AC) meetings held on 13 & 25 June 2024

MATTERS FOR PARTICULAR ATTENTION

Audit Committees sat twice in June to allow for Business As Usual items alongside the review of our year-end financial and governance positions.

June 13th

We were joined by Jo Sandford for the first time who brought us up to speed on our Freedom to Speak Up strategy and activity levels. FTSU will now be a regular feature at Audit Committee as part of our realigned governance structure.

The CMO provided a valuable interim update on Job Planning showing progress, main concerns being surgery Division but actions in place to address, and agreed to provide a fuller report at the September committee.

Internal Audit, presented the year end opinion in draft as the Agency Report was not yet finalised. This report had a positive assurance opinion (above the line) and it as also positive to see in the ongoing tracker that outstanding actions were being completed in a much more timely and effective manner.

LCFS Report showed the Trust receiving a green rating in the Counter Fraud Functional Standard Return

June 25th

The Company Secretary presented the Annual Report and Annual Governance Statement 2023/2024 which were duly approved.

The WVT Final Year End Accounts were reviewed and included Auditor Statement on the consolidation schedules, Draft WVT Audit Opinion, Draft WVT Representation letter, WVT NHS ISA 260 2023/24. A few non-material amendments were recommended before final sign off.

Thanks to all parties at WVT and Deloitte's, as due to the hard work and effort by both teams, the process this year has been completed within agreed deadlines.

OTHER MATTERS

Report	Discussion / Recommendation
Cyber Security	A verbal update was given by the CFO and full report on Trust strategy and performance due at September meeting
Single Waivers	Update provided by CFO re medical records storage off site facility and dentistry scans. Approval given.
Audit Committee Board Workshop	WVT Audit committee NEDS also met with NEDs from Worcester Acute in June to share best practise, risk management frameworks and discuss feedback from Self-Assessment Summary, chaired by Company Secretary

Prepared by:-
Nicola Twigg, Chair of Audit Committee

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 13 June 2024 at 9:30 a.m. – 11:00 a.m.
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
In attendance:		
Chizo Agwu	CA	Chief Medical Officer – For Item 5.1
Mark Coton	MC	RSM Risk Assurance Services LLP, Assistant Manager, Internal Audit
Mike Gennard	MG	RSM Risk Assurance Services LLP., Partner, Internal Audit
Erica Hermon	EH	Associate Director of Corporate Governance/Company Secretary
Sharon Hill	SH	Non-Executive Director (NED)
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP
Asam Hussain	AH	Risk Assurance Director, RSM Risk Assurance Services LLP
Ian James	IJ	Non-Executive Director (NED)
Val Jones	VJ	Executive Assistance (for the minutes)
Heather Moreton	HM	Associate Chief Finance Officer
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer – For Item 5.1
Katie Osmond	KO	Chief Finance Officer
Lauren Parsons	LP	Senior Manager, Audit & Assurance, Deloittes LLP
Jo Sandford	JS	Freedom To Speak Up Guardian – For Item 5.5
Manjit Sandhu	MS	Senior Consultant, RSM Risk Assurance Services LLP
Carolyn Trew	CT	HR Business Systems Manager – For Item 6.1

Minute		**Action**
AC001/06.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Kieran Lappin, Associate Non-Executive Director and Jo Rouse, Associate Non-Executive Director.	
AC002/06.24	**QUORUM & DECLARATION OF INTEREST**	
	The meeting was quorate. No declarations of interest were noted.	
AC003/06.24	**DRAFT MINUTES OF THE MEETING HELD ON THE 23 APRIL 2024**	
	AC004/04.24 – Matters Arising and Actions – To change - AC4.2/12.23 – PFI Dispute where services are *not* received or no longer required.	
	Resolved – that with the one agreed amendment, the draft minutes of the meeting held on the 23 April 2024 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC004/06.24	**MATTERS ARISING AND ACTIONS**	
	The complete actions were noted as completed on the action log. The actions in progress were reviewed and updated.	

	AC05.1/09.23 - Audit Committee Terms of Reference (TOR) – Mrs Twigg (NED & Chair) to add 'Consistency with ICS members' to the upcoming meeting agenda with the ICS. The Associate Director of Corporate Governance (ADCG) is aligning the TOR with Worcester with a Workshop being held on 14 June. From an ICS perspective, the Heads of Audit are now invited to the ICS meetings which is attended on a rotational basis. The plan is to align our direction of travel. It was suggested that this work could be taken as an ongoing piece of work rather than continual updates. It was agreed to discuss this with the new ADCG once she is in post. AC05.6/02.24 - Recommendations Tracker – Systematic review of the internal governance processes around action plans to be undertaken. The Chief Finance Officer (CFO) advised that it is taking time to complete the Internal Audit (IA) actions and recommendations. We are ensuring that staff are following up on these and providing updates. Meeting held with IA regarding a status update. We are in a better place regarding responses and timeliness. We will continue to monitor through the IA Action Tracker. It was agreed to close this action. AC06.1/02.24 - LCFS Progress Report – Mrs Twigg (NED & Chair) to meet with the DCFO's to respond to the question set by the Board following the cyber security and cyber risk presentation. Mrs Twigg (NED & Chair) had discussed this with the Associate Director of IM&T who advised of the difficulties around some of the actions around cyber areas regarding finances. We need to be realistic around the potential risks. Further discussion next week. AC05.1/04.24 - Sickness absence update – The Sickness Absence Report to be presented to the Trust Board for further scrutiny. On the Action Tracker. Agreed to close this action. AC05.2/04.24 - Risk assessment for 'Not paying' PFI related invoices – Discussion to take place to identify opportunities as the Trust is moving into handback. The CFO advised that the plan was to make the Committee aware of the updates occurring, noting that we need to be clear on the risks and opportunities. A Board Workshop is being held on this later in the year. It was therefore agreed to close this action. AC05.4/04.24 - Standing Orders - Standing Orders and SFI's to be included as part of the induction programme for new Non-Executive Directors. Combining with Worcester to create a formalised Check List Induction Programme. AC06.2/04.24 - Draft Head of Internal Audit Opinion - The Chief Finance Officer to identify any areas that could result in a negative opinion report and advise IA of any actions taken to provide the Trust with a positive opinion. The IA Workplan has been reviewed. There are a couple of minor suggestions. IA are reviewing the Programme accordingly. AC06.7/04.24 - Internal Audit Strategy & Internal Plan 2023/24 - The Chief Finance Officer to work with Internal Audit regarding the passing of information from the Emergency Department to other departments. This is being picked up as part of the IA scoping exercise.	**NT**

	AC07.1/04.24 - Counter Fraud workplan 2024/25 - LCFS to provide assurance to the Chief Finance Officer on the 25 risks relating to cyber risks. As this has now been resolved, agreed to close this action. AC07.1/04.24 - Counter Fraud workplan 2024/25 - The LCFS to utilise the information on work undertaken in other Trusts on car parking risks. The Senior Consultant, RSM had met with the CFO and the ADCG to discuss car parking. The aim is to get local proactive exercise scope on car parking permits approved by the end of the month. Agreed to close this action. AC07.2/02.24 – Financial Reporting Risks – Timeframe to be added to the Financial Reporting Risks Report. This has now been completed. The majority of actions have been completed for the 2023/24 period. A number of actions are continuous or need annual review which has been made clear within the Report. Mrs Hill (NED) queried if it is possible to benchmark with Foundation Group colleagues to ensure that we have a complete list of financial risks. IA advised that not many other Trusts are as far ahead in this area and therefore this may not be possible. The Associate Chief Finance Officer advised that the list came from our Internal and External Auditors which formed the basis of the risks but will discuss with Foundation Group colleagues.	**HM**
	<u>Resolved</u> – that: **(A) The Action update be received and noted.** **(B) Mrs Twigg (NED & Chair) to attend the ICS Audit Committee in October. The Company Secretary has aligned Wye Valley Trust and Worcester's Audit Committee Terms Of Reference and Mrs Twigg (NED & Chair) will discuss further with new Company Secretary when she commences in post.** **(C) To discuss with Foundation Group colleagues around whether they have a Financial Reporting Risk Report which we can benchmark ourselves against.**	**NT** **HM**
AC005/06.24	**<u>GOVERNANCE</u>**	
AC05.1/06.24	**<u>CONSULTANT JOB PLANNING</u>**	
	The Chief Medical Officer (CMO) provided a verbal update on Consultant Job Planning and the following points were noted: • Divisions are moving at different rates. Clinical Support Division have 100% Consultant Job Plans singed off. Medical Division have the majority of theirs signed off and are aiming to get everyone on Allocate. • Surgery Division are the main concern. The Elective Surgical Hub is opening in July and Job Plans need to be signed off by then. Breast Surgery and Paediatric are all completed. General Surgery and ENT are the main areas of concern. The Job Planning Committee is being held on 14 June (which the CMO Chairs). The plan is to try to get all Consultants on Allocate and then review the content of their job plans as we need more around productivity and efficiency.	

