Public Board Meeting

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

Microsoft Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Russell Hardy

13:01 - 13:02
1 min

2. Declarations of Interest

Russell Hardy

13:02 - 13:03
1 min

3. Minutes of the Meeting held on the 3rd October 2024

Decision *Russell Hardy*

3. PUBLIC BOARD MINS - OCTOBER - AD, KL, LF.pdf (11 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

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

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Glen Burley*

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

5.2. Integrated Performance Report

Discussion *Jane Ives*

WVT IPR Month 7 October 2024 - FINAL.pdf (32 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:35 - 13:55
20 min

6. Items For Approval

6.1. CNST Compliance

Decision *Amie Symes*

- CNST Board Exception Report December 2024.pdf (5 pages)

6.2. Use of Trust Seal - Elective Surgical Hub

Decision *Gwenny Scott*

- Trust Seal Report_December 2024.pdf (2 pages)

13:55 - 14:20
25 min

7. Items for Noting and Information

7.1. Perinatal Safety Report

Discussion *Amie Symes*

- Perinatal Services Safety Report October 2024 (Quarterly).pdf (16 pages)

7.2. Patient Experience Quarterly Report

Discussion *Lucy Flanagan*

- Patient Experience Report November 2024 Board right front sheet.pdf (14 pages)

7.3. EPRR Core Standards Report 2024/25

Discussion *Andrew Parker*

- 2024-2025 Report Cover Sheet - Board Response - 26 November 2024.pdf (3 pages)
- WVT EPRR Action plan 2024-25 - 7 November 2024.pdf (2 pages)

7.4. Board Assurance Framework

Discussion *Gwenny Scott*

- BAF and High Risk Report for Board_December 2024.pdf (6 pages)
- Board Assurance Framework_December 2024.pdf (4 pages)

7.5. Committee Summary Reports and Minutes

7.5.1. Audit Committee Report and Minutes 19 September 2024

Discussion *Nicola Twigg*

- AC Front Sheet.pdf (1 pages)
- Audit Summary Sept 24.pdf (1 pages)
- 3. Audit Committee minutes - 19 September 2024 - v.2 FINAL.pdf (9 pages)

7.5.2. Foundation Group Board Minutes and Action Log 6 November 2024

Discussion *Russell Hardy*

- Draft Public FGB Minutes - 6 November 2024.pdf (15 pages)
- Draft Public FGB Matters Arising and Actions Update Report.pdf (1 pages)

7.5.3. Quality Committee Report and Minutes 29 August 2024 and 26 September 2024

Discussion *Ian James*

- QC Summary August 24 Public.pdf (4 pages)
- Quality Committee Minutes August 2024 final.pdf (14 pages)
- QC Summary September 24 Public.pdf (4 pages)
- Quality Committee Minutes September 2024.pdf (21 pages)

14:20 - 14:25
5 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

Russell Hardy

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 6 March 2025 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 3 October 2024 at 1.00 pm
Via MS Teams

Present:

Frances Martin	FM	Chair/Non-Executive Director (NED)
Lucy Flanagan	LF	Chief Nursing Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Gwenny Scott	GS	(Incoming) Associate Director of Corporate Governance
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
Suzie Joberns	SJ	Deputy Chief Finance Officer
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)

BOD01/10.24 **Apologies for Absence**

Apologies were received from Chizo Agwu, Chief Medical Officer, Glen Burley, Chief Executive, Russell Hardy, Chairman and Katie Osmond, Chief Finance Officer.

Mrs Martin (Chair and NED) welcomed Gwenny Scott to the meeting as the new Company Secretary for the Trust.

BOD02/10.24 **Quorum**

The meeting was quorate.

BOD03/10.24 **Declarations of Interest**

There were no declarations of interest noted.

BOD04/10.24 **Minutes of the meeting held 5 September 2024**

Resolved – that the minutes of the meeting held on 5 September 2024 be confirmed as an accurate record and signed by the Chairman.

BOD05/10.24 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD06/10.24 **Managing Directors Report**

The Managing Director presented her Report and the following key points were noted:

(a) Lord Darzi – Independent Investigation of the NHS in England – We are now in the diagnostic phase of what the government want to do next with the NHS. The summary of this is in the Report. There are 3 causes are why we are where we are – Firstly austerity and the impact on the NHS and Social Care and the wider impact on the population. Health expectancy for both men and women has reduced. Secondly the pandemic hit the NHS harder than other parts of the world and is taking longer to recover from. Thirdly the structural reforms that came in 2012. This has all had a huge productivity impact. This is a welcome Report with nothing to suggest that there is anything wrong with our funding and basic running model. This Report also underpins the next phase which will be the development of the 10 Health Year Plan over the winter and to be published in the spring. The government want to see 3 big shifts which are from treatment to prevention, from hospital to community and from analogue to digital. The challenge is not what we are trying to achieve, the challenge is making it deliver and having a plan to deliver these things.

(b) Urgent Care – We talked about our Winter Plan in the Board Workshop. A huge amount is being done to ensure that we have safe Urgent Care Pathways over the winter. There are also 2 Business Cases on the agenda today relating to the increase in reliance on Urgent Care Pathways.

(c) Financial Recovery – We are in financial recovery under a Financial Recovery Board. We looked at our elective activity in the Board Workshop, with all of our Theatres available in September (including the Elective Surgical Hub). These positive productivity improvements give us the opportunity to earn more income over the second half of the year.

(d) From our Great Teams – Integrated Care Division – This section includes a summary of all of the services that are being put into the community to support over the winter.

Resolved – that the Managing Directors Report be received and noted.

BOD07/10.24 **Integrated Performance Report**

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

a) The Managing Director thanked staff for supporting the summer lifecycle works in Theatres and the Emergency Department (ED) which has meant that a number of services had been operating out of an environment that they were not usually in.

b) We are undertaking a review half way through the year of what we can deliver in the second half of the year in terms of elective work. This is most importantly about reducing length of stay for patients and secondly improving our financial position. The H2 Plan will be available in the next few days.

c) Staff Engagement – The Chief People Officer (CPO) and his team ran a huge amount of Staff Engagement sessions over the summer from which we have received useful feedback. The new annual Staff Survey has been sent to all staff and the Managing Director encouraged everyone to complete this as it really does impact on us and enables us to make changes due to this. We will be feeding back to Divisions on the percentage of staff completing the Survey to further encourage staff.

d) Mrs Martin (Chair and NED) echoed the Board's thanks to all of our staff. We usually see a reduction in numbers in the summer, but we are now not seeing this. Staff put in extraordinary efforts during these works to ensure that facilities remained fit for purpose.

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

BOD08/10.24 **Quality (including Mortality)**

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

(a) Safety In Sync – This is our Herefordshire Place based opportunity for Partners across the Health and Social Care and the Voluntary Sector to come together to discuss safety concerns and make improvements. Safety In Sync was shortlisted for the Health Service Journal Awards in Manchester, which is a huge achievement.

(b) Paediatric Audiology Services – Several months ago the Board received an update following the Mid Lothian review and findings. We have been participating in the Midlands Region Peer review and response to this. Quality Committee received an update last week in relation to the action plan associated with the review process. There is only 1 element outstanding and this is the Clinical Audit undertaken by the external Subject Matter Experts for the children and young people who are on the non-discharge pathway for ABR testing. This is expected by the end of October and if there are no clinical concerns raised, we hope that the ICB will shut down the incident response process and the ongoing monitoring and oversight of those services will be handed back to us as business as usual.

(c) In July NHSE wrote to all Trusts who provide Audiology Services suggesting that Trusts should work towards IQIPS accreditation and respond with our plan for that by 4 October. We have responded this week, following discussions at Quality Committee, to say that currently due to the fragility of the service, particularly in relation to our workforce, we cannot work towards IQIPS accreditation right now. Our next steps will be to undertake a GAP analysis against the accreditation standards, determine the resource required to deliver and implement the accreditation process and to determine the timescale for delivery.

(d) We have seen a spike in our perinatal mortality rates from 2.39% (well within normal range) to 4.26% per thousand births. Given our very small numbers, a slight increase in cases can cause a large spike, which is what we have seen. The stillbirths that occurred during this period have all been reviewed. Our team also recently presented at the Learning From Deaths Committee. There is a focus on the pre term pathway and sepsis management.

(e) Included in this Report are the incidents related to patient safety priorities, the number of incidents that occurred since April to date and some highlights around the quality improvement work that is occurring in relation to these priorities.

(f) Nurse Staffing Fill Rates – There are no safety concerns and there have been significant improvements in terms of reduced agency spend and very limited use of off framework agencies.

(g) Mrs Twigg (NED) queried regarding the Ombudsman cases, is there any context to understand, is there just a general increase or are they just spikes in our Trust and are there any local themes. The CNO confirmed that there is benchmarking available across the Foundation Group and possibly more broadly. There was a significant backlog of cases for the Ombudsman during Covid and they are just catching up which could be the reason. There were no themes found and reassuringly many cases have been closed down with no requirements for us to address any matters. **LF**

(h) Mrs Twigg (NED) noted that for some time there have been signs and symptoms to look out for regarding a stroke and with the increasing number of cases of sepsis, felt that we needed more public awareness around the signs of sepsis in the same way.

(i) Mrs Martin (Chair and NED) advised that detailed discussion is held on all the areas in this report at the Quality Committee where we spend time scrutinising these areas.

<u>Resolved</u> – that:

(A) The Quality Report (including Mortality) be received and noted.

(B) The Chief Nursing Officer will provide benchmarking around cases referred to the Ombudsman captured in the Quality Report. **LF**

BOD09/10.24 **<u>Activity Performance</u>**

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

(a) The work on the additional assessment space in ED has been completed. We are now able to stream and navigate people away from ED to a more suitable assessment space.

(b) We have had very high levels of ED attendances. Despite this, our winter plans continue to progress with some schemes already in place which is positive. This includes our Frailty bridging teams supporting getting patients back home to receive care rather than being admitted and the relaunch of our Community Referral Hub next week along with an enhanced combined single point of access that we can offer the Herefordshire system. Despite all of this, we still have a number of temporary escalation areas open, congestion in ED and issues with ambulance handovers. As discussed in the Board Workshop, we have a number of plans in place to progress over the next few months to ensure that we are in the best possible position ahead of the winter period.

(c) There were concerns around our 62 day cancer performance despite the fact that we are performing well against the 28 day Faster Diagnosis Standard. We had issues with Radiology and Pathology and an increase in pathway delays across a number of key specialities during July with some significant workforce challenges. This has been rectified for August and we are back above the required standard for 62 days. Early indications are that we have also performed well for September.

(d) Elective Pathways – At the Board Workshop the Theatre Team gave a presentation on some of the activity improvements that have occurred since the opening of the Day Case Surgery Unit and how we have delivered our activity plans for the first half of the year. We are meeting our trajectory and exceeding some value weighted activity against our 2019/20 trajectories.

(e) Diagnostic performance continues to improve. We continue to deliver high levels of activity against our planned assumptions for 2024/25. The number of patients waiting over 13 weeks for a diagnostic has reduced from 500 to 200 this month and we are on course to eradicate these over the next 2 months. The number of patients waiting over 6 weeks for a diagnostic over the last few weeks has also improved.

(f) Our 65WW patients on elective pathways – We set a trajectory of no more than 50 patients for the end of September. We exceeded this target and plan to have no patients waiting over 65 weeks by the end of December.

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

BOD10/10.24 **Workforce**

The CPO presented the Workforce Report and the following key points were noted:

(a) There has been a reduction in staff absence. We are taking active steps to support employees by offering flu jabs, health checks and mental health support. This will be included as part of our Health and Wellbeing Week commencing next week as we know that it is important for our staff to be vaccinated.

(b) We continue to work with our clinical leaders to fill our vacancies. We are putting in place a comprehensive recruitment and retention package to try to reduce the turnover of our Health Care Support Workers.

(c) During October, we are promoting Black History month and Freedom To Speak Up to promote and encourage good relations across the Trust.

(d) The Staff Survey has gone live and we are encouraging all staff to complete this. These results enable an enhanced working environment and care that we can offer our patients.

(e) On 25 October we are running the first University Open Day in association with Worcester University. This will show case and promote career development opportunities for our staff and members of the public.

(f) Ms Quantock (NED) queried if there was more detail around the causes of mental health illness to enable support to be tailored to specific areas and if there are any wider implications for the Trust as an employer. The CPO advised that we do have detailed reports produced by the Mental Health and Wellbeing Nurse. The main areas are stress, depression and anxiety with a lot relating to issues outside of work due to the cost of living crisis etc.

(g) The Managing Director noted that this was one of the other highlights from the Darzi Report around the increase in mental health issues and concerns over the last 10 years which has increased significantly. Often this is not work related but is around broader issues.

Resolved – that the Workforce Report be received and noted.

BOD11/10.24 **Finance Performance**

The Deputy Chief Finance Officer presented the Finance Performance Report and the following key points were noted:

(a) The Financial Recovery Board (FRB) meet regularly to scrutinise our financial stewardship.

(b) We are off plan year to date by £3.8m. This is largely due to under delivery of our CPIP. The FRB was established to work closely with Divisions on these savings plans.

(c) Currently we are continuing to forecast that we will achieve our plan, but as noted in the Report, we have around £13m of unmitigated risk at this point. We continue to review this and will bring a full forecast back once this has been assessed and developed.

(d) Given that we are a cash deficit organisation and that we are off plan, we are monitoring our cash position very closely.

(e) Mr Lappin (ANED) noted that there is £6m out of system risk which he understood related to our Welsh patients and queried if the Welsh Commissioners engaged with the Trust around this or is this something that needs more national support. The Deputy Chief Finance Officer confirmed that this around our Welsh Commissioners and establishing a parity of funding similar to what our English Commissioners provide. There is not a contractual mechanism, we have to engage with our Welsh Commissioners about this and continue to work closely with ICB colleagues and will need Regional and National support to take this further.

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

ITEMS FOR APPROVAL

BOD12/10.24 **Business Case – WVT Acute and Emergency Department Clinical Staffing**

The COO presented the Business Case – WVT Acute and Emergency Department Clinical Staffing, which was taken as read, and the following key points were noted:

(a) The COO presented a short presentation which provided a summary of the Business Case. The purpose of the paper is to detail the proposed clinical model for emergency medicine.

(b) Key Drivers – Reduction in mortality, increased efficiency, easier access to services and the same standards of care irrespective of the day and the week.

(c) There are 3 options – Option 3 – Do minimum – essential uplift of Consultants, Speciality Doctor and ACP to better meet the demand and acuity of patients is the preferred option. This will make a saving of just over £0.5m.

(d) The Deputy Chief Finance Officer provided the financial background to the Business Case.

(e) Mrs Twigg (NED) advised that NED colleagues had reviewed this Business Case to really understand the background to this. There are risks involved which require close management. Questions raised in the meeting were fully answered.

(f) Mr Lappin (ANED) support the Business Case and felt that it was a significant investment and it would be useful to have future Business Cases with significant investment to have a Commissioner comment included, appreciating that they may not have the money in-year to fund it but this would help substantially to inform future contract negotiations. The Managing Director felt that this was a good idea. She advised that something that we are looking at for next year is a reset of income for Urgent Care as we are under a block arrangement which has not grown as quickly as our urgent care demand has. The Chief Executive is having national discussions around this.

(g) The Managing Director noted that this Business Case would be an increase in our substantive senior staff. This is important as productivity of senior staff is higher than that of junior staff who are often also training. We will be doing lots of things with our partners in Primary Care and Community Services to reduce the demand on ED as the numbers will continue to grow due to the population that we serve and the aging population. This is an investment for the future.

(h) Mrs Martin (Chair and NED) noted the ongoing issues around our ability to break even due to our rurality. We also need to ensure that all the benefits included in the Business Case are tracked to ensure that they occur.

(i) The Managing Director advised that she and the COO visited the Hereford Medical Group recently who have a different way of accessing their services put in place to improve this area. They have some metrics that are already showing improvements for patients to access their services.

Resolved – that the Business Case – WVT Acute and Emergency Department Clinical Staffing be received and approved.

BOD13/10.24 **Business Case – Bed Reconfiguration for Winter 2024**

The COO presented the Business Case – Bed Reconfiguration for Winter 2024, which was taken as read, and the following key points were noted:

(a) The COO presented a short presentation which provided a summary of the Business Case.

(b) There are 2 options – Option 1 is to continue with the current bed base. Option 2 is to return to our bed base prior to 15 July. Option 1 is the preferred option.

(c) The Deputy Chief Finance Officer provided the financial background to the Business Case.

(d) Mrs Hill (NED) advised that when this Business Case was reviewed by NED colleagues, it was very useful to be able to demonstrate the benefits coming through as actual numbers rather than planning in advance.

(e) The CNO advised that we have successfully recruited in to all the Registered Nurse positions with just a few more Health Care Support Worker posts to fill.

Resolved – that the Business Case – Bed Reconfiguration for Winter 2024 be received and approved.

BOD14/10.24 **Board and Committee Dates 2025**

The Managing Director presented the Board and Committee Dates 2025 and the following key points were noted:

(a) The only change to the proposal is that in line with the rest of the Foundation Group, we will not be holding a January Board meeting. However, we will hold a Board Workshop. This is as we will be in operational planning mode then and will be looking at objectives for next year and the funding route for the new Education Centre.

(b) Mrs Martin (Chair and NED) advised that scrutiny occurs in the Board Sub-Committees which enables this public facing Board to operate effectively and at pace. It is therefore important that colleagues attend Committees to present their papers which enables the NEDS to undertake the required scrutiny and assurance.

Resolved – that with the agreed amendment, the Board and Committee Dates 2025 be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD15/10.24 **Sustainable Development Management Plan Update**

The Chief Strategy and Planning Officer (CSPO) presented the Sustainable Development Management Plan (SDMP) Update, which was taken as read, and the following key points were noted:

(a) We agreed the SDMP in 2020 but this was diverted by the Covid pandemic.

(b) This is a 5 year plan and is therefore out of date next year. We are currently working on refreshing this.

(c) Broadly two thirds of the proposal have already been delivered and about a third are in progress. The Report contains the details of the work being carried out.

(d) The CSPO highlighted the appendices which have been talked about at a previous Foundation Group Board meeting around finding metrics to demonstrate the performance improvements, which are quite hard to find. Therefore we have come up with some proxy measures ourselves. When you consider how much we have grown, especially with all the new space and buildings on the Acute Site, from an energy perspective we are using less energy per square metre than a few years ago which is positive. Water consumption has stayed flat but overall waste levels are down with more recycling. Mileage was down largely due to the Covid pandemic but this has not increased back up again.

(e) We are starting to look for ambitious plans for the future.

(f) Ms Quantock (NED) appreciated all the work that is being done especially considering we are leading on this as a small Trust.

Resolved – that the Sustainable Development Management Plan Update be received and noted.

BOD16/10.24 **Perinatal Safety Report**

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

(a) This Report is presented to the Quality Committee every month and this Report receives due scrutiny and detailed discussion there so a summary and overview will be provided to the Board of Directors.

(b) Neonatal Staffing has been on our Risk Register for some time now around individual nurses qualified with the neonatal specific qualification. The percentages are quite low but we do achieve 100% of the time having a neonatal qualified nurse on each shift. We have 2 staff undertaking their training this year and another 2 planned for next year. Our external Regulators are aware of the fragility of the staffing position yet content that this is appropriately mitigated.

(c) The Neo-natal Critical Care Peer Review is scheduled for the 1st week in November.

(d) There is a national expectation to undertake a Fresh Eyes Audit around maintaining maternal safety during the labour phase. There is not a national audit tool and therefore the audit approach can be inconsistent between services. During our Safety Walkabout we suggested that colleagues worked with the LMNS to develop a standardised audit tool across our System so that when we are comparing our audit results we are comparing like for like. We should also extend this to the Foundation Group.

(e) Quality Committee received an update on a change in plan around our Obstetric Theatre. We have 1 Obstetric Theatre that undertakes emergency and elective caesarean sections. The plan originally was to move the elective sections list down to our main Theatre Suite which would leave our Obstetric Theatre available for emergencies only. Due to good reasons, particularly around workforce, we changed these plans. The Quality Committee received the risk assessment and the appropriate mitigations which was supported in terms of our plan moving forward. There is a plan for a second Obstetric Theatre but this needs to be worked up, developed and costed.

(f) We are working towards our compliance with the 10 Standards for CNST and will be requiring later on this year for Board to delegate responsibility for sign off of these to Quality Committee as there is not a Board meeting in January.

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

BOD17/10.24 **Board Assurance Framework and High Risks**

The Associate Director of Corporate Governance presented the Board Assurance Framework (BAF) and High Risks and the following key points were noted:

(a) The Report this time includes as well as the direction of travel and identified where there are new BAF risks, where those risks appear on the Standard 5 by 5 Matrix to provide information where these risks sit.

(b) The high risks from the Trust are also included which are the more operational, dynamic risks. They are reviewed monthly at the Executive Risk Management meeting and reported to the Board quarterly. They are subject to a lot of change during these periods.

(c) Mrs Hill (NED) liked the addition of the direction of travel and asked if it could be included how long they were static at these levels for. The Associate Director of Corporate Governance will include this in future Reports including any particular blocks to move these risks forward to provide more assurance. **GS**

Resolved – that:

(A) The Board Assurance Framework and High Risks be received and noted.

(B) Future Board Assurance Framework and High Risks Reports will include how long risks have been static at the current level and any particular blocks to move these risks forward. **GS**

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD18/10.24 **Audit Committee Report and Minutes 13 June 2024 and 25 June 2024**

Resolved - that the Audit Committee Report and Minutes 13 June 2024 and 25 June 2024be received and noted.

BOD19/10.24 **Charity Trustee Report and Minutes 13 June 2024**

Resolved that the Charity Trustee Report and Minutes 13 June 2024 be received and noted.

BOD20/10.24 **Quality Committee Report and Minutes 25 July 2024**

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

BOD21/10.24 **Any Other Business**

(a) Mrs Martin (Chair and NED) thanked Executive colleagues and all staff for the humbling and impressive description of our services and the work that happened that was articulated through the Annual General meeting held last week. As a Board we inevitably concentrate on the areas that are off track and are of concern, and it was a joy to be able to celebrate the phenomenal work from all of our staff who provide care with our partners that we all want for our families, friends and our community.

(b) Mrs Martin (Chair and NED) noted that we are sometimes asked why we are continuing to hold our Public Board meetings electronically and have not reverted to face to face meetings. The Annual General Meeting is a good example of why not. Historically the number of people attending the Public Board meetings was small whereas we had 245 views of our Annual General Meeting with a significant number downloading the videos enabling them to watch them again. This enables us to be more visible and accountable to members of the public.

(c) Mrs Martin (Chair and NED) marked the celebration and contribution of Erica Hermon, our Associate Director of Corporate Governance has made over the last 6 years, providing a background of her career including being in charge of Covid responses especially around the vaccination programme.

BOD22/10.24 **Questions from Members of the Public**

There were no questions received from members of the public.

BOD23/10.24 **Date of next meeting**

The next meeting was due to be held on 5 December 2024 at 1.00 pm via MS Teams.

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

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
BOD08/10.24 Quality (including Mortality) 03.10.24	(B) The Chief Nursing Officer will provide benchmarking around cases referred to the Ombudsman captured in the Quality Report.	LF	This is included in the Patient Experience Report which is on the agenda this month.
BOD17/10.24 Board Assurance Framework and High Risks Report 03.10.24	(B) Future Board Assurance Framework and High Risks Reports will include how long risks have been static at the current level and any particular blocks to move these risks forward.	GS	Completed.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

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

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

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

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

☐ *Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*

☐ *Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*

☐ *Work with partners to deliver the improvement plan for Children's services*

Digital

☐ *Implement an electronic record into our Emergency Department that integrates with other systems*

☐ *Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*

☐ *Maximise the functionality of EMIS with 1H partners and the shared care record*

Productivity

☐ *Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*

☐ *Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*

☐ *Create system productivity indicators to understand the value of public sector spending in health and care*

Sustainability

☐ *Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks*

☐ *Redesign selected services to focus more on prevention in order to reduce secondary care activity*

☐ *Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*

Workforce

☐ *Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*

☐ *Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff*

☐ *Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*

Research

☐ *Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust*

☐ *Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff*

.

1. Revisions to the Single Operating Framework (SOF)

NHS England (NHSE) have signalled for a little while that they would be making changes to the SOF. The SOF considers a balanced scorecard of indicators which allows each Trust and Integrated Care System (ICS) to be categorised into one of 4 segments. Segment 1 Trusts are able to operate with relative freedom whereas higher segmentation brings more scrutiny and less freedom. A sub-set of Segment 4 Trusts will be in Special Measures. The latest scores from the current SOF are set out on the table below alongside our Group colleagues and University Hospitals Coventry and Warwickshire NHS Trust (UHCW), the other acute provider in the two Systems in which the Group's Trusts operate.

OrgOverview_WideTable

NHS OF Metric Name Full	Aggregation Source	Period	GEORGE ELIOT HOSPITAL NHS TRUST (RLT)	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (RJC)	PRV UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST (RKB)	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (RWP)	WYE VALLEY NHS TRUST (RLQ)
S000a: NHSOF Segmentation	Provider	2024 09	2: Flexible support	1: No specific support needs	2: Flexible support	3: Regionally mandated support	3: Regionally mandated support
S000b: Elective Tier	Provider	2024 10					
S000c: Cancer Tier	Provider	2024 10			Tier 2: Regionally led support	Tier 2: Regionally led support	
S009d: Total patients waiting more than 65 weeks to start consultant-led treatment	Provider	2024 08	9	20	496	300	108
S011a: Cancer: 62 days backlog	Provider	w/e 29/09/2024	92.9%	87.7%	171.7%	90.4%	61.6%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	Provider	2024 08	76.7%	76%	59.5%	80.4%	76.2%
S022a: Stillbirths per 1,000 total births	Provider	2022	2.29 per 1,000	1.6 per 1,000	4.66 per 1,000	3.51 per 1,000	1.83 per 1,000
S034a: Summary Hospital -level Mortality Indicator	Provider	2024 05	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected
S035a: Overall CQC rating	Provider	2024 09	2 - Requires Improvement	4 - Outstanding	3 - Good	2 - Requires Improvement	2 - Requires Improvement
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2024 03	0	1	2	5	1
S041a: Clostridium difficile infection rate	Provider	2024 03	300%	67.9%	112.5%	162.8%	86%
S042a: E. coli bloodstream infection rate	Provider	2024 03	121.4%	142.9%	90.7%	162.3%	173.3%
S059a: CQC well -led rating	Provider	2024 09	2 - Requires Improvement	4 - Outstanding	3 - Good	2 - Requires Improvement	2 - Requires Improvement
S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work fro..	Provider	2023	13%	9.18%	10.9%	11.9%	8.59%
S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work fro..	Provider	2023	19.8%	15.8%	19.9%	19.2%	18.3%
S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work fro..	Provider	2023	27.2%	22.6%	24.6%	24.7%	24.5%
S067a: Leaver rate	Provider	2024 08	7.81%	6.33%	7.38%	6.52%	8.49%
S068a: Sickness absence rate	Provider	2024 05	4.61%	4.92%	5.07%	5.58%	4.58%
S069a: Staff survey engagement theme score	Provider	2023	6.93/10	7.25/10	6.85/10	6.64/10	7.02/10
S071a: Proportion of staff in senior leadership roles who are from a BME background	Provider	2022	17.6%	26.1%	12.5%	2.99%	5.13%
S071b: Proportion of staff in senior leadership roles who are women	Provider	2024 07	51.6%	62.3%	57.4%	65.7%	63.7%
S071c: Proportion of staff in senior leadership roles who are disabled	Provider	2023	3.23%	4.41%	3.25%	2.78%	2.78%
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic backgroun..	Provider	2023	58%	64.1%	54.5%	57.5%	59.5%
S104a: Neonatal deaths per 1,000 total live births	Provider	2022	0 per 1,000	0.64 per 1,000	2.16 per 1,000	1.04 per 1,000	1.22 per 1,000
S121a: NHS Staff Survey compassionate culture people promise element sub-score	Provider	2023	7.08/10	7.58/10	6.98/10	6.66/10	6.98/10
S121b: NHS Staff Survey raising concerns people promise element sub-score	Provider	2023	6.42/10	6.83/10	6.25/10	6.15/10	6.45/10
S123a: Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2024 09	98.7%	92.9%	97%	95.3%	100%
S124a: Percentage of beds occupied by patients who no longer meet the criteria to reside	Provider	2024 09	11.8%	6.65%	17.9%	15.3%	10.3%
S126a: Diagnostic activity waiting percentage of patients on the waiting list who have been waiting more than 6 weeks	Provider	2024 08	12.8%	15.3%	16.1%	37.7%	25.3%
S133a: Staff survey - compassionate and inclusive theme score.	Provider	2023	7.23/10	7.62/10	7.11/10	7.08/10	7.36/10
S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Provider	2023	1.6	.8	1.5	1.7	1.9
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Provider	2023	1.1	.5	1.1	1	1

One
1.000

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile
- White

I am pleased to note that, due to improvements delivered, Worcester Acute Hospitals NHS Trust (WAHT) have now been deescalated from mandated support regarding cancer performance.

The updated framework is still to be finalised, this is in part due to consideration being given to some of the themes identified in Lord Darzi's review. Amanda Pritchard, Chief Executive, NHSE, has now outlined how Integrated Care Boards (ICBs) will be tasked with leading on strategic commissioning in their systems, with NHSE providing targeted support and appropriate regulatory oversight and performance management. Secretary of State, Wes Streeting has also reinforced that point with a clear direction for ICBs to focus on developing neighbourhood health services. NHSE's new Insightful ICB Board guidance, also reframes ICBs' role to emphasise strategic leadership focused on achieving the four core aims of ICSs: improving population health, tackling inequalities, enhancing financial sustainability, and contributing to their local economies. ICBs' ability to focus on longer-term aims is vital to shifting care closer to home and towards a prevention-focused model - two of the government's three "big shifts".

It has also been encouraging to hear that the revised SOF will include a stronger focus on earned autonomy for trusts which are evidently performing. The introduction of incentives relating to capital freedoms have also been promised.

2. Insightful Board

Strong boards are essential for all organisations if the NHS is to deliver its objectives. To be effective, boards need the right information at the right time and used in the right way. As part of our commitment to support leaders to deliver and improve, and to set them up for success, NHSE have now published Insightful Board guides for both ICBs and providers. These guides provide clarity around the critical information boards need to understand their organisations, and the culture and governance necessary to support information flow, so it can be used most effectively when overseeing their organisations. These build on the previous 'Productive Board' series but have been updated to reflect a more currently relevant set of indicators and considerations, including a greater focus on productivity. I was involved in the work to create the NHS Trust Boards version and shared our Integrated Performance Report format with the national team as an example of good practice. We are therefore already reasonably well aligned with some of the reporting suggestions, but I have asked the Board Secretaries to consider what changes we could make for the better based on the guidance. The full guide can be found on the NHSE website via this link: NHS England » The insightful provider board

3. More From Our Great Teams – Update From the Surgical Division

Much has occurred since the last Surgical Divisional update within this report. Most significantly, the opening of the new Day Case Surgical Unit in July was a huge success and was the culmination of many months of hard work by Estates, operational, clinical and nursing colleagues in both building but also operationalising this fantastic new facility. It was also great to see these new operating theatres officially opened by the unit's own staff at a dedicated opening ceremony in September.

The Surgical Division's key areas of focus since the last update has centred on improving operating theatre throughput and productivity, while harnessing the benefits and opportunities the Day Case Surgical Unit has brought not only to improve activity levels through the new unit, but also allowing the Division to increase productivity in the main theatre estate also. The last update in late spring highlighted record numbers of patients being treated through our theatres. This trend has continued over the summer and autumn months: In October, the Division achieved another key milestone, treating over 1,000 patients within the month. This is set against an average of 764 patients per month for the 6 months prior to October, building on the average of 688 patients per month for the 6 month period before that. This increase in has not only been driven by the opening of the new Day Case Surgical Unit, but also by being more productive within our existing theatre estate: the average number of patients per theatre list has historically averaged 3.2, with this increasing by almost 20% in September. This improvement has been realised across a number of specialities with 7 of the Division's services seeing notable increases in patients per theatre list.

These key improvements in productivity have helped improve theatre utilisation to 80%, against a 6 month average of 76%, but this remains below target and there is still a huge amount more to do to sustain these gains and further improve over the coming months. While gains have been made, further improvements are front and centre of the Division's plans for the remainder of 24/25 and into 25/26 that also directly align to the Division's objectives to maximise income opportunities.