	• Mrs Twigg (NED & Chair) noted that it was helpful when there is a lot of data/statistics being provided to have a paper to read through in advance. The CMO will produce an interim report on the position on Job Plans by the beginning of August to be circulated to the Audit Committee. • IA advised that they are carrying out a piece of work around Medical Job Planning for October which will provide assurance.	**CA**
	Resolved – that: **(A) The Consultant Job Planning verbal update be received and noted.** **(B) The Chief Medical Officer will circulate an interim report on the position on Job Plans by the beginning of August to be circulated to the Audit Committee.**	**CA**
AC05.2/06.24	**CONSISTENCY WITH ICS MEMBERS**	
	This was covered under the Action Log.	
AC05.3/06.24	**DHCS GATEWAY 5 REVIEW REPORT (HUTTED WARDS)**	
	Report delayed until September.	
AC05.4/06.24	**SYSTEMATIC REIVEW OF INTERNAL GOVERNANCE PROCESSES**	
	This was covered under the Action Log.	
AC06/06.24	**INTERNAL AUDIT**	
AC06.1/06.24	**IA PROGRESS REPORT (INCLUDING HEALTH ROSTERING REPORT)**	
	IA presented the IA Progress Report (including the Health Rostering Report) and the following points were noted: • Both remaining pieces of work on the 2023/24 Plan have been completed. Health Rostering was issued with Reasonable Assurance and Agency Spend (draft) was issued with Reasonable Assurance. The headline findings are included in the Report. • This year we are making progress already with the ED Pathways Data Quality piece of work started and the Mortuary Review brought forward to commence on 15 July. The Medical and Surgical Junior Review is ongoing. We are mindful of the industrial action causing issues with resources which has been flagged as a concern.	

	• Headline Findings Health Rostering Report – This was issued with reasonable assurance (above the line). The Review looked at the application of the E-Rostering Policy and Allocate. The implementation of Allocate is fundamentally complete. It is useful that the functionality allows you to ensure staff have completed their contacted hours before taking on additional hours on the Bank or overtime. Actions agreed on updates on Policies and How To Guides. Just need to ensure that training is sufficient at Ward level in terms of Allocate. There was also a glitch on the System which was not showing the rostered establishment date on the Rosters which has now been addressed. A low priority action is updating the Quality Committee Terms Of Reference to ensure that their role in terms of challenging and scrutiny of the Safer Staffing Report is being reported. There is a report on Safer Staffing every month on the website with a narrative around this helpful in terms of supporting this paper. Formal approval was sought from the Chief Nursing Officer prior to this Report being published. • The CFO advised that we are seeing a number of benefits from this which the team are able to quantify with this System working effectively. • Mr James (NED and Chair of the Quality Committee) welcomed and supported this and agreed that the Safer Staffing Report needs to be clearer to understand which is being worked upon. Actions are being taken to ensure that the baseline figures are correct. • Agency Spend – Received positive assurance (still in draft). This reviewed both Medical and Nursing Agency. Actions were highlighted around further promoting Bank and opportunities of working on the Bank to increase this and reduce reliance on agency. • At Ward level, improvements could be made to the information that is being captured on the attendance sheets, which within our chosen sample were found to have not been fully completed. This report is due to be finalised shortly.	
	<u>Resolved</u> – that the IA Progress Report (including Health Rostering Report be received and noted.	
AC06.2/06.24	**<u>RECOMMENDATION TRACKER</u>**	
	IA presented the Recommendation Tracker, which was taken as read, and the following points were noted: • There have been a significant number of actions (68). Of these, 24 have been implemented, 36 due dates had not been reached and 8 were being implemented with requests for an implementation date extension.	

	• There are 8 actions for formal ratification by the Committee due to revised implementation dates being requested. Prior to the meeting, these had been reviewed and approved by the Chief Finance Officer. Three of these are relating to the Job Planning Review. These will be reviewed later in the year as updates to the Policy are required. Admin time and supervision were areas under debate which are preventing the finalisation of the policy. For these, an extension to 31 August 2024 had been requested. The remaining five actions were from the EMIS Community EPR Post Implementation Review (1), Discharge Planning (1) Strategic Workforce Planning (2) and Key Financial Controls – Income Collection and General Ledger (1). • Mrs Twigg (NED and Chair) noted that we appear to be in a better position regarding outstanding actions and questioned how a "no response" is followed up. IA advised that reminders are sent and Executives included in these. If there are still issues, this is escalated to the CFO. • Mrs Hill (NED) found the inclusion of the key developments useful including the drive of recruitment of Armed Forces Veterans and queried whether the Trust are actively targeting Veterans as part of our recruitment process. The ADCG advised that there are a number of recruitment events with one that we are invited to that specifically targets former Armed Forces members into the NHS.	
	Resolved – that the Recommendation Tracker be received and noted.	
AC06.3/06.24	**DRAFT INTERNAL AUDIT ANNUAL 2023/24 REPORT**	
	The IA presented the Draft Internal Audit Annual 2023/24 Report and the following points were noted: • The opinion is in draft as the Agency Report is not yet finalised. This report has a positive assurance opinion (above the line). There are some enhancements and actions that this review has highlighted but nothing classed as major. All actions have been accepted by Trust management. • Based on the 8 Reports finalised, 4 of these are positive, 2 advisory and 2 issued with a Negative Assurance opinion, with these being Sickness Absence and Directorate/Divisional Governance. Included in the annual report is an update in terms of the progress made in implementing the management actions from these two reports, where it is positive to note that this has been good. • KPIs – All of these have been met which is positive.	
	Resolved – that the Draft Internal Audit 2023/24 Report be received and noted.	

	GOVERNANCE	
AC07/06.24	**FREEDOM TO SPEAK UP AUDIT**	
	The Freedom To Speak Up Guardian (FTSUG) presented the Freedom To Speak Up Audit and the following points were noted: • KPI Model Hospital – Quartile 3 has gone up considerably to 40 cases. • KPI – Mandatory Speak Up Training – Nearly all Divisions are above 90%. • Staff Survey Results – We are hoping to see further improvement next year with all the work put in around this. • Time Allocation – The FTSUG started on 11.5 hours, increased to 22.5 hours and now extended to 37.5 hours due to the increase in workload. • FTSU Champions – We had 22 Champions in April 2023 which has increased to 102 in April 2024. • FTSU Cases – There were 70 cases in 2021/22 increasing to 102 in April 2024. • Promotional Work – This includes the HR Roadshow, Speak Up Month, Trust Talk (regular slot), QR Code around speaking up, Champion Recruitment and the BAME Community. • Acts on Feedback Received – Feedback, action, result. An example of this was provided. From this week, Listen Up Training has been made mandatory for all managers. A film has been made showing staff that the Executive Team are available and will listen and act on any concerns raised. • Mrs Hill (NED) questioned whether data on queries was being collated to understand if there were any groups which were not being represented from an EDI perspective through the FTSU queries, The FTSUG confirmed that each referral is understood from both source and an EDI perspective, which should highlight any omissions. • Mrs Hill (NED) then questioned whether data on enquiries is being collated to see whether this is translating to more hours than the current 37.5 allocated to the FTSUG. If there is an increase, is there a plan to deal with this. The FTSUG advised that she records any enquires made even if they are not taken forward, with the nature of the enquiries varying. The FTSUG also has an Assistant for 6 hours a week on the Bank to support. They are trained to help deliver Civility Saves Lives.	

	• Mr James (NED) advised that he has been the NED Link Champion for 2 years with quarterly meetings held with the Managing Director and the FTSUG along with regular separate meetings between himself and the FTSUG. When he commenced in role there was a well embedded FTSU process which we administered effectively. We needed to address the wider cultural issues in the organisation which the FTSUG is doing. We have gone from process to culture, with the number of cases going up showing that this is working. • Mr James (NED) noted in the report the Bank and Agency staff concerns and queried if there is anything that we can do to highlight this more through FTSU. The FTSUG advised that she attends the Corporate Induction which new Bank staff attend. The Bank Staff Manager has been recruited as a FTSU Champion to further support on this. • Mrs Twigg (Chair and NED) noted the cultural change piece which is very positive. We need to work with our Education Team to ensure that our leaders and managers have the support they require to deal with issues before they become a FTSU concern.	
	Resolved – that the Freedom To Speak Up Audit be received and noted.	
AC08/06.24	**LCFS**	
AC08.1/06.24	**ANNUAL COUNTER FRAUD 2023/24 REPORT**	
	The Senior Consultant, IA presented the Annual Counter Fraud 2023/24 Report and the following points were noted: • Included in the Report is a summary of the Reports undertaken, including the Trust receiving a green rating in the Counter Fraud Functional Standard Return and also the completion of a Trustwide Fraud and Bribery Risk Assessment which was presented at the last Audit Committee. • Details of the 2 key fraud risk areas are included in the Report, with work scheduled for this. • There are 3 Standards out of the 12 rated as amber with work with plans to improve this to a green rating. • There were 6 cases brought forward to this financial year. Two are now closed with 4 still in progress. • Mrs Twigg (NED and Chair) noted that it we filled in more returns from the organisation, we would probably be green in all areas. This is an area that we need to move forward on. • The CFO advised that great work has been carried out in the right areas for Counter Fraud. There is a need for further work on how we know that the measures in place are having an impact and making a difference. This will need to be our focus for this year.	
	Resolved – that the Annual Counter Fraud 2023/24 Report be received and noted.	