These key improvements in productivity have directly translated into patient care. Another focus over the last quarter has been reducing the number of patients waiting more than 65 weeks for routine elective care, particularly in Ophthalmology and Orthopaedics, which have been the Division's most challenged specialities. The number of patients waiting over this time period in these specialities reduced from circa 800 in each speciality in April to 20 and 22 respectively at the end of September. Plans are in place to maintain this and drive down backlogs further to 52 weeks.

Improving access for our patients to cancer services has been central to the Surgical Division's cancer objectives in recent months. The introduction of new triage services and one stop pathways in a number of tumour sites have been implemented, with further developments planed in Gynaecology for example over the coming months. Further improvement is required however in some of the Division's areas, particularly pertaining to ensuring patients received quicker diagnosis: improving performance against the 28 Day Faster Diagnosis standard is key in Gynaecology.

Other key service developments have been introduced during in recent months within the Division that have aimed to improve the quality of care offered to our patients. The Critical Care team were proud to launch an expanded 24/7 outreach service in October that will improve patient outcomes and experience while also supporting the Emergency Department and ward based teams across the Trust. The theatre redesign has also allowed the Division to introduce a number of new emergency pathways such as the emergency laparoscopic cholecystectomy pathway that has significantly reduced wait times for this procedure, along with reducing the number of inpatient admissions ahead of surgery, while ensuring improved clinical outcomes and patient experience.

Glen Burley
Chief Executive Officer

NHS
Wye Valley
NHS Trust

Integrated Performance Report

October 2024

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

My focus for this months overview is how we improve our operational performance as part of how we improve the finances of the Trust. It has long been a mantra that getting it right first time and improving quality will lead to better financial performance. Whilst we remain behind our financial plan, we have seen run rate improvement in month 7 that belies a lot of underpinning work on improvement.

Our elective performance has strengthened. We have improved productivity through our theatres and out patient capacity. The result of this is falling waiting times, improved cancer performance and better performance on income than plan. There is further to go particularly in driving theatre utilisation to 85% and improving pre-operative pathways that will improve the position further as we go into the quarter of the year.

This is dependent though on management of emergency pathways so that elective bed capacity is available. Across the region in the latter part of November we have seen significant ambulance delays due to offload problems in ED's. Herefordshire has been affected with increases in emergency admissions outstripping discharges. This has led to very high numbers of boarding (temporary escalation space) patients across all of our wards. I would like to pay tribute to our clinical staff managing patient care is such difficult circumstances – it is not easy.

A reduction in required acute beds and congestion in ED will lead to a reduction in temporary workforce costs to provide care to these patientsso providing care in the right setting will improve our financial position.

To achieve this plans to reduce admissions and reduce length of stay are being implemented. Increased capacity and effectiveness across integrated neighbourhood teams, urgent community response, IVOPAT (home intravenous anti-biotic therapy) and virtual ward services in the community are coming into place. The recent co-location of our community teams with 24/7 general practice in Nelsons House provides further opportunities to improve community urgent access with medical support to appropriately manage risk. At the same time the work with the council to improve access to pathway 2 and 3 discharge capacity has not yet provided much improvement and this is a focus for the operational executive lead for One Herefordshire working across partners.

Also part of our financial recovery is making sure that we get paid appropriately for the work that we do. We are scrutinising our coding of activity which has not had much attention during the covid years of block contracts and have found that in many areas we are not coding accurately so improving the capture of our data has a direct impact on income. We also became aware that due to a technical omission in the elective recovery fund (ERF) national calculation that we were receiving no income for bilateral cataract operations. We have implemented an adjustment to our submitted data so that we can be paid for the work as a temporary workaround. We have informed national bodies that our submitted data includes this adjustment until the payment issue is resolved.

Given the pressures on staff it is important that we do everything we can to support them and it is pleasing to note that our turnover of staff has remained under 10% this year from a high of 14% in 2022. This and managing our sickness absence levels also impacts on our finances and the reduction in agency nurse use is notable.

Lastly I want to draw attention to the work that we are doing to increase the use of volunteers to support patients and the work of the trust. Volunteering is a win-win for the local community who enjoy contributing to their local services and for the organisation and our staff. Using the experience from the George Eliot hospital and the national Helpforce organisation we are ramping up volunteers in our contact centre to help reduce DNA rates delivering both a quality and financial benefit and well as expanding the recruitment and deployment of volunteers across the organisation more generally.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Paediatric audiology services

The trust has received the final outcome of the external clinical review of ABR cases on the non discharge pathway. 142 cases were reviewed resulting in 10 children needing recall for further testing and 6 record reviews to be undertaken. When recalled, a harm review will be undertaken and duty of candour applied where appropriate.

Neonatal Peer Review visit

The neonatal unit hosted a peer review visit on 4th November. The visit went well and no immediate or serious concerns were identified requiring an immediate response. Whilst the full report has not been received, high level feedback included;

- Some areas for improvement including positioning of cots, storage arrangements for formula milk and duration of storage for breast milk and no centralised monitoring (acknowledged that this is in progress and will be resolved shortly)
- Workforce challenges for neonatal nurses qualified in specialty, although the team accepted this was sufficiently mitigated and limited therapy input especially in relation to psychology
- The visiting team commended the unit on perinatal and MDT working, high levels of staff retention and satisfaction. The unit was observed to be friendly and welcoming with plentiful information for families and very positive feedback received from parents using the service

Volunteer Strategy Group – Launch meeting

The Trust Volunteer Strategy Group launched in October 2024. The purpose of the group is to engage key stakeholders to ensure development of roles and recruitment of volunteers aligns with the Trust, Group and System objectives. The key focus for the volunteer team currently was agreed as follows;

- Volunteer Contact Centre- GEH colleagues presented the model they have implemented alongside Helpforce to reduce outpatient DNA's. The Trust commence their pilot of the model with Ophthalmology in December. A stakeholder group is being arranged to prioritise roll out of the model following evaluation of the pilot.
- Gardening- volunteers are keen to support the Trust in managing garden areas to improve patient experience and support the Trust green and sustainable objectives.

The recently appointed Volunteer Services Manager has developed performance measures to demonstrate the impact of volunteer support. This has enabled the team to further focus their efforts on meaningful recruitment to support the services most in need. Role innovation and supporting volunteers to carry out tasks to improve patient experience is a key focus, particularly in the Emergency Department.

Quality & Safety Performance – Mortality

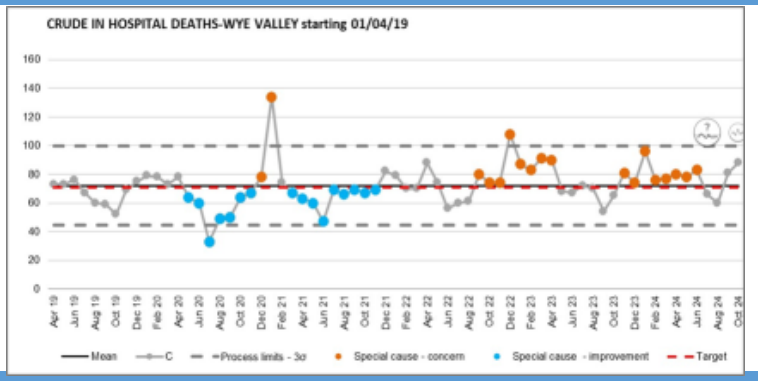
We are driving this measure because:

. 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)*	**Jun-24**	100.0	*1.8*
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Jul-24**	99.0	*-0.5*
SHMI (in hospital)			93.8	*-1.6*
SHMI (out-of-hospital SHMI)			111.1	*1.82*

CCS Group/Origin of Alert	Date Period	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	**August 2023 - July 2024**	**96.53**	27	26	4.68
Congestive Heart Failure		**109.17**	66	72	-2.30
Fractured Neck of Femur		**127.32**	32	41	3.75
Pneumonia		**98.17**	205	201	-2.29
Septicemia		**119.35**	110	131	-0.36
Stroke *(Acute Cerebrovascular Disease)*		**104.79**	83	87	-4.05



Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from August 2023 to July 2024 shows Wye Valley NHS Trust at 99.0. The NHS Digital, which is for the period of July 2023 to June 2024, also shows a positive position at 100.0.
- Latest **crude mortality** rate for September 2024 is 1.81% for all admissions, which equates to 81 deaths. (*Emergency – 2.94% All – 1.33%*).
- An overall positive month for our key mortality outlier groups:

⇒ **#NOF**

A follow-up workshop was held in November to help develop a future state pathway, which involved all key stakeholders from across Divisions. The workshop aims to improve our patient outcomes through the development of a fast-track pathway, ensuring patients reach the specialist ward (<4hrs) and surgery (<36hrs) .

Some of the key areas of focus will include:

- Pre-alert from WMAS to ED
- ED staff to bleep '#NOF team', which will start planning and preparing the patient care much earlier.
- Development of a dashboard to visual patients who are actively on the #NOF pathway.

⇒ **Stroke.** A presentation of the latest SJR cases from Stroke deaths, including the findings and learning, will be presented at this month's Learning from Deaths Committee.

The latest 12 month rolling SHMI has reported a significant reduction, and remains within 'as expected' ranges at 104.8.

⇒ **Sepsis.** A further audit on the implementation of the Sepsis 6 care bundle will be conducted by the Sepsis Lead. The audit focuses on the completion of all 6 key elements of the care bundle, in addition to the timeliness of each.

The findings from the audits are driving a clear and focused action plan to improve the pathway. A presentation of the findings and suggested next steps will be provided through the Clinical Effectiveness and Audit Committee.

- **Medical Examiner Service.** During November, a meeting was held with the local Medical Examiner, Coroner and Registry Office. The meeting was aimed at reviewing the impact of recent implementation of the new legislation, which has highlighted some significant benefits, including a reduced turnaround time for death certificates and a significant reduction in the number of Coroner referrals.
- At the **October LfD Committee**, there were a variety of presentations including updates from Trauma & Orthopaedics, Respiratory and Emergency Department.

Quality & Safety Performance – Mixed Sex Accommodation Breaches

We are driving this measure because:

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

Data

	April	May	Jun	Jul	Aug	Sept	Oct
Total admissions	2095	2137	2057	2030	1878	2020	2107
Patients affected by a MSB	54	51	50	59	93	113	201
	2.6%	2.4%	2.4%	3.0%	5.0%	5.6%	9.5%
Occasions	14	27	21	24	28	34	58
Areas	Day Case	Day Case	Primrose Surgical Unit	AMU	Frome	AMU	AMU
	ITU	ITU	Redbrook	Ashgrove	Gilwern	Gilwern	Garway
	Wye	Redbrook	Wye	ITU	ITU	Wye	Gilwern
		Wye		Primrose	Primrose Surgical Unit		Primrose Surgical Unit
				Redbrook	Redbrook		Wye
				Wye	Wye		

Top 3 Breach rate (Midlands region)

Apr	Rate	May	Rate	Jun	Rate
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	18.7	WYE VALLEY NHS TRUST	14.8	WYE VALLEY NHS TRUST	12.4
WYE VALLEY NHS TRUST	9.6	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	8.2	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	5.6
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	7.5	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	6.9	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	4.1

Top 3 Breach rate (Midlands region)

Jul	Rate	Aug	Rate	Sep	Rate
WYE VALLEY NHS TRUST	4.7	WYE VALLEY NHS TRUST	19.7	Wye Valley NHS Trust	31.3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	4.6	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	4.0	Kettering General Hospital NHS Foundation Trust	4.5
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	3.6	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	3.6	Worcestershire Acute Hospitals NHS Trust	3.9

Headlines

The first table identifies the total number of patients affected and the number of occasions a breach occurred. As can be seen the number of occasions a decision is taken to allow a breach can lead to a large volume of breaches (number of patients affected). Due to the counting rules one patient can be subject to multiple breaches.

In the context of total admissions month on month, patients affected by a breach is a small percentage of patients in Q1 yet increases significantly in Q2 despite admissions remaining stable. The wards were reconfigured in July and this is certainly a factor in the rising number of breaches particularly on primrose surgical unit and Gilwern Ward (previously Redbrook). Additionally, operational pressures have led to high numbers of patients in temporary escalation spaces (boarders) which is also driving this performance.

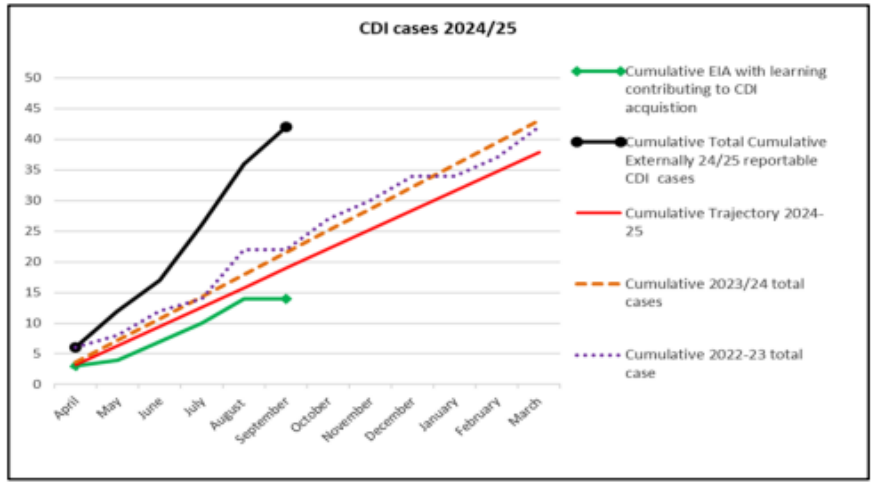
The national team report the rate of breaches per 1000 finished consultant episodes (from the previous year sourced from HES). The Trust is flagging as a outlier regionally month on month having the highest breach rate in the region since May 2024. The same Trusts feature each time the data is released and may be linked to estate constraints.

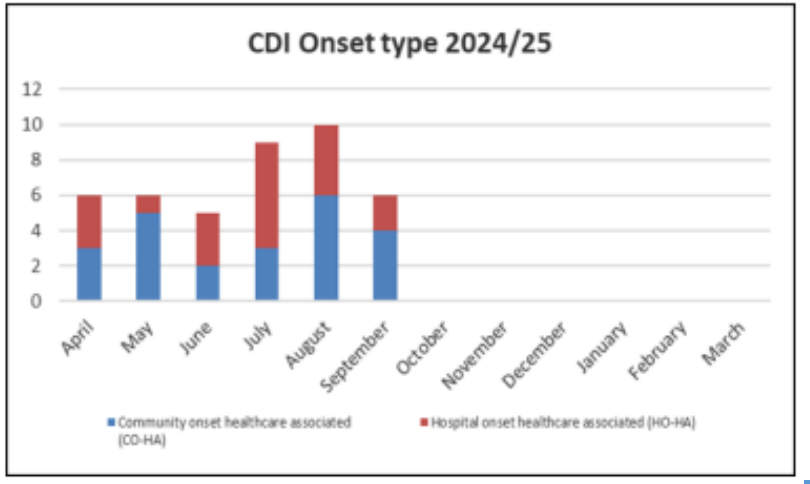
Quality & Safety Performance – Clostridioide Difficile rates

We are driving this measure because:

The Trust has exceeded the trajectory for clostridioide difficile cases in 2024-25.

Data





Headlines

In Q2 the Trust reported 25 clostridioide difficile (CDI) cases exceeding the quarter and annual trajectory of 38, with 17 cases being reported in Q1. In Q2 13 cases were community onset infections and 12 hospital onset. To date we have received ribotyping on all 42 cases and their contacts. Positively there is no evidence of cross contamination (same ribotype) between the patients or locations. A summit meeting chaired by the Director of Infection Prevention & Control (CNO) was held in September and a further meeting with the CMO present in November. The following actions were agreed:

- A sample review of CDI positive patients' pre admission antibiotic history is being undertaken to determine patient risk factors
- Liaise with Informatics to develop data sets to support effective analysis
- Review current patient demographics alongside 2023-24 data to identify if any changes in demographic and/or treatment pathways are linked to the rise in case
- Review current case review processes in line with the patient safety incident response framework; Consider stopping individual reviews to enable more focused audits/ QI initiatives
- To focus on antibiotic stewardship, in particular the duration of antibiotics and the switch from intravenous to oral therapy
- Identifying high risk definite cases – ensuring patient on correct antibiotics, including FMT treatment where necessary and fluid/electrolyte management
- Identifying patients who are colonised but high risk of developing active disease – and avoiding antibiotics
- Increase (where resource allows) antibiotic ward rounds and audit the impact of these
- Awareness campaign for clinicians, including Trust talk, grand rounds, teaching and screensavers
- To identify a dedicated role within the infection prevention team (existing resource) for targeting infections and quality improvement

Quality & Safety Performance – Staffing

Fill Rate & CHPPD Data

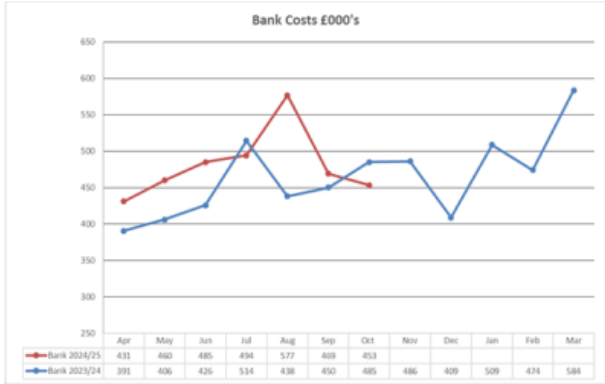
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPP
Primrose Unit	154%	130%	98%	94%	10.7
Maternity Ward	85%	89%	95%	87%	6.3
Children's Ward	110%	148%	92%	76%	14.4
Lugg Ward	126%	82%	118%	102%	6.6
Wye Ward	123%	82%	118%	94%	7.2
Cardiac Care Unit	100%	97%	100%	91%	11.8
Leominster Community Hospital	154%	94%	108%	155%	7.0
Bromyard Community Hospital	118%	125%	100%	165%	7.6
Ross Community Hospital	117%	125%	131%	135%	7.4
Teme Ward	141%	64%	90%	70%	10.7
Redbrook Ward	107%	134%	101%	118%	6.8
Special Baby Care Unit	98%	-	107%	-	9.7
Intensive Care Unit	101%	-	84%	-	23.4
Gilwern Ward	108%	138%	100%	101%	6.6
Acute Medical Unit	123%	73%	96%	113%	7.1
Ashgrove Ward	126%	87%	101%	104%	6.7
Dinmore Ward	131%	74%	100%	100%	7.0
Garway Ward	122%	84%	101%	113%	6.8
Frome Ward	124%	82%	98%	103%	6.7
Arrow Ward	141%	73%	135%	88%	7.5
Women's Health	130%	94%	100%	-	10.3

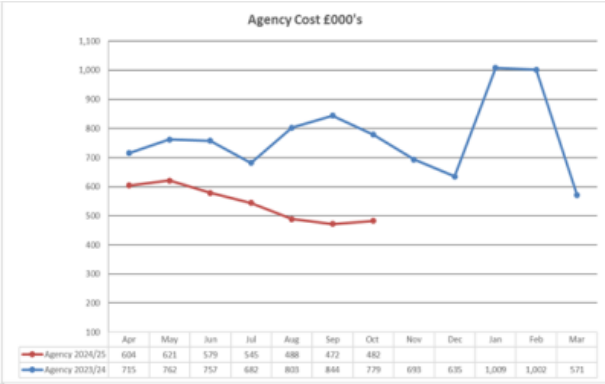
The NHS England staffing return is detailed above and includes the minimum expectations in terms of national quality board reporting requirements.

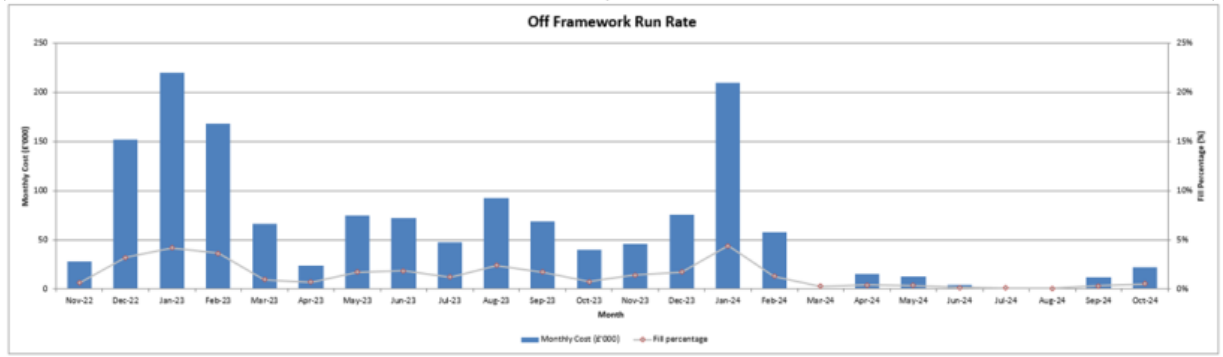
Board will note that the figures overall are more aligned to planned levels and where over fill is seen this is either due to:

- registered nurses backfilling band 4 roles (with a commensurate reduction in care support worker fill)
- Additional beds (community hospitals)
- Higher levels of acuity and/or dependency and patients being cared for in Temporary Escalation Spaces (TES)

Bank & Agency







Since the last Board Report, month 6 and 7 saw further reductions in agency spend and the bank position return to more usual levels. There has been a marginal increase in off framework shifts, although these do remain small in number. The majority were last minute shifts required to cover short term sickness for operating department practitioner shifts which were deemed essential to maintain planned surgical lists.

We hosted a regional visit focusing on nurse agency reduction and the team were impressed with the performance thus far and commitment to agency reduction – we are working towards agency cap compliance for general nursing shifts by the end of January in line with the regional collaborative.

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Delivering and maintaining our Elective activity to reduce the lengthy waits for patients remain, as important, as improving our Urgent and Emergency Care [UEC] pathways and services to patients.

Last month we saw record numbers of patients being treated in our Operating Theatres, through increased numbers Theatre sessions. This has seen a week on week reduction in the number of patients waiting over 65 weeks for treatment, down to under 40 at the end of October with the plan to eradicate all patients waiting over 65 weeks by the end of the calendar year, and our patients waiting over 52 weeks for treatment reduced from 1,300 in mid-July to 850 at the start of November, a 35% reduction. Our actions over the remainder of this year is to continue to increase our Theatre utilisation and ensure all our specialities maximise their Theatre capacity and reduce their waiting lists further.

Our Diagnostic waits have also seen a significant improvement over the last few months with 85% of patients now waiting 6 weeks or less for their Diagnostic appointment. At the start of July we have over 2,000 patients waiting over 6 weeks at the start of November this had reduced to less than 700 patients, a 65% reduction. In particular with have seen a significant improvement in the number of patients waiting for echocardiography, an endoscopy procedure, Magnetic Resonance Imaging [MRI] and Computed Tomography [CT].

These improvement in our Diagnostics waits has made a significant impact in our cancer pathways delivering a consist Faster Diagnosis standard which has been maintained during the course of year, despite increased referrals. Improvements in Endoscopy access for cancer patients along with improvements with Radiology and Pathology have supported our ability to maintain this standard and provides as sound basis to deliver 80% of patients diagnosed or have cancer ruled out within 28 days of their referral to secondary care in 2025/26.

Winter has already started for our UEC pathways and we are starting to see increased levels of emergency admissions and record levels of ED attendances in both adult and paediatric pathways over recent weeks.

We are starting to see some of our winter schemes make some improvements, although we still have a lot work to do both internally and with system partners, there are schemes coming on line:

- Community Referral Hub [CRH]. Relaunched and co-located in Nelson House which provides a single point of access to a range of community services to support people leave hospital earlier, or to keep them well at home for longer. We now have a team embedded with Taurus GP Federation colleagues in the CRH which can provide access to a range of services. Including Virtual Wards, Hospital@Home, District Nursing, Urgent Community Response, along with 7 days / 12 hours access to a General Practitioner [GP] and from mid-November GP Out of Hours [OoH] services. Along with strengthen a “Call before Convey” priority phone line service to Ambulance Service colleagues to reduce acute admissions to ED and treat patients closer to home.
- Virtual Wards [VW]. Along with the relocation to CRH we have increased the capacity of VW to include “step-up” beds for acute admission avoidance. Since the move to CRH we have seen an increase in the step down beds utilisation for Frailty and Acute Medicine patients from approximately 40% capacity utilisation to over 80% over the last few weeks.
- Embedding Nurse Navigation at the front door of ED across 7 days / hours streaming to internal SDEC pathways, hot clinic capacity and externally to GP OoH, which is increasing over each weekend.

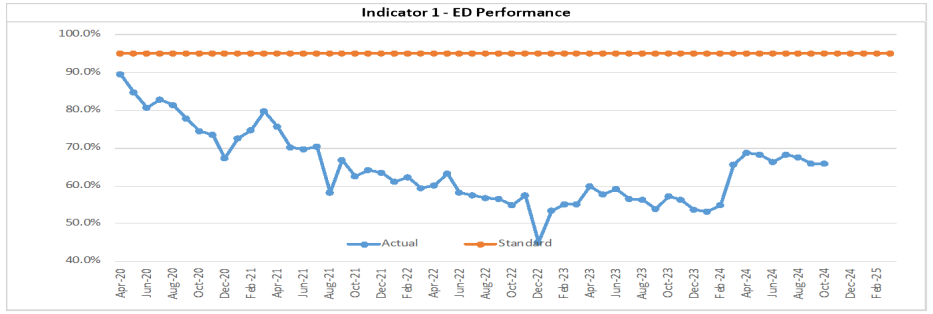
Despite this work, and the plans due to come on line over the rest of the year, we are continuing to utilise Temporary Escalation Spaces [TES] across our inpatient wards and have congestion in our ED, this then leads to increased Ambulance Handover delays. All of which is not a position we would want for out patients and staff. Our on-going Trust wide work and developments with system partners across the Integrated Care System, Herefordshire and Powys is key to improve this position as we go into the depths of winter.

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

We are driving this measure because:

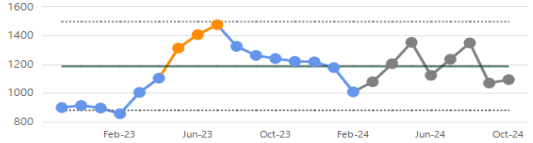
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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



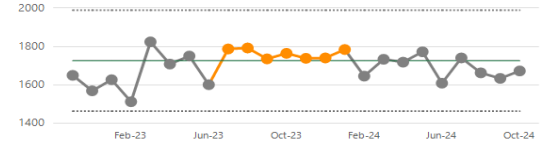
% Patients Spending More Than 12 Hours In ED

Type 1 Minors Attendances



% Admissions on Same Day Emergency Care (SDEC) Pathway

Ambulance Conveyances



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.

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.
Octobers 4 hour Emergency Access Standard [EAS] Performance was 65.8%

Performance & actions

- 6,290 Type 1 patients attended ED in October which was the highest volume since May-24. The range of all attendances varied from 166 to 250 with 202 being the average daily attendances.
- 1,672 ambulances conveyed to the Trust in month which was 39 more than last month. The range in month was 42 to 66. This includes 10% from Powys [165].
- Ambulance handover delays over 1hr were 26.5% [443] of all conveyances and 68% [537] of all ambulance conveyances had a handover within 45 minutes.
- Same Day Emergency Care [SDEC] treated 1,329 of all admissions [48% of all admissions] via a Same Day pathway within no overnight admissions. This is a 3.7% increase over last month.
- Our Type 1 ED attendances 4 hour Emergency Access Standard ranks 73/122 Type 1 Trust in England for October.
- Our Valuing Patients Time Programme Board [VPTB] has oversight of the current UEC improvement schemes:

➢ Community Referral Hub [CRH] moved to Nelson House in Hereford. This brings together our Urgent Community Response [UCR] Team, Hospital@Home team, Virtual Ward co-ordination, Single Point of Access, Primary Care out of hours, along with 12hrs a day 7 days a week GP support for Community Team and managing referrals.

➢ Discharge to Assess [D2A]. Sustained improvement in Herefordshire Pathway 1 delays. The focus now is working with system partner ahead of the winter period to improve Pathway 2 and 3 discharges within Herefordshire.

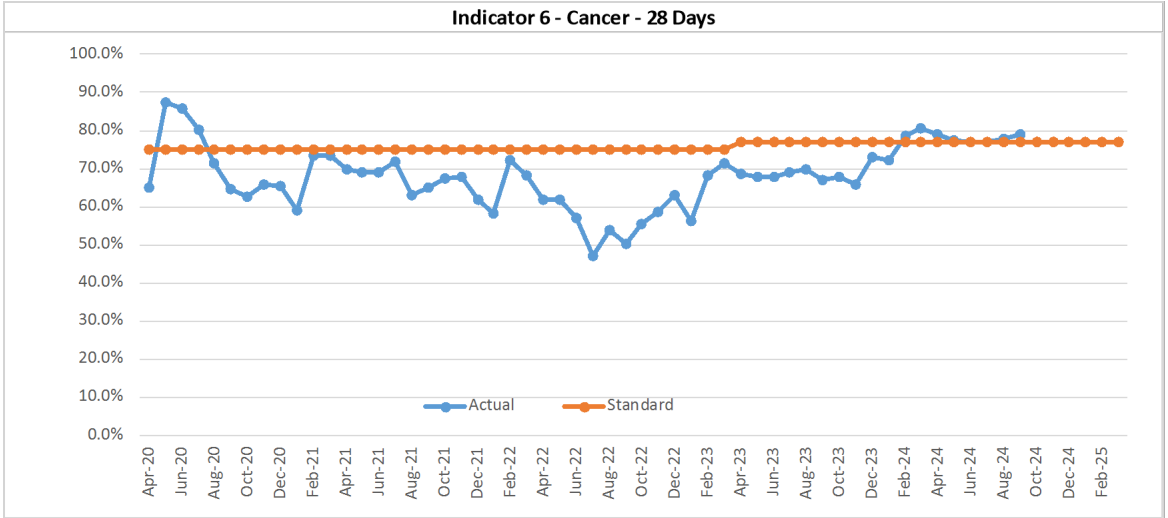
➢ ED Navigation at the Front Door. This role is now a core function of our ED and will develop and evolve over the next few months as recruitment to the revised Nursing establishment is on-going. This role will be supported by our UCR team to develop their skills to utilise community pathways via CRH and assess and refer Ambulance conveyances to more patients can be treated closer to home and reduce Hospital admissions.

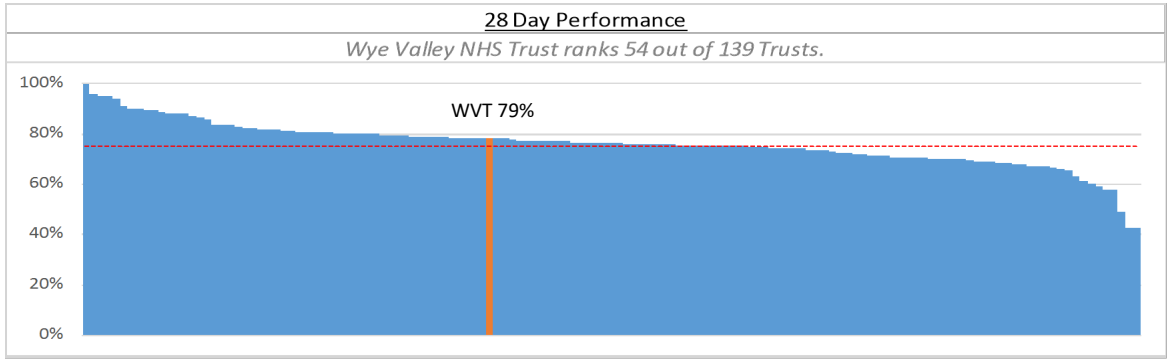
Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [FDS] [September 24]

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 77% 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:
As of the end of September, referrals were 5.2% up on the same time last year and 19.3% higher when compared the same time 3 years ago. Noticeable increases have been seen in Gynaecology , reporting an 8.5% increase against the last year. Colorectal continue to see a decrease, at 15% as of the end of September which is attributed to the implementation of the Faecal Immunochemical Test (FIT) pathway used to stratify patients from primary care.