AC09/06.24	**FINANCIAL REPORTING**	
	The CFO provided a verbal update on the Financial Reporting and the following key points were noted: • The CFO advised that consideration was needed on how to present this Report in future, suggesting a periodic report rather than a verbal update. • The ICS Finance Committee was held last week with Mrs Hill (NED) our NED Representative. This has morphed from a Finance Forum into a more formal Finance Sub-Committee of the ICB. • One of the sub groups that sits beneath this Sub-Committee has been the Investment and Expenditure Group which has been operating for about 18 months linked to some of the need for enhanced controls and for the dual approval needed for certain items. We have stood down a number of these meetings. We discussed at the Finance Committee around reviewing the Terms Of Reference to ensure that it is fit for purpose in the current environment in 2024/25 given the significant financial challenges and the escalated controls that we expect will be required, particularly linked to capital. We know that capital is restrained, and the area that we need to sort as a System is around greater visibility on everyone's prioritisation of their limited capital resource. We need to be assured that where we have escalated risk in 1 organisation because of that limited access to funds that we understand that collectively and that there is visibility of that across the System. The intention is for a review of the Terms of Reference and a reset for that forum which will the add value in terms of that feeding into the Finance Committee. • Discussion has been held around how we approach future meetings of the Finance Committee and how we get the most out of it and also what would add most value back into the organisations. The Chair has advised that she is happy to meet with all of the Audit Committees to discuss where we take the ICB Finance Committee and how this interacts with other forums within the respective organisations. • Mrs Hill (NED) agreed that we need to get value out of the Investment and Expenditure Group as opposed to just being a signing off forum.	
	Resolved – that the Financial Report verbal update be received and noted.	
AC09.1/06.24	**Single Tender Waivers**	
	The CFO presented the Single Tender Waivers verbal update and the following points were noted: • Two single waivers were approved in April and May. • One was around our medical records storage off site facility. We have used the same organisation for a number of years. We have been working with Procurement colleagues to move this onto a more robust contract, which has now occurred. We did not initially go out to tender as we needed the updated Terms and Conditions in place to allow us to go out to market and re-procure.	

	• The second was around a specific type of scan for one of the Dentists in the community which was for just over £10k. • The formal updates on these 2 waivers will be included in the next Report to the Committee. • IA have advised that they will be starting their annual benchmarking exercises around tender wavering which will provide more intelligence around this outside of the organisation.	
	Resolved – that the Single Tender Waivers verbal update be received and noted.	
AC10/06.24	**EXTERNAL AUDIT**	
	External Audit presented the External Audit verbal update and the following points were noted: • There are no concerns regarding progress. The teams are working really well together with just a few issues that they are working on regarding the way that revaluations were being processed in the past • PFI Accounting – We have been through all of the models. There is just a final issue around the accounting to resolve and a few issues around accruals that we are working through. • We raised a question around Salix Grants which have been correctly accounted for this year. • There are issues around the REM Report due to the difficulties around the guidance.	
	Resolved – that the External Audit verbal update be received and noted.	
AC11/06.24	**ANY OTHER BUSINESS**	
	• The ADCG reminded the attendees of the Audit Committee Board Workshop being held the next day. As Audit colleagues are not invited, the ADCG advised that the meeting is with Worcester Audit Committee members looking at best practice so that we can benchmark between ourselves. A Report will be presented back to the next Audit Committee.	
AC012/06.24	**DATE OF THE NEXT MEETING** **Tuesday 25 June 2024 (End Of Year) – 9:30 a.m. – 10.30 a.m. via TEAMS**	

WYE VALLEY NHS TRUST
Minutes of the Audit Committee (End of Year)
Held on 25 June 2024 at 9:30 a.m. – 10:00 a.m.
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
In attendance:		
Glen Burley	GB	Chief Executive Officer
Jessica Connelly	JC	Assistant Manager, Deloitte LLP
Mark Coton	MC	RSM Risk Assurance Services LLP, Assistant Manager, Internal Audit
Mike Gennard	MG	RSM Risk Assurance Services LLP., Partner, Internal Audit
Erica Hermon	EH	Associate Director of Corporate Governance/Company Secretary
Sharon Hill	SH	Non-Executive Director (NED)
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP
Asam Hussain	AH	Risk Assurance Director, RSM Risk Assurance Services LLP
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Heather Moreton	HM	Associate Chief Finance Officer
Katie Osmond	KO	Chief Finance Officer
Lauren Parsons	LP	Senior Manager, Audit & Assurance, Deloitte LLP
Louise Robinson	LR	Deputy Company Secretary
Manjit Sandhu	MS	Senior Consultant, RSM Risk Assurance Services LLP
Wendy Twigg	WT	Executive Assistant (for the Minutes)
Antony Upton	AU	Assistant Manager, RSM Risk Assurance Services LLP

Minute		Action
AC001/06.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Ian James, Non-Executive Director.	
AC002/06.24	**MINUTES OF THE MEETING HELD ON THE 23 APRIL 2024**	
	The minutes were approved as an accurate record of the meeting.	
	Resolved – that the minutes be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC003/06.24	**MATTERS ARISING AND ACTIONS**	
	The complete actions were noted as completed on the action log. The Chair commented that the actions had been reviewed with no outstanding actions for this meeting. It was agreed that the action log would be discussed at the next meeting.	
	Resolved – that action log to be discussed at the next meeting.	

AC004/06.24	**GOVERNANCE**	
AC004.1/06.24	**DRAFT ANNUAL REPORT AND ANNUAL GOVERNANCE STATEMENT 2023/24**	
	The Associate Director of Corporate Governance/Company Secretary provided an update on the draft annual report and annual governance statement 2023/24 and the following points were noted:- • An apology was provided for the late publication of the paper (version 21). The paper was presented at a previous Audit Committee and Board with delegated powers provided to approve the papers at this Audit Committee. Ongoing amendments and inclusions have been made in consultation with External Audit colleagues; • An update to the annual governance statement conclusion (on page 95 of the annual report) has been provided to demonstrate that as a Trust the Chief Executive Officer (CEO) indicated that there are no significant internal control issues within the Trust; • The remuneration table requires an amendment, the salary of Frances Martin, Non-Executive Director as the Deputy Chair has not been correctly reflected, which is a minor update and will be rectified after the meeting; • The Chief Finance Officer (CFO) commented on the changes to the conclusion (page 95 of the annual report), two paragraphs have been added to the final Conclusion for clarity that from a Value for Money (VFM) assessment perspective the EA had flagged some weaknesses within financial sustainability areas and in light of the CQC inspection of ED in December, whilst referenced in the annual report were not indicative of significant internal control weaknesses; • The External Auditors (EA) commented that the explanation on the conclusion was helpful and easy to understand. The EA will check the document but in terms of the initial read, the EA was happy with the wording within the report; • The Chief Executive Officer (CEO) confirmed his approval of the wording within the document.	
	Resolved – that: **A) The draft annual report and annual governance statement was formally APPROVED and acknowledged the update to the remuneration salary table.**	
AC004.2/06.24	**REVIEW OF WVT ANNUAL ACCOUNTS (FINAL)**	
	The Chief Finance Officer (CFO) presented the review of WVT annual accounts (final) and the following points were noted:- • The draft WVT annual accounts were previously reviewed at Audit Committee in April 2024; • It was noted that there had been some presentational changes to the document; • The schedule of changes has been set out as a separate document;	

	• The Associate Chief Finance Officer (ACFO) highlighted that there had been some tweaks to the document, including the statement of changes in equity and corrections made to some prior year values in notes to match last year's accounts, which are referenced in the notes; • A version is now available for the CEO to sign off; • There were no material changes to the main financial statements to the schedule of changes; • Mr Lappin (ANED) commented on the different amounts stated in the annual accounts relating to the audit fee compared to the figure in the External Auditors report. The EA provided an explanation that the current year's fee is plus the adjusted fee from the previous year's being corrected. The CFO commented that there is a footnote in the main accounts which provides an explanation, but it was agreed that a footnote is added to the External Auditors report for clarity. **ACTION** • The ACFO and the Finance team were thanked for their hard work.	**EA**
	<u>Resolved</u> – that: **A) The WVT annual accounts (final) was formally APPROVED.** **B) A footnote to be included in the External Auditors report to clarify the audit fee.**	
AC005/06.24	**<u>EXTERNAL AUDIT</u>**	
	External Audit provided a verbal update and the following points were noted:- The auditor statement on the consolidation schedules, Draft WVT audit opinion, Draft WVT representation letter and the WVT ISA 260 2023/24 were included as appendices in the papers and were taken as read. • The External Audit report was taken as read. In terms of the Status (page 219 of 269) the completion of some non-significant risk areas of testing has now been completed with no major concerns noted and some comments in the documentation are to be reviewed and completed; • Once the EA are in receipt of the signed management representation letter, the EA annual report will be issued in July followed by the certificate once the NAO return has been completed; • Some weaknesses have been raised in terms of Value for Money (VFM). The EA have identified the underlying financial position and a Section 30 report will be required; • Challenges with meeting the CIP programme has also been identified as a weakness, together with the CQC and national oversight framework score, which requires improvement; • The EA highlighted the quality indicators (pages 221/222) and the transformation of the quality of the reporting is being shared as an example of the standard of reporting;	