Main Issues impacting on performance and actions:
Gynaecology FDS for September was 57%, a 9% increase on August. Recruitment to the team in December to support solely with cancer letters to help reduce the delays seen in this area and the planned improvement workshop will launch week commencing 18th November. The workshop is now being facilitated by the Trusts transformation team to bring focus to key issues in the pathway with key stakeholders to foster change and improvement.
Workforce constraints in Endoscopy have occurred due to long term sickness within the team which threaten endoscopy waits. Plans are being drafted to mitigate the risk with operational leads in endoscopy and cancer services working closely across Divisions and with ICB colleagues to address.

Improvements:
The business justification to recruit four substantive cancer navigator roles was approved at Trust Management Board. The roles have now been appointed too, awaiting start dates. These posts will ensure ring fenced resource for continued pathway improvement to ensure compliance with best practice timed pathways and national targets

What the charts tell us

28 Day faster diagnosis: Performance against this target was 79% and remained below the target of 77% and below our trajectory for the month.

Risks

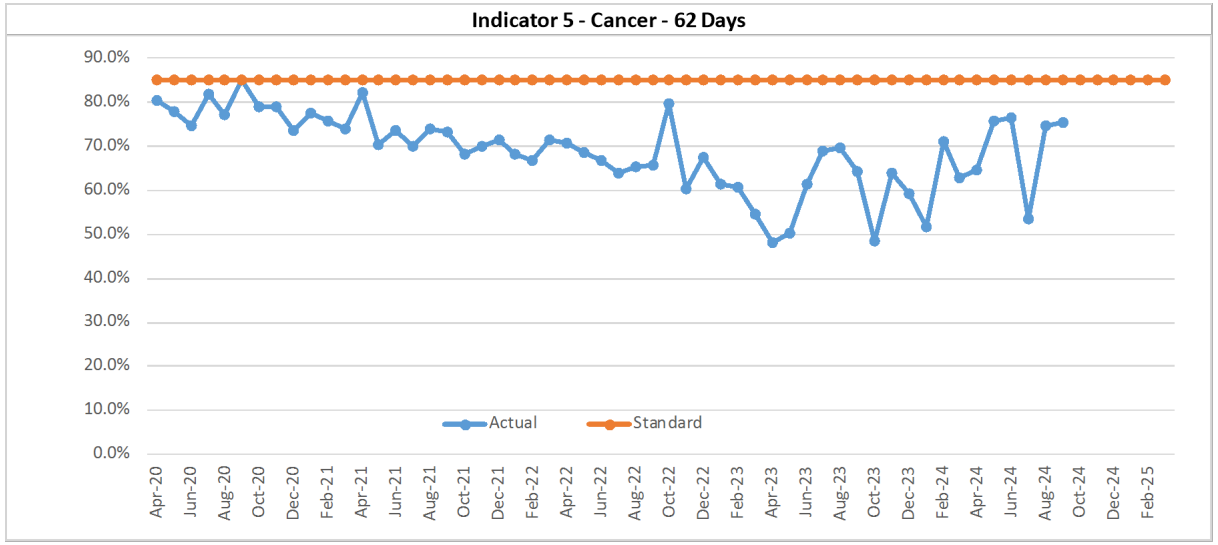
Cancer referrals continuing to remain above 19/20 levels/Histology Endoscopy and Radiology capacity still remain an issue.

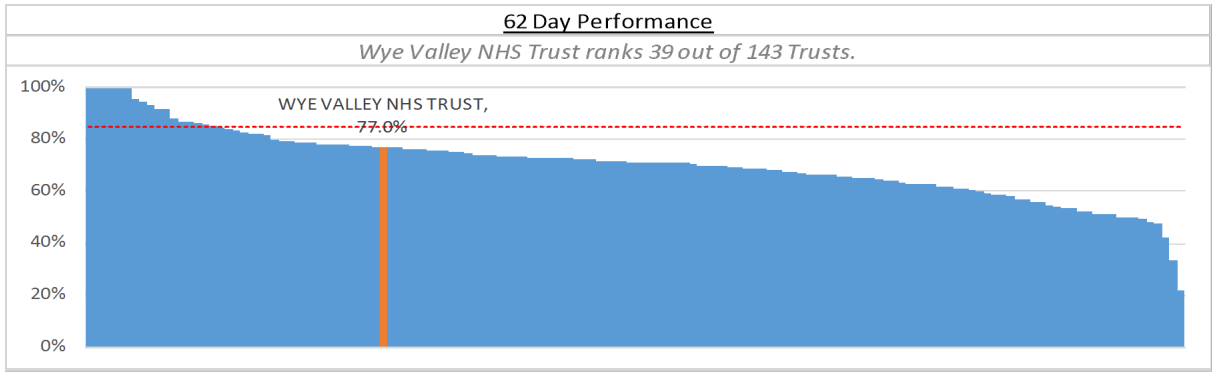
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [September 24]

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

62 Days:
Concerns regarding 62 day performance remains in our surgical specialties. Utilising the cancer Patient Tracking List(PTL), clear actions have been identified on how 62 day performance can be improved following the work undertaken to improve FDS performance.

Pre-operative Assessment delays have been identified with clear actions identified to resolve and support improved use of daily ring fenced slots to provide patient with earlier access to this ahead of surgical procedures

Continued deep dives focusing on specialties struggling to meet performance targets to understand issues and develop actions plans.

Improvements:

Turn around times for urgent specimens in Pathology continue to perform well with WVT being tabled top in the region.

Over 62 day backlog for the end of month of September was 61, with highest number of patients seen in Urology, Gynaecology and Colorectal. Specialties continue to review this weekly via the Cancer PTL, with focus being made lower down the pathway to reduce the number of patients exceeding 62 days. Admin delays previously noted are now reducing with specialty administration teams adopting and utilising the cancer escalation

The Best Practice timed pathway dashboard has now been developed, launched in Gynaecology, and is currently going through User Acceptance testing to ensure it provides the visibility required. Now that piece of work has been completed, the template for the dashboard can be used to develop other specialty dashboards as part of a phased approach

What the charts tell us

62 day Treatment Standard: The Trust's performance was 77% against a target of 85%.

Risks

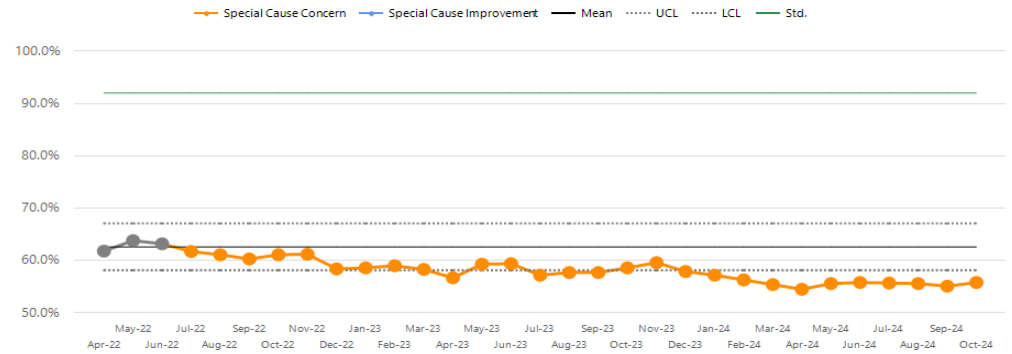
Workforce capacity and shortfalls in some specialities along with the impact of tertiary referrals. Impact of reduction In Oncology support from Gloucestershire Hospitals NHS Foundation Trust impacting of Gynaecology pathways.

Operational Performance – Referral To Treatment Performance

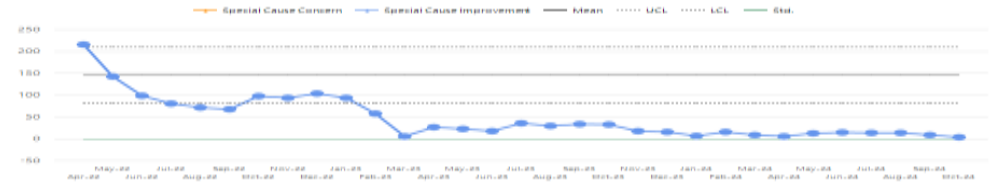
We are driving this measure because:

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

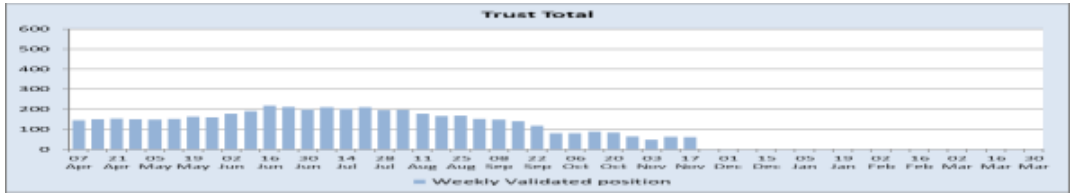
Referral To Treatment – Open Pathways (English)



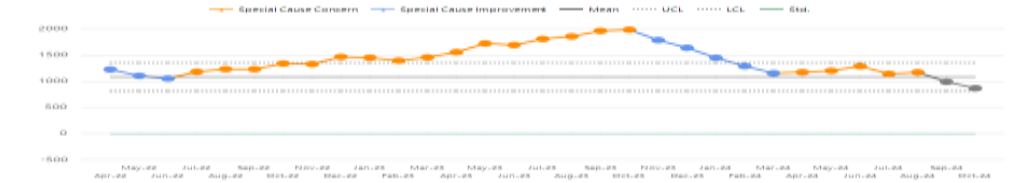
Patients over 78 weeks on Incomplete Pathways Waiting List



Weekly tracking of patients over 65 weeks on Incomplete Pathways Waiting List



Patients over 52 weeks on Incomplete Pathways Waiting List



Performance & actions

Long Waiting Patients

- 4 English and zero Welsh patients waited over 78 weeks at the end of October.
- 65 week position at the end of October was 28 English and 10 Welsh patients.
- This is a reduction of from over 220 patient during mid-June

The Trust is has seen a significant reduction in 52 week waits over the last few months. Our combined Welsh and English position at the start of April was almost 1300 patient waiting for their treatment, at the start of November this has reduced to just 860 patients.

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.

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.

Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

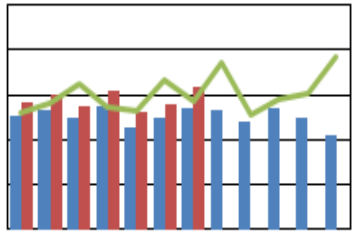
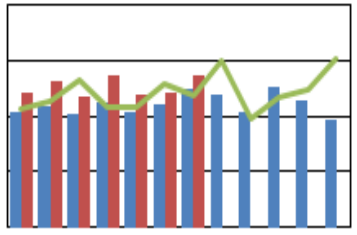
What the charts tell us

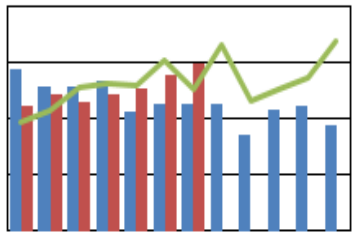
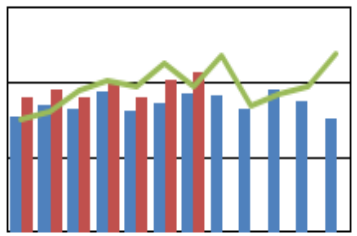
Performance against English RTT standard in October was 55.8%. Performance against the Welsh RTT standard in October was 70%.

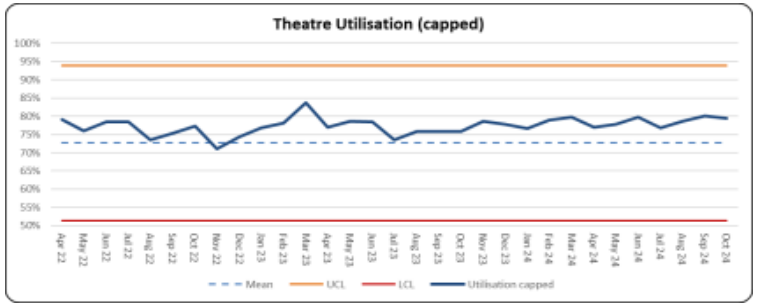
Operational Performance – Activity / Productivity

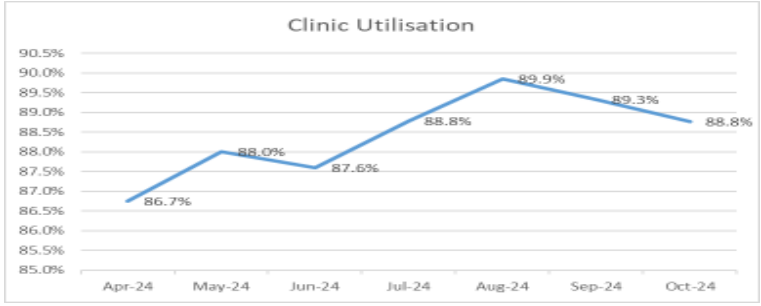
We are driving this measure because:

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	35722	
	Plan This Year	40381	
	This Year	40432	
	Diff vs 19/20	4710	
	Variance	13%	
	Diff vs Plan	51	
	Variance	0%	
Follow Up	2019/20	76690	
	Plan This Year	81548	
	This Year	88628	
	Diff vs 19/20	11938	
	Variance	16%	
	Diff vs Plan	7080	
	Variance	9%	

Admissions		Year To Date	Charts
Elective Inpatient	2019/20	1737	
	Plan This Year	1744	
	This Year	1774	
	Diff vs 19/20	37	
	Variance	2%	
	Diff vs Plan	30	
	Variance	2%	
Elective Daycase	2019/20	11969	
	Plan This Year	13168	
	This Year	13499	
	Diff vs 19/20	1530	
	Variance	13%	
	Diff vs Plan	331	
	Variance	3%	





Performance & actions

Activity Summary

- New Outpatients [OP] Year to Date [YTD] activity was on plan.
- 44.1 % of OP were either new or a follow-up patients with a procedure. 49.8% for RTT pathways for October 24
- Elective inpatient was 2% above plan YTD/Elective Day Cases was 3% above plan YTD at end of October 24.

Theatre Productivity

- The average number of cases per theatre list was 3.8 in October, a slight drop from September, as did Theatre Utilisation which achieved 79.5% driven by some workforce challenged in anesthetics
- The total number of patients treated last month through Theatres reached 1019 patients an increase from 985 last month
- There are key specialties that are not yet delivering 80%+ Theatre utilsiation that are the focus for the next few month; Ophthalmology, Gynaecology, General Surgery and Ear, Nose and Throat.

Outpatient Productivity

- Our Outpatient clinic utiilisation remain positive after a decrease in the volume of patients who Did Not Attend [DNAs] in October
- October also saw an increase in the percentage of our Outpatient clinics which had New patients or patient who had a procedure undertake reaching the highest volume so far this year at just over 44%

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

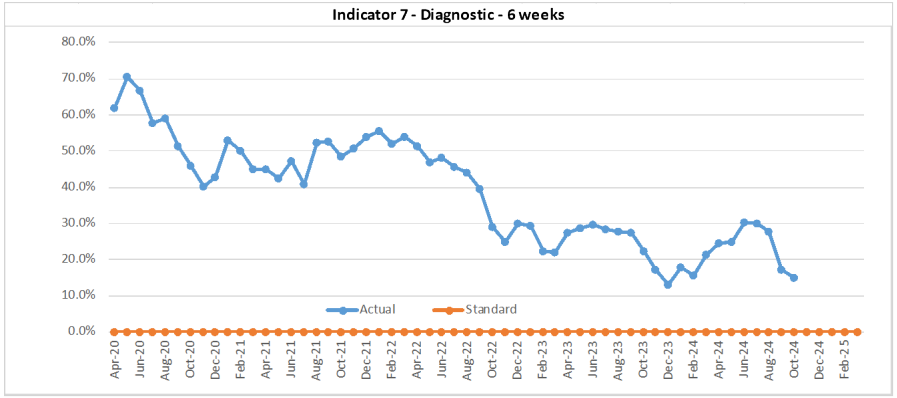
Performance against English RTT standard in July was 55.6%. Performance against the Welsh RTT standard in July was 69.4%.

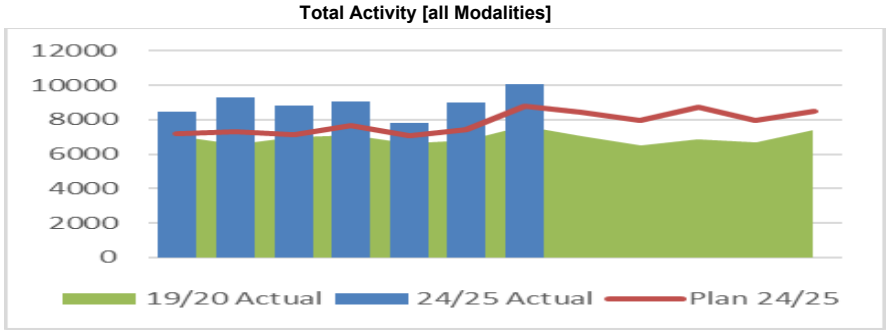
Operational Performance – Diagnostic Performance

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 114% of Octobers activity plan and 131% of the same month 2019/20

Imaging:
Overall Imaging`s 6 week wait position at end of month 7 was 92% compared to 86% month prior. Currently zero CT waiting >13 weeks. Zero MRI >13 weeks and 5 NOUS >13 weeks.

- Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 10 and 16 days respectively. CTC has reduced from 28 days.
- The main drivers for longer waits are patient choice and bloods/prescription delays, the latter being addressed with an addition of the prescription to the referral form.
- Average report turnaround times for MRI prostate and CTC was 2 days.

Audiology:

- Audiology 6 week wait position improved in month 7 to 88% in adult services, compared to 80.1% in August, whilst paediatrics has also improved from 30%.to 40%
- Audiology patients waiting >13 weeks (driven by paeds) reduced to 34 mid November compared to 69 the month prior. A Locum Paediatric Audiologist has been sourced and will commence one day per week shortly. Agreed insourcing solution commences in mid November. Together with a recruitment plan to improve the sustainability of the service this will aim is to eliminate the 13 week backlog to zero by the end of December and provide a sustainable plan into the new year.

Echocardiography [Echos]

- Additional insourcing commenced, average increase of 50 patients seen per week started in August. At the end of October only 4 patients were waiting over 13 weeks for their Echo. Insourcing will be reduced in December and January now waiting list is under control.
- Operational trajectory aims to clear the 6 week backlog cleared by December this year.

Neurophysiology

- Fragility of Consultant led clinics due to bank weekend working only is driving the long waits over 13 weeks. A service review is currently being instigated in order to develop more sustainable plans.

Risks

Increased inpatient / acute floor referring impacting on capacity of service.
Audiology, Non-Obstetric ultrasound and Neurophysiology capacity / workforce challenges

What the charts tell us

End of October 85% of patients waiting less than 6 weeks for a diagnostic test. The position at the start of year April was 75%, a 10% improvement and a reduction of almost 800 patients waiting beyond 6 weeks.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

With effect from 26 October 2024 there is a new legal duty on employers (The Worker Protection Act 2023) to take reasonable steps to prevent sexual harassment in the workplace. The law covers sexual harassment from other employees and third parties and applies to any unwanted sexual behaviour in the workplace. The Trust has adopted the NHS policy on sexual harassment and the NHS e-learning programme is being promoted to employees. HR policy awareness raising sessions are being held over the next few months with teams across all sites.

In November the Trust successfully defended a disability discrimination case and the employment tribunal found that WVT had taken reasonable practical steps expected of an employer to support a disabled nurse at work. We will continue providing employment law and HR training to our line managers to ensure they are fully aware of their legal obligations.

Sickness absence stands at 5.3% with Long Term Sickness at 2.52%.and Short Term sickness at 2.78%. The main reasons for sickness absence are colds/flu. mental health conditions, gastro and msk. We are taking appropriate management actions to reduce sickness in line with our absence policy and this remains a priority area for HR. OH teams are leading the flu vaccination programme and to-date 1300 staff have been vaccinated. Working with Taurus healthcare we are offering health checks to staff and over 150 employees have had a health check.

Staff turnover has dropped to 9.4% and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at to 7.27% but turnover for band 2/3 hcsw staff now stands at 17.20%. We have restarted the centralised recruitment process and are running a major recruitment campaign on Sunshine Radio and working actively with the DWP to fill our vacancies. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments

We supported Disability History Month , World Kindness Day and promoted the anti– bullying week in November. We will be launching a WVT Women's Staff Network in January and we are involved in the ICS Active Bystander trainers programme which has now commenced.

Through our workforce opportunities working group we are implementing schemes to enhance workforce productivity. E-expenses is being rolled out over the next 10 weeks and e-rostering for community nursing will be implemented in 2025. E-rostering will be rolled out to other clinical areas in 2025/26 as this is seen as one key measure to enhance workforce productivity..

A first all day careers development event for staff with the University of Worcester at the County Hospital site was well attended and successful. The event highlighted and promoted opportunities for staff development using the apprenticeship levy and other NHS related CPD funds. Plans are being discussed for this to be an annual event for WVT staff in view of our ambition to grow and develop our employees.

The 2024 NHS National Staff Survey has commenced and our response rate is currently 33%. The survey will close on the 29 November 2024.
Working with ICS colleagues we are supporting the NHSE sponsored Care Leaver pilot programme which aims to find employment opportunities for Care Leavers in Herefordshire & Worcestershire over the next 3 months.

Final year business students from the University of Derby will be undertaking their management projects at WVT working on schemes including health & wellbeing, volunteering, workforce productivity, sustainability and recruitment & retention.

Performance appraisals have improved to 80.1% and WVT continues to perform well with mandatory training which now stands at 88.3%.

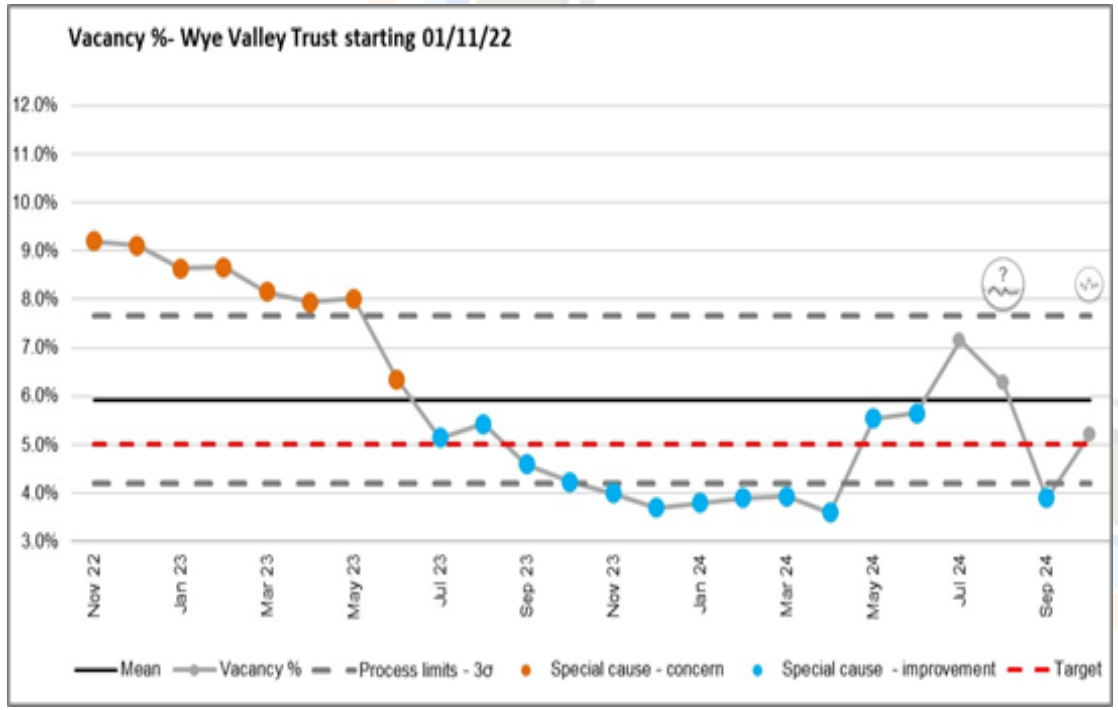
tforce Performance – Vacancy

We are driving this measure because:

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

Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
4.2%	4.0%	3.7%	3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%	3.9%	5.2%

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



Performance & actions

HCSW – with 33.67 wte vacancies we have re-introduced the centralised recruitment process and are running a major recruitment campaign on Sunshine Radio with open day recruitment sessions. We are also working actively with the DWP to fill our vacancies.

N&M - we are on track with international recruitment and to-date 53 new nurses have joined WVT. In 2025 we intend to pause international recruitment as we are starting to see a significant increase in applications from UK based applicants. ..

CDC – 34.49 wte appointments have been made and we are on track to fill all clinical vacancies by June.

M&D - we are now working with a new international recruitment agency (Tern) who have a platform of UK based and global drs seeking new job opportunities. Regular meetings with CMD, Medical Staffing Manager & Strategic Medical HR Lead to review progress with vacancies and cases of concern. Overseas recruitment of medics to continue over the coming year. We currently have 57.62wte vacancies.

Pharmacy - initiatives in place including advertising all jobs as open to flexible working, extending relocation packages in hard to fill areas, highlighting opportunities for personal and career development and an innovative on-call system is stabilising the workforce and reducing staff turnover.

In 2025, we will be extending our recruitment events and promoting our vacancies Herefordshire wide with a series of events. We will also be extending WVT presence at regional and national fairs to promote our job opportunities.

The Hereford Youth Hub is now live and situated next to the Franklin Barnes building. HR continues to work closely with DWP officers in finding suitable job opportunities for young people. 46 WVT Ambassadors have signed up to support career events at schools, colleges and universities and this reflects our aim to support 'young people' within the county.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

The rolling 12 month position remains fairly consistent, with a large improvement at the beginning of the 23/24 financial year down to a decrease in substantive budget along with an increase in staff in post which has continued for the first 10 months of the year, with a slight increase in the last 2 months of 23/24. There was a decrease 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 in August, followed by a large decrease in September due to a realignment of budgets for OSCE Nurses and the Education contract. An Increase in October due to realignment of OSCE nurse budget and the education contract as well as the additional of approved business cases.

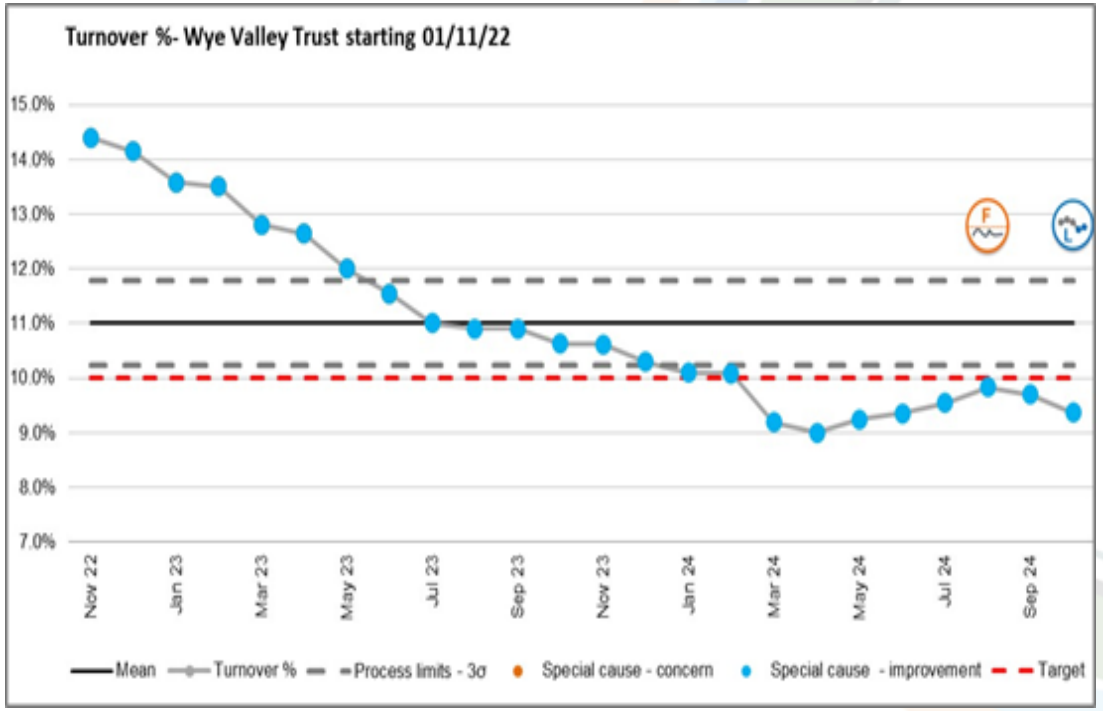
Workforce Performance – Turnover

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.

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

Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
10.6%	10.6%	10.3%	10.1%	10.1%	9.2%	9.0%	9.2%	9.4%	9.5%	9.8%	9.7%	9.4%



Performance & actions

The overall rolling 12 month turnover at Trust level is at 9.4% 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 (17.20%) and this is still the case across the NHS. We have reintroduced the centralised recruitment process and are strengthening the pastoral care support and training being provided. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships.
Turnover rates for qualified nurses remains steady at 7.27% 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 chart tells us

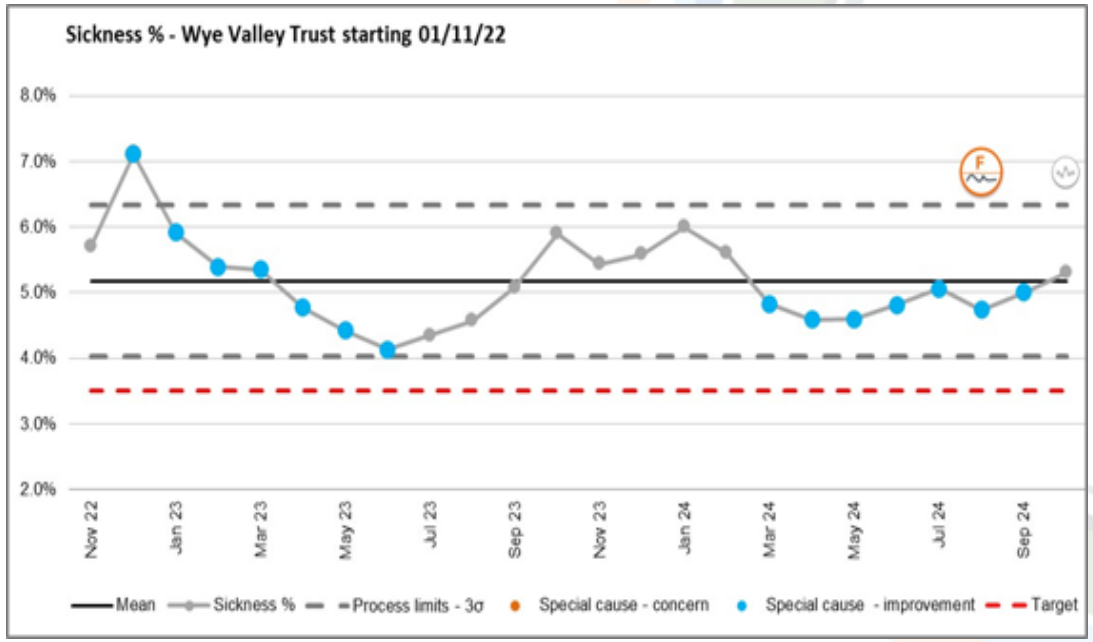
The rolling 12 month position shows a decreasing trend in the last 12 months. An improved position present in March and April 24 due to now removing retire and returnees, with an increase in the last 4 months, which has deceased last two months.

Workforce Performance – Sickness

We are driving this measure because:

We aim to reduce absence so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staff.

Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
5.9%	5.4%	5.6%	6.0%	5.6%	4.8%	4.6%	4.6%	4.8%	5.1%	4.7%	5.0%	5.3%



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

During this month, overall sickness at Trust level has increased to 5.3% and the main reasons for absence are colds/winter ailments, mental health issues, msk and long term conditions.

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

The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for all long term sickness absence and short term absence cases of concern to ensure the absence process is being managed appropriately. The HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence.

Risks

What the chart tells us

The rolling 12 month position shows an increase in the first 6 months of the period, with a fluctuating pattern following due winter pressures and an increase of Covid and flu cases. The was a reduction in the last quarter of the financial year, which has remained consistent for the first 2 months of this year, increasing in the next 2 months before decreasing again in August then increasing again last two months.