	• The REM report was highlighted as an issue by the EA and improvements can be made. The EA have included additional controls and recommendations; • Heather Moreton, Associate Chief Finance Officer and the Finance team were congratulated on their work on the report this year; • The EA highlighted that the Trust has made a pre-payment to the capital programme funded by SALIX grant funding. The accounting was not an issue, however managing public money states that the public sector should not make pre-payments. Treasury approval should be obtained and the EA will report the pre-payment to the NAO. The Trust is to avoid any future pre-payments wherever possible; • The EA had originally estimated that the audit could take 2400 hours, the actual number is currently below the expected number of hours due to the efficiency of the process; • The Associate Director of Corporate Governance (ADoCG) highlighted the complication of ensuring that the final version of the annual report is available by the 25 April 2024 as the performance data was not available and the associated commentary was required to be completed. The ADoCG also requested that the GAM checklist is available in a word format and not excel document next year; • The Chief Finance Officer (CFO) commented on the auditor reporting recommendations. The lengthy list of control efficiencies and suggestions will assist in guiding phase 2 of the Improvement Plan and thanked the EA's for their working relationship with the team; • Mrs Twigg (NED & Chair) questioned the framework scores referred to. The Managing Director (MD) responded that this is part of the outcomes framework, which include levels 1 – 4. WVT are in governance level 3 and are aiming to get to level 2 this year. With regard to other members of the ICS, Worcestershire Acute Healthcare Trust (WAHT) are at level 3 and the Health & Care Trust are at level 2. The Chief Executive Officer (CEO) commented that George Eliot Hospital (GEH) are level 2 and South Warwickshire Foundation Trust (SWFT) are level 1. The CEO agreed to provide an update on the governance levels as part of the outcomes framework. **ACTION** • Mrs Hill (Non-Executive Director) provided an observation on the control efficiencies and the approach the Trust has with the EA's which reflects a healthy balance of challenge to the organisation and is a really positive dynamic for the business. ❖ Post meeting note regarding the Letter of Representation - As part of the audit finalisation, it was identified that Hoople should have been listed in the related parties note as well as the existing disclose in note 18. This has not been changed in the accounts as it is not material but has been logged as a disclosure deficiency in the revised letter of representation. The revised letter of representation was signed last week.	**GB**

	<u>Resolved</u> – that: **(A) The External Audit verbal update be received and noted.** **(B) The Chief Executive Officer to provide an update on the governance levels as part of the outcomes framework.** **(C) The draft External audit report was received and will be approved following final amendments.**	
AC006/06.24	**<u>ANY OTHER BUSINESS</u>**	
	• The Chair thanked all involved in the reports for their hard work.	
	<u>DATE OF THE NEXT MEETING</u> **Thursday 19th September 2024 – 9:45 a.m. – 12:00 p.m. via TEAMS**	

Report to:	**Public Board**
Date of Meeting:	**3 October 2024**
Title of Report:	Charity Trustee Summary Report 13 June 2024
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	
Lead Executive Director:	Select Director
Author:	Ms Quantock, Non-Executive Director
Documents covered by this report:	

1. Purpose of the report

To brief the Board on the main issues arising from the Charity Trustee held on 13 June 2024.

2. Recommendation(s)

To receive the Report.

3. Executive Director Opinion[1]

N/A

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.

Charitable Funds Committee Report

June 13, 2024

Matters for Noting

1. Audited Accounts 2022/23: The Committee reviewed and approved the audited accounts for the financial year ended 31st March 2023. Due to income exceeding £1m, a full external audit was required. Key changes from the draft accounts include an £85k increase in 2022/23 income due to legacy recognition timing, with a corresponding reduction in 2023/24 income. The audit highlighted areas for process improvement, including legacy income accrual, administration cost recharge updates, and restricted fund marking for specific-purpose legacies.

2. Appointment of Independent Examiner: The Committee discussed the process for selecting an independent examiner for the 2023/24 accounts. A recommendation for appointment was presented for approval.

3. Fund Balances as at 31/3/24: The Committee reviewed the fund balances, with a focus on the split between restricted and unrestricted funds. A proposal was discussed to establish a clearer process for increasing visibility of fund restrictions to aid effective use.

4. Financial Position Q4 2023/24: An update on the overall financial position was provided, including recent income and expenditure and individual fund balances. Previous quarters were restated to reflect the £85k income movement into 2022/23. A reclassification exercise between unrestricted and restricted funds was undertaken following the 2022/23 audit recommendations.

5. Investment Update: Funds have been transferred into two Barclays notice accounts as per the investment policy. The CCLA account is now live, with further funds being transferred to leave £50k in the day-to-day account.

6. Staff Wellbeing and Volunteer Schemes Funding: Trustees agreed offline on the preferred approach to funding these schemes. The exact allocation from unrestricted funds is being finalized, taking into account the 2022/23 audit findings.

7. Fundraising Update:

- Maternity Bereavement Garden: Plans are agreed, with work scheduled to start imminently. The total cost is around £50,000, with funds already exceeding the required amount.

- Green Spaces: Increased requests for redeveloping green spaces across the Trust. A green spaces committee has been formed to manage volunteering and long-term planning.

- Theatre LED Panels: Plans to provide the anaesthetic room in Theatre 3 with LED panels for child distraction during procedures.

- Urology Department: Received a £3k donation from the Masonic Lodge for a new stepper machine.

- Children's Development Centre: Working on acquiring funding to replace sensory equipment and refurbish the outside play area.

- Staff Lottery: Many staff participating, lottery are raising funds and proving popular.

- Education Centre: The Campaign Director continues to develop bids for charitable trusts. The Trust is in the process of appointing a partner to deliver the building and expects to submit a planning application at the end of July. A proposal to utilize over £600k of charitable funds set aside for the Education Centre for upfront costs is being considered.

Matters for Escalation

None.

WYE VALLEY NHS TRUST

Minutes of the Charity Trustee
Held on 13th June 2024
Via MS Teams

Present:

Grace Quantock	GQ	Non-Executive Director and Chair
Chizo Agwu	CA	Chief Medical Officer
Eleanor Bulmer	EB	Associate Non-Executive Director
Katie Farmer	KF	Charity Fundraiser
Alan Dawson	AD	Chief Strategy and Planning Officer
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FM	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Alison Bolton	AB	Fundraising Director
Heather Moreton	HM	Head of Commissioning, Contracts and Income
Vicky Roberts	VR	Executive Assistant – For the minutes

Minute		Action
CT01/06.24	**Apologies for Absence**	
	Apologies were received from: Glen Burley, Chief Executive, Geoffrey Etule, Chief People Officer, Lucy Flanagan, Chief Nursing Officer, Russell Hardy, Trust Chairman, Kieran Lappin Associate Non-Executive Director, Andrew Parker, Chief Operating Officer and Jo Rouse, Associate Non-Executive Director	
CT02/06.24	**Quorum**	
	The meeting was quorate.	
CT03/06.24	**Declarations of Interest**	
	There were no new declarations of interest.	
CT04/06.24	**Minutes of the meeting held on 14th March 2024**	
	The minutes of the meeting held on 14th March 2024 were agreed as an accurate record of the meeting and signed by the Chair.	
	Resolved – that the minutes of the meeting held on 14th March 2024 be received and approved.	

CT05/06.24	**<u>Matters Arising and Action Log</u>**	
	Kieran Lappin was unable to attend the meeting but had sent some comments and questions via email which will be appended to the minutes. Heather Moreton answered the below questions • Noted June submission to Charity Commission. This is the third consecutive year the Trust has substantially missed the reporting deadline of 10 months after year end. Appreciate the reason for this year, but need assurance that both the June date and the date for the 23/24 submission will be met. Heather Moreton confirmed that 2022-23 accounts will be submitted in June and signatures will be obtained this week. • Page 50 refers to transfer of funds to CCLA. They offer higher interest and are a well respected organisation, but are not underwritten by the Government. In the event of financial failure of the entity (very low risk) all funds in it are at risk. How much is being transferred to them? Heather Moreton confirmed that £490K has been transferred to CCLA. All actions were reviewed and updated. CT006/02.22. Charity Fundraiser will provide an update on the progress of the delivery suite refurbishment at the next meeting. A restricted fund is available for the delivery suite. £25K from staff lottery is on hold for this purpose. Action CLOSED	
	<u>Resolved</u> – that: The action log updates be received and noted	
CT06/06.24	**ITEMS FOR REVIEW AND ASSURANCE**	
	6.1 2022/23 Audited Accounts Heather Moreton, Head of Commissioning, Contracts and Income presented the audited accounts for 2022-23. Some changes have been made to the set of accounts as a result of the timing of receipt of two legacies resulting in an increase in income of £85K There was also some changes to the classification of funds from unrestricted to restricted. The audit management paper was also included and key recommendations to note are as follows: • A process is needed to show the accuracy of legacy income	

- Administration costs recharge from the Trust to the charity need to be updated

- Legacies made for restricted funds need to be clearly marked.

Management responses will be brought to the next meeting along with a progress update.

Katie Osmond (KO) commented that the full audit had been a useful way to review processes.

6.2 Appointment of Independent Examiner for 2023/24 Accounts

Heather Moreton, Head of Commissioning, Contracts and Income presented the report to outline the process undertaken to select an independent examiner of the 2023-24 accounts.

As turnover for 2023-24 accounts was below £1M an independent examination of the accounts was possible, rather than the requirement for a full audit.

Quotes for the service were sought and it is proposed to appoint RD Accounting, who provided the lowest quote, and approval is sought from the Trustees to appoint them.

The Trustees were in agreement for RD Accounting to be appointed to examine the 2023-24 accounts.

6.3 Fund Balances as at 31 March 2024

Heather Moreton, Head of Commissioning, Contracts and Income also presented the report of fund balances both restricted and unrestricted.

The report is to show how much of the overall fund is held for restricted purposes and also shows the proposed allocation for staff wellbeing.

Letters will go out to fund managers next week and it is proposed to establish a clear process to be clearer on lengths to restriction and to ensure most effective use of the funds.

Alan Dawson added his support for this approach.

6.4 Quarter 4 2023/24 Finance Report

The report was taken as read and no further comments were made.