Our Finance– Executive Summary

Katie Osmond
Chief Finance Officer

Month 7 Income and Expenditure position

Overall month 7 has resulted in a YTD adverse variance of £4.6m against the revised deficit plan, largely driven by unplanned expenditure pressures and slippage on the CPIP programme. Revised national funding for the provision of healthcare in deficit systems of £28.3m was released in month 6, this has resulted in a revised deficit plan of £3.1m (previously £31.4m).

The Month 7 position resulted in an overall YTD deficit of £6.8m. This was behind the current planned deficit, with an overall adverse variance of £4.6m. The previously established Financial Recovery Board (FRB) continues to 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 7 YTD, planned pay costs are unfavourable to budget by £3.7m, (a deterioration of £1.3m in month), non-pay £3.5m (a deterioration of £1m in month including a £0.5m YTD adjustment). These were partially offset by additional income of £4.1m, mainly achieved through an over performance in ERF, contractual gains and excluded drugs income.

The national pay award was accounted for in M7. The pay variance increase in month is largely due to the pay award, however this is also reflected in an over-performing income position. The impact of the pay award for staff in post YTD, including both cost and income, is £0.3m adverse. As further recruitment is expected later in the year, the full year impact of the pay award will be £1.2m adverse if no further funding becomes available to offset. This variance would be £2.1m for full year however £0.9m has been awarded by the ICB as a non recurrent mitigation.

The primary reason for expenditure overspend relates to unplanned cost pressures and the under delivery of CPIP (£3.2m YTD), which are partly mitigated. The majority of the CPIP variance relates to planned CPIP schemes that remain in the unidentified phase, requiring further action to result in deliverable schemes — these are examined in Check and Challenge meetings with Divisions as part of the FRB.
Outside of CPIP, there is also a £1.2m 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 unidentified 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. A full review of the forecast risks and mitigations is currently under way which will include an assessment of the pay award impact.

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 £0.1m 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 both within the limited funding available and to align the timing of expenditure with funding availability. To date we have invested £9.5m of capital spend.

Cash

Cash remains a risk which continues to be closely managed. Although £28.3m of revenue funding has now been agreed, through additional non-recurrent income, if the adverse variance isn't rectified this will become a real risk to the Trusts ability to pay suppliers on time. It remains more difficult to access additional cash support where the requirement is driven by us 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 7 - 31st October 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	310,595	181,512	183,566	2,054	1,295
Excluded Drugs	10,484	6,116	6,154	38	(595)
Excluded Drugs	12,801	7,468	8,649	1,181	1,181
Non Contracted Activity (NCA's)	1,768	1,031	1,138	107	19
Other Income for Patient Care	11,133	6,671	6,756	85	(67)
Donations For Non Current Assets	4,168	3,075	3,074	(1)	(1)
Other Non Patient Income	7,738	4,511	4,506	(5)	88
ERF	6,925	3,673	4,330	657	(166)
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**365,612**	**214,057**	**218,173**	**4,116**	**1,755**
Pay Expenditure	224,399	131,647	135,328	(3,681)	(1,263)
Non Pay Expenditure	92,054	52,436	55,941	(3,505)	(787)
Excluded Drugs	23,934	13,961	14,542	(581)	242
Total Operating Expenditure	**340,387**	**198,045**	**205,811**	**(7,767)**	**(1,808)**
EBITDA	**25,225**	**16,012**	**12,362**	**(3,651)**	**(53)**
Depreciation	14,130	8,271	8,105	167	9
Gain or loss on asset disposal	5,141	5,141	4,842	299	299
Interest Receivable	1,352	1,061	1,061	(0)	(0)
Interest Payable on Loans	262	153	105	48	9
Interest Payable on PFI	1,993	1,162	1,162	0	0
Dividends on PDC	4,244	2,397	2,397	0	0
Operating Surplus/ (Deficit)	**812**	**(50)**	**(3,188)**	**(3,137)**	**264**
Donated Assets Adjustment	3,335	2,589	2,590	1	1
Net impact of asset impairments	(5,141)	(5,141)	(4,842)	299	299
IFRS16 2425 PFI re-measurement adjustment	(2,490)	0	0	1,190	143
Impact of IFRS16 Implementation of PFI Contract	8,214	4,704	5,894	0	0
Adj. financial performance retained Surplus/ (Deficit)	**(3,104)**	**(2,205)**	**(6,830)**	**(4,627)**	**(179)**

Performance & actions

The position at the end of Month 7 (October) was a deficit of £6.8m YTD. This was behind the current plan with an overall adverse variance of £4.6m YTD.

- Income shows a positive variance of £4.1m. Within this £1.2m is over performance of the 23/24 and 24/25 Powys contract, £0.6m is in relation to ERF over performance in 23/24 (£0.5m of which is prior year funding), £1.2m for excluded drugs/devices, £1m contract income gains and £0.1m smaller variances.

- Pay is adverse YTD due to the pay award, undelivered CPIP, escalation areas, 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 — 4.13% of total pay costs in month which is a decrease from 4.52% in M6, although agency spend increased in month. Medical bank use at premium rates further increases this to 8.13% of overall pay, driven by volume and price.

- Total Non Pay (incl. dep'n & interest) is adverse by £3.9m YTD largely due to undelivered CPIP, continued high 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 and excluded drugs income.

PFI £1.2m adverse variance driven by a technical adjustment to the control total for historical accounting changes on PFI

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 YTD
- Change in performance adjustment regarding PFI accounting
- Winter impact on financial performance
- Marginal Cost of delivering activity

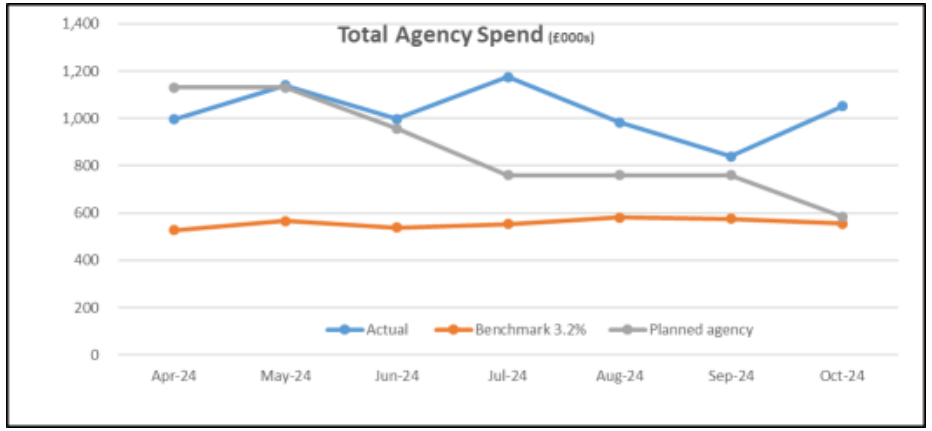
What the chart tells us

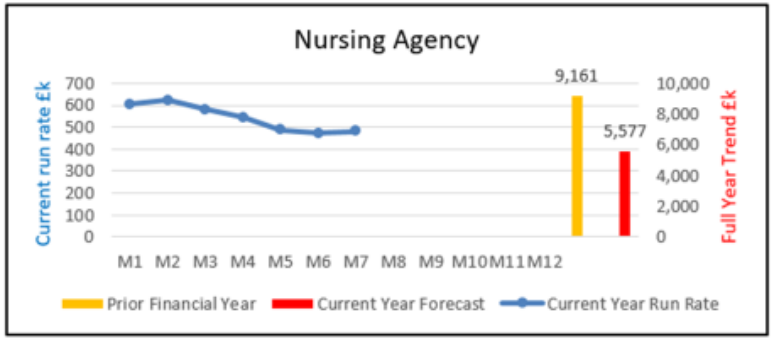
Known financial risks are putting greater pressure on delivery of our planned financial position.

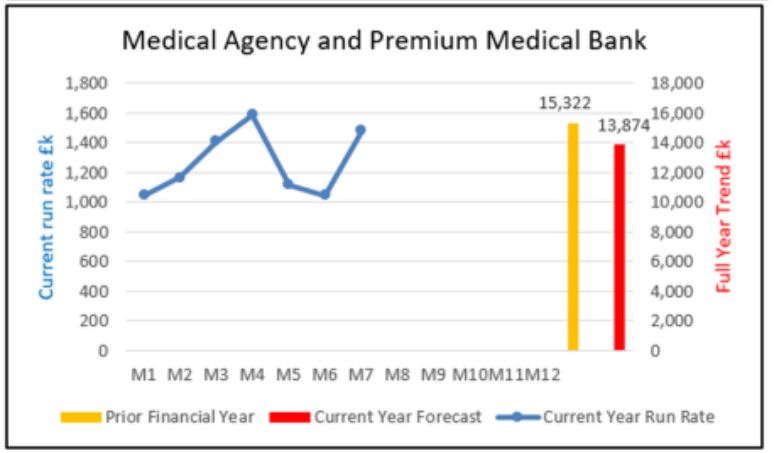
Finance Performance – Agency Spend

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 £7.2m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** The trend shows an in year reduction in spend, 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 £6.5m. Approved rate changes initiated throughout the Trust from July 24, should further reduce nursing agency spend, other plans are also in place to further improve the trend. Bank and Substantive performance will also need monitoring to ensure costs elsewhere are not offsetting the good performance seen in agency reduction.
- **Off framework Nurse Agency:** there has been an increase in off framework use in month with 18 shifts booked in October, a total of 71 shifts YTD. This is a significant reduction on the level of 2324 booking, but had been holding at around 3 shifts in previous months, increasing to 12 in September and further increasing to 18 in October.
- **Medical staffing agency and premium cost bank:** M7 has seen a marked increase in Medical in both bank and agency, largely due to sickness and short-term bookings. A Temporary Staffing Co-coordinator in post since M6 is working on 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 which has increased from £14.7m in M6. This demonstrates more work is required to continue to address the increased use of bank and agency.

Risks

Level of Agency (% of pay)

Increased workforce gaps resulting in greater requirement for temporary workforce.

Supply and Demand price pressures

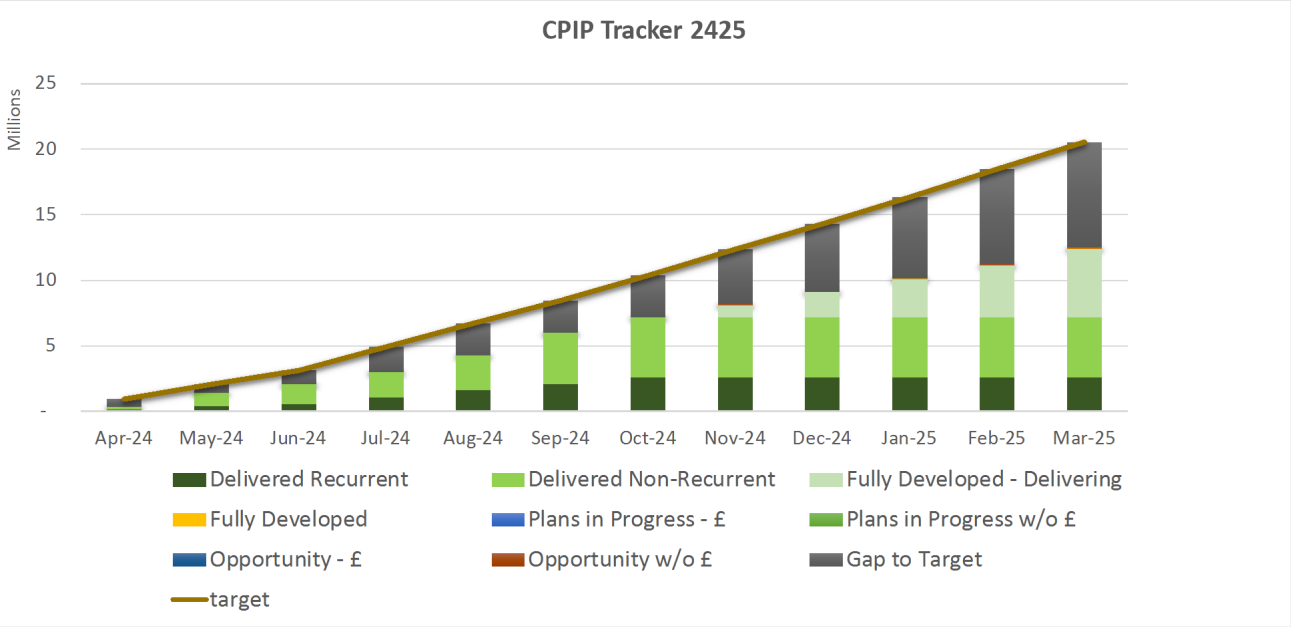
What the charts tell us

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

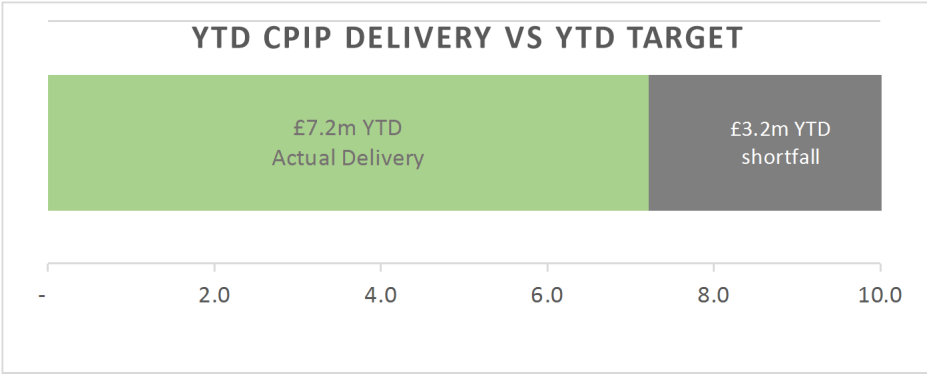
The £20.6m target breaks down into two areas: £19.4m cost out efficiency (of which £4.4m relates to 2324 NR items, of which we are targeting a £8.0m agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

The current position on CPIP delivery YTD reflects a plan of £10.4m with a Trust delivery of £7.2m resulting in a £3.2m 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 7, the forecast total of developed schemes (including MARP & NARP) amount to £12.5m, 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 – Elective Recovery

We are driving this measure because:

Capitalising on the elective recovery funding mechanism is key to successfully delivering the financial plan. Maximising the activity we undertake within the resources available will ensure best use of system resources and support financial sustainability

Performance & actions

2024/25 Plan & months 1-6
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 24/25 tariff's (Value weighted activity - VWA). For H&W this is 106% and we have been 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%
- **Financial:** We included £6.1m of additional income for over performing against our ERF target
- **Estimate in month** is based on a detailed calculation for H&W activity (92% of our activity) For Gloucestershire, Shropshire and Specialised Commissioning we used national data. At month 6 the latest national data was the 23/24 outturn position.
- At month 6, the positional across all commissioners, we were ahead of plan and if that continued we were forecasting performance over and above our plan

Update in October 2024 M7
There are a number of elements that have changed

- **Baseline**. New national VWA baselines were issued in the summer. Despite further investigation with national colleagues its unclear how and why those changes have been made, particularly to H&W which saw a £990k increase.
- **New tariffs**: updated 24/25 tariffs for the CUF (uplift of 3.3%) this impacted the baselines and actuals, including the ERF over performance which is now £6.4m
- **National data**: now available across all commissioners for 24/25 month 1-4.Shows deterioration of our activity performance for Shropshire.