6.5 Fundraising Update

Katie Farmer, Charity Fundraiser gave an update. A report had been pre-circulated and the following points were highlighted:

Work is due to start imminently on the Baby Memorial Garden. The fund raised is in excess of the total needed however, given that the Maternity Bereavement fund will continue beyond this project a public push will continue.

Several requests have been made to redevelop green spaces and the Bromyard Sensory Garden is nearing completion

Have seen an increase in bids for general purpose funds, especially to replace seating in corridors and add to picnic benches which were introduced during Covid.

Frances Martin (FM) noted that it is possibly much easier to fundraise for a garden than for a counselling service such as Petals and perhaps those using the Petals Service could be encouraged to contribute.

Jane Ives (JI) commented that at the Royal Orthopaedic Hospital used volunteers to look after the gardens and wondered if that approach could be adopted at WVT.

Katie Farmer (KF) confirmed that we are working with Sodexo on this and that St Michaels Hospice had provided some insight into the gardening volunteer model and shared knowledge and expertise.

Jane Ives (JI) asked if the contactless giving machine had proved to be successful.

Katie Farmer (KF) confirmed that it has not been as successful as was hoped but that this could be due to it not being in the right place. It was suggested that perhaps it should be placed in high footfall area such as Out Patients.

Katie Farmer (KF) also added that the QR codes which have been placed on lift doors had not been successful and no funds have been raised.

Alison Bolton, Fundraising Director, gave an update on progress of the fundraising for the Education Centre and the Staff Lottery.

420 members of staff are taking part in the lottery and it has banked £4,500 for the charity so far. The top prize in the most recent draw was £750.

	Education Centre Grant Finder has not resulted in any successful recent bids. We are currently seeking a venue for a Charity ball to take place in June 2025 Speller Metcalfe have been appointed to deliver the building of the Education Centre. The main source of funding from Herefordshire Council cannot be accessed until the full business case is finalised. The total costs to build are considerable, between £7-800K however, the trust is working to progress to full business case and access the loan from Herefordshire Council. It is proposed to access £500K of funds from the sum set aside in charitable funds to start the process. Due to the timing of meetings of the Charity Trustees it is likely that offline approval for that sum will be sought. It is also noted the need to be cognisant of the risks of the project not going to completion. Frances Martin (FM) asked for clarification of the extent of the risk involved. Alan Dawson (AD) noted that the risk is low as is subject to CDEL cover. The Council are able to provide the loan within 7 days of completion of the full business case. Jane Ives (JI) added that in order to keep to timescale and open the centre in July 2026 it will be necessary to proceed and take the risk.	
	Resolved – that: **(A) The finance and fundraising updates be received and noted.** **(B) It was agreed that RD Accounting be appointed to examine the 2023-24 accounts.**	
CT07/06.24	**Any Other Business**	
	Grace Quantock (GQ) has received an email from Frank Myers regarding Community First and asked if there is a possibility to access some funds from the charity to assist. It was decided that it is likely that this is related to the Health and Wellbeing College and would be discussed with Frank Myers but that any requests for charitable funds would require a proper business case and to go through formal discussion and process.	

CT08/06.24	**<u>Date of next meeting</u>**	
	The next meeting is due to be held on 12th September 2024, 1300, via MS Teams	

Report to:	**Public Board**
Date of Meeting:	**03/10/2024**
Title of Report:	Quality Committee 25 July 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 July 2024

1. Purpose of the report

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

To consider the summary report and minutes and to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

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

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

Matters for Noting

1. **Safeguarding Quarterly Reports** – Quality Committee continues to scrutinise the Trust's responsibilities under the Mental Capacity Act (MCA) and for Deprivation of Liberty Safeguards (DoLS) and this was the focus of the Adults Safeguarding report, which noted an increase continued work to raise awareness and the resultant increase in referrals over the past 4 quarters. A planned audit review, however, is still outstanding.

   Committee noted a number of positive developments in Children's Safeguarding including filling of posts in the Multi-Agency Safeguarding Hub (MASH), mandatory training compliance levels and work to promote the role of the Local Authority Designated Officer (LADO) in cases where possible harm to a child arises from behaviour of a professional or volunteer. LADO referrals have increased and are being reviewed to assess any common features.

   The wider challenges for children's services across the health and care system continue to be addressed through the work of the LA Improvement Board with a recent Task and Finish Group addressing a range of health needs for Looked After Children. The Trust is engaging at all levels but there has been an increasing need to escalate operational issues to senior level.

2. **Quality Priority – Timely Administrations of Critical Medicines** – The focus continues to be Parkinson's medication where we have seen improvements but expanding the work to other medications is still to happen. Committee expressed frustration at the lack of progress with a medicines self-administration procedure, an aspect of which is the need to ensure appropriate functionality in the EPMA system.

3. **Mortality Report** – Committee welcomed the SHMI death rate dropping below 100 for the first time (97.6 in the 12 months to March 24). Work continues in areas where we remain an outlier with focus particularly on stroke deaths.

   Committee noted the good work to embed the Medical Examiner Service which, from September, will scrutinise also all community deaths not referred to the Coroner. Learning is the main focus of this new process supported by the new Learning from Deaths Committee which considers both areas for improvement and examples excellence in care.

4. **Quality Priority – Improving Care of the Deteriorating Patient** – Work continues on developing a Quality Dashboard and, in the meantime, we continue to use the previous CQUIN reporting data which has seen an overall improvement.

   Committee was updated on plans to implement a 24 hour critical care team which have now been approved by Trust Management Board.

5. **Boarding Report** – We continue to see high numbers of boarded patients and reducing these numbers continues to be improved flow of patients into, through and out from the hospital. Current focus is on admissions where we have 5 additional admissions per day compared with 3 years ago and we are working with integrated neighbourhood teams, GPs and community teams address these challenges.

6. **Surgical Division Quarterly Report** – Committee welcomed the focus on complaints and noted the additional staff resource had supported improvement in response times. More specifically an improvement project in gynaecology/women's health is addressing a number of complaint themes and has resulted in a reduction in complaints in the quarter.

   Other areas of positive note were the exemplar status acknowledged by NHSE for our Children's Epilepsy service and WVT being in the top 10% of Trusts for scores relating to emergency laparotomy (NELA Audit).

   The new Surgical Hub has opened and we need to see the impact on surgical waiting lists as it becomes fully operational.
   Which remain a concern.

7. **Maternity Service – CQC Action Plan Update** – Quality Committee continues to scrutinise progress on the actions to address CQC concerns while acknowledging the overall positive outcome of that inspection. 2 areas in particular were subject of discussion:

   - The continuing review of the role of the Obstetric Support Worker, with a proposal due by the end of 2024;
   - Plans for a 2nd obstetric theatre

   In view of the need to be fully sighted on these issues, Quality Committee asked for a fuller "deep dive" report to come to its September meeting covering these and any other outstanding CQC matters.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 25 July 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 (CMO)
Ellie Bulmer	EB	Associate Non-Executive Director (ANED) – Left at end of item 16
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Rachael Hebbert	RH	Associate Chief Nursing Officer (ACNO)
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director (MD)
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance (ADCG)
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Jonathan Boulter	JB	Associate Chief Operating Officer, Surgical Division
Jo Clutterbuck	JC	Acting Associate Chief Operating Officer – Medical Division
Hazel French	HF	Named Nurse Safeguarding Children (NNSC) (for item 6.2)
Kirstie Gardiner	KG	Named Nurse Children in Care (for item 6.3)
Rebecca Haywood-Tibbets	BH-T	ICB Deputy Named Nurse, Adult Safeguarding (for item 6.1)
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Sarah Holliehead	SH	Associate Chief Nursing Officer, Medical Division
Leah Hughes	LH	Advanced Practitioner Radiographer
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division
Tony McConkey	TM	Clinical Director (CD), Pharmacy & Medicines Optimisation
Sue Moody	SM	Associate Chief AHP, Integrated Care Division
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Vicky Roberts	VR	Executive Assistant (for the minutes)
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division
Amie Symes	AS	Associate Director Midwifery (ADM)
Emma Wales	EW	Associate Chief Medical Officer (ACMO), Medical Division

QC001/07.24	**APOLOGIES FOR ABSENCE**	
	Dan Harding (Associate Director Diagnostic Programmes) and Heidi Sinclair (Head of Quality and Safety, Powys Health Board)	
QC002/07.24	**QUORUM**	
	The meeting was quorate.	
QC003/07.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC004/07.24	**MINUTES OF THE MEETING HELD ON 27 JUNE 2024**	
	Resolved – that the minutes of the meeting held on 27 June 2024 be received and approved.	

QC005/07.24	**ACTION LOG AND MATTERS ARISING**	
	All reports on the action log are due to be presented at either the August or September meetings. Matters Arising: Update section 28, Prevention of Future Deaths notice The CNO informed the Committee that two inquests had taken place where bed rails had contributed to a patient fall. Consequently, the Coroner issued a Section 28 notice on Monday 22 August 24; the trust has 56 days to respond with a deadline for response by 12 September 24. The two main issues are: 1. Our process for assessment and determination to establish whether to use bed rails or not. 2. The process for testing whether call bells are working. The CNO will lead the response to the Section 28 which will be brought back to either the August or September meeting of the Quality Committee.	
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The Section 28 response be brought back to Quality Committee in August or September.**	**LF**
	BUSINESS SECTION	
QC006/07.24	**SAFEGUARDING REPORTS QUARTER 1 2024/25**	
	The ACNO and the ICB Deputy Named Nurse, Adult Safeguarding, and the Named Nurse Safeguarding Children presented the safeguarding updates. The reports were taken as read and the following points were highlighted: 6.1 Adult Safeguarding • Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) have been a quality priority over the last few years and will continue to report through adult safeguarding. • Training continues to be delivered and has increased awareness leading to an increase in referrals. Work continues to improve the quality of referrals and staff actions from them. • DoLs referrals are increasing in each of the last four quarters from 97 to 181. The main focus of attention is to ensure the quality of referrals and actions.	

	• The Deputy Designated Nurse continues to support the team whilst the Lead Safeguarding Nurse is on maternity leave. • General referrals have also risen and in particular those cases put forward for a full safeguarding adult review; the numbers currently meeting the threshold has, put increased pressure on the team. • The Chair noted that it was good to see detail around MCA DoLs as this was a quality priority in 2023/24. Although no longer a quality priority, it was agreed that quarterly reviews would continue through this report. The ACMO, Medical Division explained that it is not uncommon for West Midlands Ambulance Service (WMAS) to make a safeguarding referral that Wye Valley Trust (WVT) are not sighted on. The ICB Deputy Named Nurse, Adult Safeguarding added that referrals from WMAS have historically been problematic as they will put in calls for concerns but this is not communicated at handover to ED. The ACNO explained that WMAS and WVT safeguarding processes are different but there is working group in place to establish a more integrated ways of working, similar to that used for children's safeguarding. That said, due to staff changes in the Local Authority (LA), this work was temporarily on hold. The Chair reinforced that constant dialogue between WVT and the LA is needed around appropriate referrals and that, if there is a specific issue with WMAS, this should be picked up on 1:1 basis. • WVT continue to work on the referral itself and an online portal. It is hoped that a digital format will lead to better access and integration. Nicola Twigg (NED) noted that, as Chair of Audit Committee, they had received an internal audit report on Mental Capacity Act in February with a number of findings/recommendation. Although a further audit review had been planned for June, the CNO advised that this had not yet taken place due to the continued fragility of the team. However, given the importance of responding to audits and after discussion with the CMO, other resources, including junior doctors, were being sought to support audit activity instead of relying on a very small team who need to maintain a timely response to referrals. The MD asked that, given that 174 DoLs were submitted and 123 patients were discharged before assessment, were all referrals required or was the response not good enough? The ACNO advised that delays in the process were reflected nationally and that liberty protection safeguards (to replace DoLs) has also been delayed. The trust is able to grant authorisation for up to 7 days after which the patient should have	

	an assessment by the LA, given these timescales the assessments rarely happen prior to discharge. Referring to the increased workload for MCA DoLs, and mindful of the changing nature of patient co-horts, the Chair reinforced the need to plan for these changes and provide appropriate resources and capacity to meet demand. <u>6.2 Children's Safeguarding</u> • Appointment to the MASH Band 6 and Band 7 posts had been successful. The B7 will lead on the Multi-agency Get Safe Strategy to respond to the exploitation of young people. • The report had been updated to show the training figures for June. Training figures remain high seeing ED staff 85% complaint with Level 3 training. This was partly due to having a nominated Safeguarding Lead in ED. Funding was available for Level 4 training which would start in November. • A Section 11 requirement to increase awareness of the role of LADO had been achieved with two successful training sessions. The training had been over-subscribed so would be repeated in the autumn. • Of concern, there had been an increase in referrals to LADO from seven in the last quarter compared to 12 for the whole of 2023/24. Analysis of referrals is taking place to identify trends/common themes to check if there is a need to do specific work with specific staff groups. • The supervision rate was 100% for midwifery. The health visiting service has struggled to achieve high levels of supervision due to vacancy and sickness rates seeing public health (PH) nursing in relation to school nurses decreasing to 58%. Measures were being put in place to improve this position. • The main risk to timely response to cases remains with the LA as a significant number of cases need to be escalated to senior level. Work is needed to improve working relationships across agencies, particularly health staff and LA children social care teams. Further resolution is required, the CNO is meeting with the interim Director of Children's Services in August to discuss team working and how we work better together. Additionally, the LGA undertook a governance review to support the LA improvement board. The report is due to be shared with partners in the forthcoming month.	

	The Chair observed that the level 4 training was at 50%, and questioned if the data was correct, the Named Nurse Child Safeguarding acknowledged the training was not compliant but should be resolved for the next quarter. The ICB Representative noted the continuing decrease in the number of children with a child protection plan and asked if there was a specific reason. The NNSC suggested that there was a need for more detailed analysis in order to ensure the right children have protection plans and that, despite the decrease, numbers are still higher than they should be. Alongside LA and MASH audits, internal WVT audits are being undertaken to check the appropriateness and status of referrals. Turning to early help, the NNSC confirmed that WVT's contribution is mainly health visiting and the school nursing service. Early help had been funded significantly by LA but funds have since been diverted to child protection. One of the outcomes of this was that some schools have had to invest in posts to offer early help. The Improvement Board have been considering options to re-distribute resources, both financially and staffing, back into early help including a universal offer from multiple agencies and a targeted offer from social care. <u>6.3 Looked After Children (LAC)</u> • There has been a decrease in the number of children in care this quarter. The overall decrease seen is due to children turning 18 and no longer being looked after. • Staffing remains a challenge due to long term sickness and vacancies though we are assured that children's health needs are being met. • The Named Nurse for Children in Care has met with members of the new local authority leadership team at Children's Social Care and is working directly with the Deputy Director for Safeguarding in terms of difficulties with access to local authority health systems. • Exception report around dental challenges for children in care will be included in the next quarterly report. The Chair asked if, as the ICB had two new contracts for NHS dentistry, LAC could be prioritised for these. The Named Nurse for Children in Care advised that the decision rests with individual dentists and that, despite children being seen in an emergency, children are not getting 6 monthly checks. The ICB Representative asked for this issue to be escalated via the dental commissioning quality route.	

	The Chair noted that one LAC notification had taken 205 days to be actioned and asked whether this was a one-off case. The meeting established that 2 siblings had delayed notification. The work of an LA task and finish group continues, with all relevant Children's Services professionals involved. The focus is the health and prioritisation of children in care. Meeting fortnightly, the group is looking at medical consent, dental KPIs, health passports and promoting LA responsibility for health of children in care.	
	<u>Resolved</u> – that: **(A) The Safeguarding updates be received and noted.** **(B) ICB Representative to escalate LAC dental check-ups via the dental commissioning quality route**	**BH-T**
QC007/07.24	**<u>QUALITY AND PATIENT SAFETY PRIORITY UPDATE – CRITICAL MEDICINES</u>**	
	The CD, Pharmacy & Medicines Optimisation presented the quality priority update for critical medications. The pre-circulated Powerpoint presentation was taken as read with the following points highlighted. • The Foundation Group signed up to the initiative to reduce delayed or missed doses of medication for Parkinson's disease for patients in our care as priority for 2023-24. • During 2023-24, in terms of missed or delayed Parkinson's medication, a reduction from 26% to 16% has been achieved. Continuing as a priority into 2024-25, it was 18.6% in June. • Expanding the data set beyond Parkinson's, data for insulin has been requested but delayed. • Progress will continue to be reported through the Patient Safety Committee, ensuring face to face working with the Medicines Safety team to highlight issues. • The self-administration of medicines procedure needed review but was reliant on working with the clinical systems team and changes to the EPMA system. The Chair highlighted a lack of progress with the self-administration procedure. Frances Martin (NED) shared his frustrations and, although understanding of the reasons, was keen to identify what more can be done.	

	The ACMO Medical Division added that despite the Parkinson's team have worked on this for some time and EPMA making the process easier, the problem was that the drugs have to be taken at specific times which does not always align with the drugs rounds. A resolution to this was to encourage self-medication and, for those patients unable to self-administer, to encourage carers to assist. The MD noted that some benchmarking would be welcomed. In response to her question as to whether missed doses were measured in ED, it was confirmed that the numbers apply to inpatients only as ED record through symphony, not EPMA. That said, if patients are in ED for a long period of time (other than minors), they are prescribed on EPMA. The CMO stated that ED had identified this gap in reporting and are building a dashboard from Symphony to provide this data. The Associate Chief AHP, Integrated Care Division noted that, where patients have been in hospital for some time, they become de-skilled in self-administering insulin. Therefore, it would be beneficial if, during their stay, patients dependant on insulin are encouraged to inject themselves. That said, the committee acknowledged that the EPMA system does not allow self-administered medication – this function was previously deactivated but would be reinstated. Grace Quantock (NED) reported that the Diabetes Safety Committee had established that some patients had had insulin taken from them on wards especially where staff are unsure of self-administration and non-safety sharps. Conversely, many diabetic patients are confident to self-administer. It has been established that there is a gap in education of our staff regarding the self-administration of insulin. In summary, it was essential that patients had ownership and were capable of taking medication themselves, supported by WVT policies/procedures and EPMA recording. The ACNO, Medical Division was able to provide assurance that ED staff review times for critical meds, also working closely working with Pharmacy colleagues in the department.	
	<u>Resolved</u> – that the Quality and Patient Safety Update – critical medicines be received and noted.	
QC008/07.24	**<u>MORTALITY REPORT</u>**	
	The CMO presented that: • The latest SHMI, April 2023 - March 2024 shows a reduction to 97.6 which is below 100 for the first time. • There is an improved #NOF mortality rate which continues to decrease, returning to expected levels.	

	• The number of stroke deaths have risen; a deep dive is scheduled to take place in August. • The CMO met with public health. There is a high number of females dying from stroke in Herefordshire (death outside hospital). Information was being sought to determine if they had left hospital, and died 60-90 days afterwards, if at all. • The Learning from Deaths Committee is now well embedded. Mortality Leads are present in departments, reviewing deaths, presenting outcomes and initiating quality improvements. • The CMO stressed the importance of structure judgement reviews to identify issues and best practice in care. The report identified a number of examples of excellent care. • From 9 September 2024 it will be mandatory for all community deaths not referred to the Coroner to be scrutinised by Medical Examiners. It will be mandatory, prior to signature of the certifying doctor and medical examiner, for them to check the accuracy of the certificate, speak to next of kin to see if they have issues in care and to scrutinise patient notes for the same. The Chair acknowledged the reduction of SHMI to below 100 but noted that both sepsis and stroke are higher. The CMO explained that details for stroke will be available at the next Quality Committee. All stroke deaths from January to May 2024 have been audited and are at a lower percentage than the national average. A number came from catastrophic stroke so had to be palliative. She advised that the key to improvement is getting patients in to a stroke bed within 4 hours. SHMI picks up deaths in hospital as well as 30 days after discharge. Grace Quantock (NED) signposted in the chat the publication of a recent report around deaths of people with learning disabilities (LD). The MD noted that many adults and children with LD have congenital issues also. The CMO advised that patients often end up frailer than their chronological age and can have co-morbidities which can increase mortality. In support, Grace Quantock (NED) added that this is part of Mencap's research into health inequalities which is taking into account of impairments and co-morbidities. The CMO drew attention to the WVT policy that, for any patient with LD who dies in our care, a structured judgement review is mandated to establish if it might have been avoided. These reviews are open to external scrutiny through the LeDeR process. The ICB Representative added that, in a Midlands wide presentation on LD deaths, it was noted that Herefordshire and Worcestershire prioritise	

	dementia, pneumonia and cancer and profile slightly higher for depression, dementia and respiratory.	
	<u>Resolved</u> – that the Mortality Report be received and noted.	
QC009/07.24	**<u>QUALITY PRIORITY – IMPROVING CARE OF DETERIORATING PATIENTS</u>**	
	The CMO gave an update on progress to improve the care of deteriorating patients. • At the monthly Deteriorating Patient Committee, directorates report: compliance with standards for detection, escalation and management of deteriorated patients; compliance with next standard and education and training; and, updates on quality improvement. • Plans were in place for Martha's Rule to be introduced once the 24-hour outreach team is embedded. • The CQUIN has shown an overall improvement from quarter 1 to 3. Progress continues on delivering a quality improvement dashboard, currently in its roll out phase. Although this CQUIN is no longer in place, the dashboard for live performance data will provide individual compliance and be able to easily access historic data easily. The Chair noted that having a CQUIN had been useful from a Quality Committee perspective and a way to assess overall progress is helpful. The MD thanked the CMO and ACMOs for their work on the dashboard and noted that it will make a big difference, both from an operational and understanding perspective. In response to the recent peer review of critical care identifying the lack of 24 hour critical care outreach as an immediate risk, Frances Martin (NED) asked what was the level of clinical risk regarding this. The CMO advised that there was no immediate risk other than being an outlier. The CNO added that TMB have now approved the establishment of a 24-hour critical care outreach team and that recruitment to posts would be internal in the first instance. The DCMO indicated that the News2 CIQUIN scores, showing frequency of work for the outreach team first thing in the morning, suggested that a 24-hour service would improve the speed at which patients are identified plus reduce calls and unplanned admissions.	
	<u>Resolved</u> – that the Quality Priority – improving care of deteriorating patients report be received and noted.	

QC010/07.24	**BOARDING REPORT**	
	The ACOO Medical Division presented the boarding report. • There was a slight decrease in boarding in June, down to 38, although the last 2 weeks have been particularly difficult. • 33% of discharges go via the discharge lounge which is better than expected. Further analysis is being completed to determine if this varies on different days of the week. • A new process for handover to the discharge lounge has been implemented to make it easier to get patients down from the wards. • A reduction in quality and safety incidents has been seen in relation to boarding. However, the Medicines Safety Officer does not get specific data for boarding, just general medicines incidents. • Admission rates remain high with 5 more admissions per day than 2 years ago. The division will do a criteria to admit audit to see what is driving this. • There has been a CPE out-break at Ross Community Hospital (RCH) and acute beds closed due Covid & Norovirus. • A reconfiguration of wards took place in July to increase the medical bed base. Opening of the surgical hub has freed up the day case area which will be used to decant for some estates work during September. • There have also been some planned move around of wards. The medical ward has moved from Gilwern (16 beds) to Redbook (24 beds) and day case is being used for planned short stay surgery. It is hoped that having patients co-horted on one ward will help reduce the length of stay (LoS). A substantive Consultant will run the ward from July. • Work continues to review processes to improve the discharge flow including the establishment of a cross-divisional working group. • The CNO had recently reviewed boarding spaces across our wards and described the problems in protecting patient dignity and experience.	

	The Chair asked what the impact would be on the bed base if admissions, flow and discharges were all working effectively. Could boarding be avoided? The MD confirmed that Alan Dawson, Chief Strategy and Planning Officer, is leading a piece of work on this and analysis over 3 years has shown growth in admissions of 5 per day and a stay 6-7 days as the main driver. Work is ongoing with integrated neighbourhood teams, GPs and community teams to see what can be done both in terms of demand management and LoS reduction ahead of and in preparation for winter. In response to the ADQG's question, it was established that the patient eligibility for the discharge lounge criteria is set locally and, although national benchmarking is not available, this was considered when the discharge lounge was set up. The ACMO Medical Division noted that when compared to Worcester, relative to our bed base, WVT have a much higher boarding level which is due to the fact that we have prioritised ambulance off loads. The CMO noted that according to the NHS discharge database WVT are at 111% more admissions than pre-pandemic. Ellie Bulmer (NED) asked the following questions: • Is the GP service at the front door a 24 hour service and what impact is it having? The ACOO confirmed that the GP service is not 24 hours but that there is an agreement with Taurus for out of hours slots that we are able refer into and this is working well. • Feedback from a recent visit to the discharge lounge was frustration with a digital problem. Has this part of the process been removed while work is ongoing to fix the problem? It was confirmed that this part of the process has been removed pending resolution. In order to manage demand, would ethnicity coding help to find trends of patients coming from areas that could be dealt with by primary care?	
	<u>Resolved</u> – **(A) The boarding report update be received and noted.**	
QC011/07.24	**<u>DIVISIONAL QUARTERLY REPORT – SURGICAL DIVISION</u>**	
	The ACNO Surgical Division presented the quarterly report for the Surgical Division. • There have been two patient safety incidents during the quarter: o A never event in Ophthalmology relating to a foreign object retained in the eye. The patient returned to hospital	

	with a lot of trauma to the eye but the foreign object (ring) was not found. The ring was subsequently found at a follow up appointment and the patient was returned to surgery for removal. The initial learning was that the ring was not written on the WHO check list. ○ A patient was brought in to ED with a head injury and suspected spinal injuries following a fall caused by a potential bleed. Some of the documentation was open to interpretation and there was a misunderstanding over which team should look after the patient leading to the patient not being admitted under Trauma and Orthopaedics (T&O) but instead going to Redbrook Ward without being clerked by a doctor. Following admission the patient deteriorated and the emergency team were called. The patient went to ITU and was transferred to Birmingham. Work on the head injury pathway is ongoing • There were continuing improvements in the Gynaecology service and a lot of work has been done to ensure VTE compliance, now over 95%. • A review of every surgical procedure is ongoing to remove those cohorts that do not require VTE. • 27 complaints have been received in this quarter. The focus is to action and close them as soon as possible to reduce the backlog. There are currently 41 open complaints, reduced from 66 in April. • A peer review took place in ITU which highlighted a risk in the policy and process for care of the deteriorating patient and also a serious concern regarding Allied Health Professional provision in ITU. An action plan was in place to increase support for therapy and pharmacy support in ITU but not plan was yet available for the provision of psychology support. • Positive feedback had been received for the work done regarding parents in ITU. Play therapists come to support children to be able to visit and prepare them for any bad news they may receive. • Following concern over the volume of complaints in women's health/gynaecology, a PSIRF improvement project has been started with clear themes identified: knowledge of clinicians and nurses in relation to early pregnancy and bereavement processes; compassion, kindness and empathy of staff; use of gynaecology SDEC area; lack of scanning out of hours; communication between clinicians and admin teams and some admin processes. This has resulted in a significant improvement in the number of complaints in the quarter. The project is	

	expected to complete in November and the findings will be presented to Quality Committee. • The school nursing and Health visiting Nursing Service has been recommissioned following a tender process in April. Much more focus is placed on PH and early interventions from birth onwards. The team will also deliver assemblies/group workshops to children and young people in relation to public health. • The new surgical hub opened on 8 July. • The Health Visiting team have achieved higher than national breast feeding compliance (50%) with 70% of babies still breast feeding at 6-8 weeks. • School nursing team has done some work with LGBT community support groups and supported Pride events. The School Nurse has also provided teaching sessions and is working with the PH team to provide education and teaching for local authority colleagues. • The Trust has been identified as a positive outlier in regard to the Children's Epilepsy Service and have been asked to work with other areas where there are concerns to improve compliance levels. • The NELA audit best practice tariff shows WVT has achieved PBT. One of 17 trusts from 179 who have achieved NILA BPT over the last 2 quarters. • There is some concern regarding surgical waiting lists. There has been some improvement but more is required and it is hoped that the surgical hub will help with this. • Concern around the use of Gynaecology assessment area as an inpatient area as it is not suitable for this and back log has been affecting flow. Discussions have taken place with the site team regarding out hours and is reporting in more detail at bed meetings. The actions are being monitored for progress Nicola Twigg (NED) acknowledged the work on complaints but still had concern over the number of open complaints and asked how many concerns were overdue and was there confidence that all those overdue would be complete by end September? She requested that the report contain overdue numbers for concerns as well as complaints in future. The ACNO Surgical Division explained that, following a member of staff going on secondment, some funding had been identified to employ a member of Bank staff until September to support the division in responding to complaints.	

	The ADCG noted that benchmarking has been done within the Foundation Group around concerns seeing Worcester have 3 times more concerns than WVT but with 81% of concerns being turned around within 24 hours. Learning from Worcester is being obtained. The MD asked the ACOO Surgical Division if there was a target date to do 10 cataracts per list as standard; an exact date is needed for when 10 per list might be achieved given that this was the basis of the funding of the new hub. The ACOO Surgical Division confirmed that a locum had been employed who was doing 24 cataracts per day and that he would provide best practice. With additional middle grade upskilling, we were now performing 8 per session. All weekends are booked to end September plus there is additional out-patient activity on week days. The surgical hub completed 7-8 in the first week. The ACMO, Clinical Support Division commented that the new hub was fantastic and that on first impressions, the increase in volume of patients in day cases is likely to decrease the rate of complaints. Also, the privacy afforded to patients is much improved when compared to day case.	
	<u>Resolved</u> – that the Divisional Quarterly Report for the Surgical Division be received and noted.	
QC012/07.24	**<u>PERINATAL SAFETY REPORT</u>**	
	The ADM presented the perinatal safety report. The report was taken as read and the following points were highlighted: • There were 148 births in June. • The increase in red flags seen in June is based on an increase in acuity over a 2 week period during which there were significant peaks and troughs and it was necessary to call the Community Midwives on 8 occasions. • There were 3 out of a total 8 cases where cat 1 delivery took longer than 30 minutes and reasons why were documented with no adverse outcomes. • RCOG Obstetric attendance is good with no exceptions • There was 1 PMRT case in June • An increase has been seen in concerns and complaints with 1 concern and 4 complaints raised. The main themes are patient care; analgesia; not feeling listened to and communication. The quarterly report next month will triangulate across all quarter to look at themes.	

	• Complaints are also outlined in minimum data set as an appendix to the report. • Birth rate plus acuity tool was completed and showed no cause for concern. • There has been a significant increase in short term sickness mainly due to Covid and diarrhoea & vomiting. Cover overall has been consistent and there are no concerns • A worsening picture was seen in June in the obstetric workforce, particularly the Consultant body. Some adjustment to the figures are needed as one locum is included in locum rate and as he is here long term will be included in substantive figures. • All anaesthetic rotas were covered throughout June The Chair asked if the new report was now in the cross-foundation group format. The ADM confirmed that the next report August would be a quarterly report and will give more information on sickness and triangulation of our findings, reporting against actions and progress since the last report. This was agreed across foundation but is not necessarily a standard template.	
	Resolved – that the Perinatal Safety Report be received and noted.	
QC013/07.24	**EXCEPTION REPORT MATERNITY SERVICE – CQC ACTION PLAN PROGRESS**	
	The CNO updated the meeting and described the purpose of receiving this report: • Given the positive CQC report the frequency of reporting progress against the action plan had been limited and it was important this was tracked for governance purposes • The CQC had raised concerns during the inspection in relation to obstetric support workers and care of level 2 women and it is important that committee is appraised of progress and updates on these matters • That the plan for the obstetric theatre and elective sections had changed since the inspection and that Committee needed to be comfortable with the associated risk assessment and mitigations for this. The ADM continued with the update on the CQC action plan. • A copy of the action plan was attached and it was acknowledged that under item 17 there is an error in that Sarah Ashwood's name remains in progress column although action sits with Amie Symes.	

	• Work is ongoing around a risk assessment associated with the role of Obstetric Support Worker who CQC perceived to be a surgical assistant. This is forming part of a wider piece work to review the B3/B4 support worker workforce, and particularly the high turnover of B3 staff. We have been awarded £17K from NHSE and LMNS to support this work. Proposals will be presented once in a better position, hoped by end of 2024. • Further to an action taken in May - monitoring compliance with handover at shift changes. Work is completed on a documentation audit undertaken by staff using the Formic tool and an update on progress will be brought to the next meeting. • Work is taking place on the telephone system in maternity triage which was a CQC recommendation. • A risk assessment of the obstetric theatre requires further work. Have risk scored the existing provision without use of the anaesthesia space as a second theatre scored 16. With mitigations in place this reduces to 12. If we are able to undertake building work in costing phase would reduce further to a risk of 3. The CNO requested an update on the journey of the obstetrics theatre in September together with a deep dive of some of the CQC issues which we are much more concerned about i.e., Obstetric Support Worker, management of women with high care needs cared for in maternity when normally they would be part of the ITU environment also for governance and audit trail. **ACTION**	**AS**
	<u>Resolved</u> – that: **(A) The Exception Report Maternity Services – CQC Action Plan Progress be received and noted.** **(B) An update on the journey of the obstetric theatre to be presented in September together with the other CQC issues highlighted as of greatest concern.**	**AS**
QC014/07.24	**<u>QUALITY ENGAGEMENT VISITS</u>**	
	The ADQG gave the first report on quality engagement visits, providing an overview of the visits to date and future planned visits prior to sharing this with divisions. The Chair noted the particularly helpful summary of incidents, complaints and risks. Feedback from those who have been visited would also be helpful. The Chair added that it is a useful system to provide assurance and to add value, avoiding the need for large spread sheets and reports. Reinforcing this point, Frances Martin (NED) noted that, following a foundation group NED discussion, the feedback had been that the quality	

	engagement visits alongside exec colleagues were really helpful, improving on the previous system. That said, Nicola Twigg (NED) noted that although going well, some visits had been cancelled or changed due to operational pressures and was mindful of the extra work created by these changes. The CNO is keen to establish how the feedback from visits is shared and acted upon without creating an industry around visits and associated actions. ACMO Medical Division asked that visitors be cautious with throw away comments that can become facts to those that are hearing them. Supported by the ADQG, they identified that generating divisional action plans in response to visits didn't always achieve what was set out to achieve. An update report to be brought to Quality Committee in 3 months' time **ACTION**	**NO**
	Resolved – that **(A) The Quality Engagement visits update be received and noted.** **(B) Update report would be brought to Quality Committee in October**	**NO**
	CONFIDENTIAL SECTION	
QC015/07.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
	BUSINESS SECTION	
QC016/07.24	**STAFFING REPORT**	
	The ACNO Surgical Division gave an update on the staffing report. • ED attendance and admissions had been high. Most escalation areas were in use: day case, endoscopy, additional beds in community hospitals, plus boarding patients on wards. • Work has been completed on fill rate data seeing better compliance with the 100% fill rate. That said, it is variable between wards with some still over 100%. Reasons include patient acuity and backfilling of staff. • July's opening of the surgical hub and ward re-configuration has impacted staffing levels and changes. The data in the report did not include the hub as it did not come on line until 8 July but will be included from August. • There has been an increases in: o staffing incidents, the majority in Paediatrics ED. These are now documented and being addressed through the ED staffing paper.	

	○ sickness, with a number of Covid and diarrhoea and vomiting cases. • There has been an increase in vacancies, mainly with Health Care Assistants (HCAs) caused by many undergoing nursing training which impacts on turnover. Centralised recruitment for HCAs as recommenced. • Agency spend has decreased throughout June and bank usage has slightly increased. • A break glass process is now in place for Thornbury. Level 3 and 4 colleagues have been trained in the out of hours process. There were three Thornbury authorisations this month; two mental health risks and one nurse for theatre.	
	Resolved – that the Staffing Report be received and noted.	
QC017/07.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The Patient Experience Committee Summary Report was taken as read and approved by the Committee.	
	Resolved – that the Patient Experience Committee Summary Report be received and noted.	
QC018/07.24	**CLINICAL EFFECTIVENESS AND AUDIT SUMMARY REPORT – CEAC**	
	The Chair noted that there had been a concern regarding quoracy at CEAC and, although not mentioned in the summary report, questioned if the issue had been resolved. The CNO confirmed that both she and the CMO had been present at the last meeting but that there would be a review of sub-committee scheduling to maximise attendance and ensure quoracy.	
	Resolved – that the Clinical Effectiveness and Audit Summary Report was received and noted	
QC019/07.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	The report was taken as read but the CNO alerted the committee to the fact that there has been a large CPE outbreak at RCH. A meeting with external partners, to include PH, ICB, region and water specialists, is scheduled to take place on 26 July, to distil learning from the management of the outbreak. Further updates would be available after that meeting. There has also been a significant outbreak of Norovirus on Garway Ward and 50% of the patients on Arrow Ward have Covid infection.	
	Resolved – that the Infection Prevention Committee summary report be received and noted.	

QC020/07.24	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC021/07.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 29 August 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