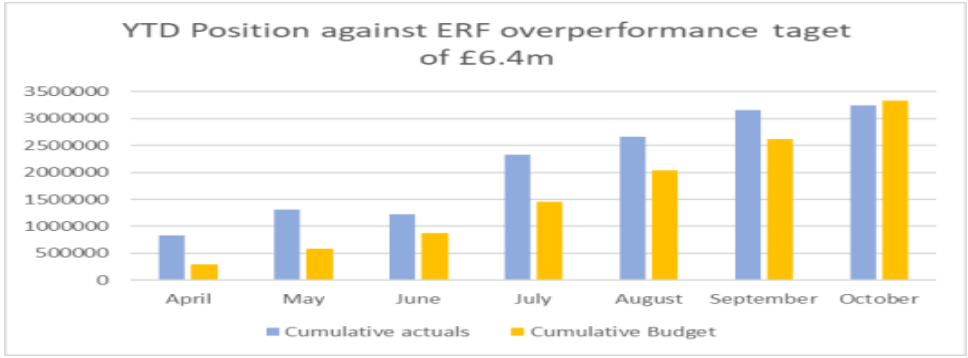
Month 7 Impact

- For H&W, despite the increased baseline, our performance remains strong, with the Trust delivering 120% of 19/20 VWA in month and 114.6% YTD. See table 1.
- At month 6 the estimate for the activity for the other commissioners reflected an underperformance of c£113k. At month 7 this had risen to £269k underperformance, driven be a combination of increase in baselines and decrease in performance.
- Overall this has resulted in us, YTD, being slightly behind the ERF over performance target. Continued strong activity performance should see us achieve our planned ERF over performance of £6.4m

Table 1: H&W ICB Baseline V Actual

Hefordshire ICB only 19/20 baseline V 24/25 actual	April	May	June	July	August	September	October
1920 BASELINE	£4,142,948	£3,954,684	£3,877,435	£4,427,044	£3,695,154	£3,897,051	£4,096,656
2045/25 Actuals	£4,267,697	£4,422,573	£4,349,864	£4,602,194	£4,303,130	£4,740,083	£4,917,197
In month actual % of 19/20	122.9%	119.4%	104.2%	117.2%	116.5%	121.6%	120.0%
YTD actual % of 19/20	122.9%	107.3%	108.9%	107.6%	109.2%	112.9%	114.6%

Chart 1: ERF over performance(YTD position)



Risks

Deterioration in the operational performance resulting in underachievement of ERF plans. . Non budgeted spend to achieve the elective activity

Mitigation - Close monitoring of activity performance and productivity.

What the charts tell us

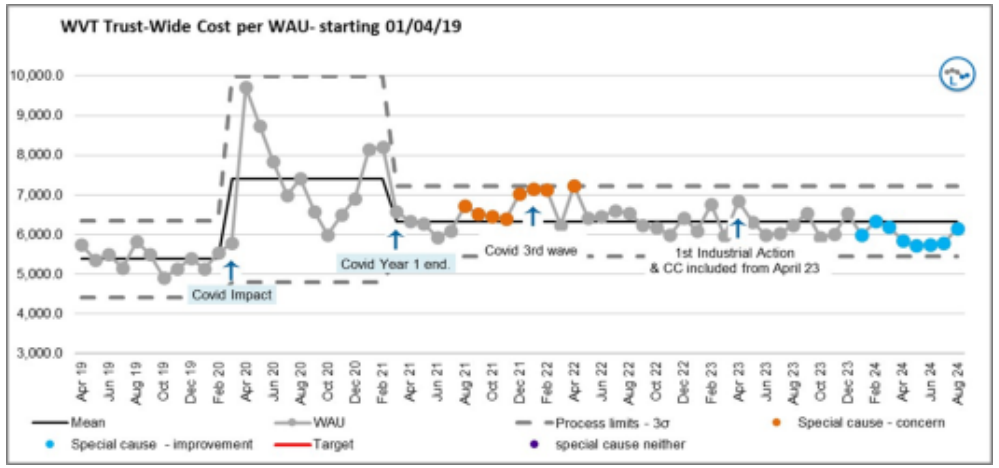
Despite the significant operational challenges activity levels of elective recovering and in line with target and planned level.

Finance Performance – Productivity Improvement

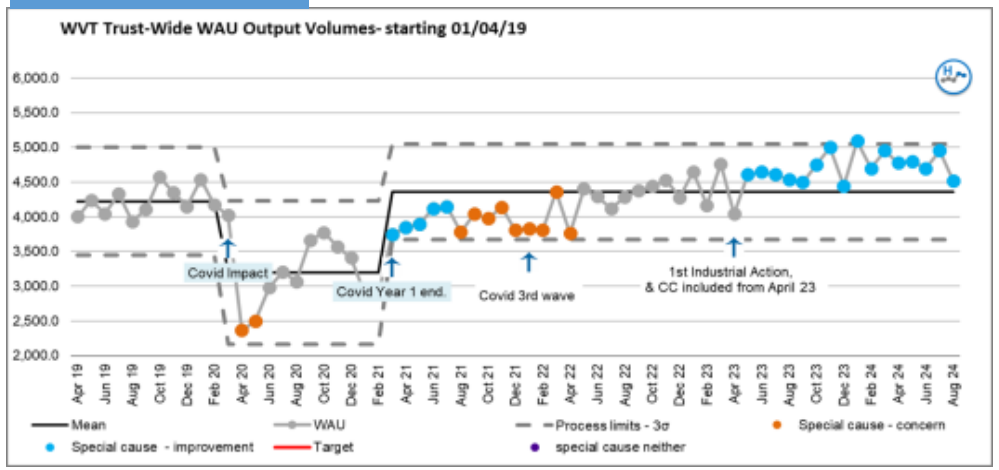
Cost per Weighted Activity Unit (WAU) – Group Aligned Methodology

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

Cost per WAU



WAU Output Volumes



Cost per WAU - Alignment in methodology across the Foundation Group

Work has recently been undertaken across the Foundation Group to agree and establish a methodology which could be adopted by each Trust when calculating the Cost per Weighted Activity Unit (WAU). This has resulted in an alignment of the base data, financials and inflationary adjustments used within the calculation and provides a more meaningful trend comparison across the Foundation Group.

The cost per WAU is reported two months in arrears. This is due to dependency on capturing fully coded data to achieve a more robust result.

Care must be taken when comparing WAU's reported in different places, e.g. model hospital, as data sources will vary and will not be directly comparable to the group methodology.

This WAU is a long term trend measure, and as productivity improves you would expect to see a reduction in the cost per WAU over time

What the charts tell us

The upper and lower control limits within the SPC Charts have been set based on three date ranges as follows:

- 11 months April 2019 to Feb 2020 (Pre Covid Impact)
- 12 months March 2020 to March 2021 (Main impact of Covid pandemic)
- April 2021 onwards (recovery)

Based on the above parameters the graphs show that despite the significant operational challenges overall activity levels are recovering. WAU output volumes have moved to be above the average and have remained so over the last 12 month period.

From Jan 2024 the cost per WAU is showing an improving position, indicating improved efficiency in delivering activity. Whilst productivity initiatives have started to deliver, we are not yet seeing the overall level of productivity required to improve the cost per WAU to the 2019/20 levels.

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	227	0	227	960	(484)
ICT - Hardware	Owned	782	294	10	284	782	0
ICT - Software	Owned	52	21	0	21	52	(0)
Estates Works	Owned	797	449	73	376	913	(116)
ESH 2324 Underspend	Owned	615	615	673	(58)	615	0
CDC 2324 Underspend	Owned	1,408	768	1,408	(640)	1,408	(0)
Clinical Equipment	Owned	343	132	40	92	323	20
ESH - Local Funding	Owned	2,924	1,500	0	1,500	278	2,646
CDC - Phase 2 initial funding	Owned	0	0	0	0	170	(170)
23/24 Cfwd	Owned	0	0	479	(479)	479	(479)
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*0*	(924)
System Capital Over-commitment	*Owned*	*(633)*	*(275)*	*0*	*(275)*	*(140)*	*(493)*
Total - Local CDEL funded		**5,840**	**3,731**	**2,683**	**1,048**	**5,840**	**(0)**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	5,982	3,458	2,524	10,972	(0)
Donated assets	Owned	240	111	0	111	233	7
Education Centre	Owned	0	0	46	(46)	500	(500)
Donated Clinical Equpt	Owned	33	0	0	0	33	0
Total - Grant funded and Donated		**11,245**	**6,093**	**3,504**	**2,589**	**11,738**	**(493)**
National funding							
Clinical Diagnostics Centre	Owned	11,460	6,202	1,503	4,699	11,460	(0)
Imaging PDC	Owned	0	0	0	0	415	(415)
ESH - PDC Funding	Owned	2,161	2,161	1,502	659	2,130	31
ICT - FLD	Owned	750	322	30	292	1,750	(1,000)
Total - National PDC schemes		**14,371**	**8,685**	**3,036**	**5,649**	**15,755**	**(1,384)**
Leases							
Vehicle	Lease	10	5	0	5	10	0
IFRS16 Clinical Equipment	Lease	400	161	308	(147)	400	(0)
Total - IFRS16 Leases		**410**	**166**	**308**	**(142)**	**410**	**(0)**
Total Capital Programme		**31,866**	**18,675**	**9,531**	**9,144**	**33,744**	**(1,878)**

Performance & actions

The lines in yellow reflect over-commitments within the capital position. The over-commitment is now £140k which has reduced as a result of savings on the ESH scheme. The savings have offset significant initial over-commitments.

Changes on last month
Additional ICT clinical schemes and Estate works schemes have been added to the programme through the operation of CPEC. The ESH local funding requirement forecast has also reduced significantly. The forecast position for IFRS16 equipment has also been reviewed downward with the attendant over-commitment removed.

Variance - Year to Date
The variance against local CDEL funded schemes has increased due the phasing of the plan stepping up against low expenditure in Month 07. Work will be undertaken to produce a cash-flow forecast for the remainder of the financial year in order to manage capital expenditure. IES and CDC are also behind plan. Whilst CDC is still expected to meet the plan by the end of the financial year, the IES programme (which is grant funded not CDEL) needs further review.

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. CDEL funded expenditure is currently projected to be in line with plan. The spend on the Education Centre funded by charitable funds also contributes to the full year variance against the plan.

Risks

The main risk relating to the over-commitment against capital resources has further reduced this this month as a result of lower costs relating to ESH .

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.

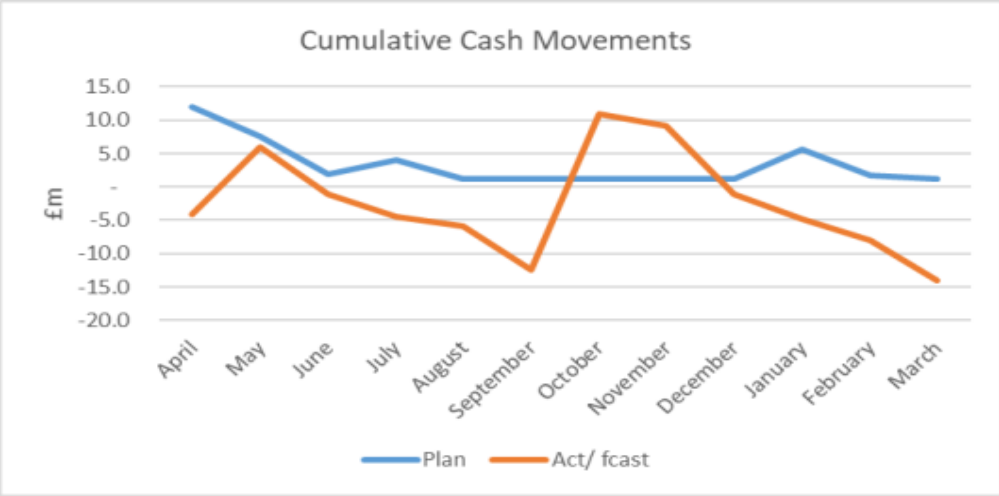
What the chart tells us

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
August	18.5	27.4		
September	13.9	27.4		
October	37.3	27.4		

Cash balances are higher than planned, in October, due to the non-recurrent deficit funding, an advance on pay award funding and slippage on the capital plan. Once the pay award is paid to staff, throughout the year and once the planned capital programme is spent then, CPIP non-delivery will lead to a greater monthly cash outflow than the trust has the ability to cover.

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
August	99.3%	95.0%		
September	99.3%	95.0%		
October	97.4%	95.0%		

In October, the Trust paid 97.4% of invoices within 30 days. This equates to 95.2% by invoice value. This is the tenth month, in a row, that we have achieved the 95% (by volume) target.

Performance & actions

Cash balances are higher than planned, in October, due to the receipt of non-recurrent deficit funding, an advance on pay award funding and slippage on the capital plan. The PAYE element of the backdated pay award will be paid out in November and the majority of the deficit funding will have been received by the end of December (see table below). This leads to a forecast reduction in cash over the final quarter of the year.

	Phasing of non recurrent income to support deficit							
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
£k	0	20,129	2,816	2,807	860	861	866	**28,339**

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.
- Liaison with the ICB and NHSE to confirm the payment mechanism for ERF over-performance to continue as no cash has yet been received for 24/25 (or the settlement of 23/24).

What the chart tells us

The month end cash balance has increased due to cash advance for the pay award (PAYE element) and the favorable phasing of the deficit support funding (compared to the phasing of revenue PDC support originally planned).

The Trust remains above the 95% target for Better Payment Practice although the performance in October is lower than previous months due to the Trust reducing creditor payment runs for the first few weeks to ensure sufficient cash balances to cover the backdated pay awards.

Finance Performance – Statement of Financial Position

We are driving this measure because:

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

Statement of Financial Position

September 2024	2023/24	2024/25			2024/25 Full Year		
	Accounts £000s	M7 Plan £000s	M7 YTD £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	151,182	158,666	151,232	7,434	167,117	169,102	1,985
Intangible Assets	14,359	12,178	10,895	1,283	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	408	408	0
TOTAL Non Current Assets	**165,949**	**171,252**	**162,549**	**8,703**	**178,445**	**180,430**	**1,985**
CURRENT ASSETS:							
Inventories	4,878	4,878	5,071	(193)	4,878	4,878	0
Trade and Other Receivables	35,635	21,456	28,658	(7,202)	28,856	47,356	18,500
Cash and Cash Equivalents	26,228	27,447	37,349	(9,902)	27,447	10,081	(17,366)
TOTAL Current Assets	**66,741**	**53,781**	**71,078**	**(17,297)**	**61,181**	**62,315**	**1,134**
TOTAL ASSETS	**232,690**	**225,033**	**233,627**	**(8,594)**	**239,626**	**242,745**	**3,119**
CURRENT LIABILITIES							
Trade and other payables	(37,101)	(37,631)	(44,920)	7,289	(37,275)	(37,275)	0
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(6,487)	(6,206)	(12,693)	(13,538)	(845)
Provisions	(192)	(192)	(46)	(146)	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(50,516)**	**(51,453)**	**937**	**(50,160)**	**(51,005)**	**(845)**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**3,265**	**19,625**	**(16,360)**	**11,021**	**11,310**	**289**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**174,517**	**182,174**	**(7,657)**	**189,466**	**191,740**	**2,274**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(53,916)	(44,060)	(52,782)	8,722	(42,935)	(42,935)	0
Provisions	(1,619)	(1,619)	(1,736)	117	(1,619)	(1,590)	29
Total Non-Current Liabilities	**(55,535)**	**(45,679)**	**(54,518)**	**8,839**	**(44,554)**	**(44,525)**	**29**
ASSETS LESS LIABILITIES	**127,165**	**128,838**	**127,656**	**1,182**	**144,912**	**147,215**	**2,303**
TAXPAYERS EQUITY							
Public dividend capital	306,421	327,544	310,344	17,200	351,694	325,658	(26,036)
Revaluation reserve	22,047	22,047	18,107	3,940	22,047	18,107	(3,940)
Income and expenditure reserve	(201,303)	(220,753)	(200,795)	(19,958)	(228,829)	(196,550)	32,279
TOTAL	**127,165**	**128,838**	**127,656**	**1,182**	**144,912**	**147,215**	**2,303**

Performance & actions

General
The table identifies the statement of financial position as at 31 October against the plan. The forecast for the year has been updated to reflect both the revised I&E plan and a cash forecast more aligned to the current run rate.

Non-Current Assets
Non-Current assets are £9m lower than plan due to slippage in the capital programme (see capital section, above).

Working balances
Net working balances - receivables less payables - have remained in line with plan. Cash balances are £9.9m better than plan, largely due to a favourable phasing of the deficit support income and a cash advance from the ICB to cover the impact of backdated pay awards on PAYE which is paid in November.

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

Taxpayers Equity
PDC is lower than plan as less additional PDC has been drawn because of slippage in our capital programme and the additional income for deficit funding negating the requirement to draw PDC revenue support.
The revaluation reserve has reduced, compared to the plan, reflecting a correction between the revaluation reserve and the I&E reserve identified during the year end audit.
The income and expenditure reserve reflects the deficit for the year to date.

Risks

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

What the chart tells us

Current assets outweigh current liabilities. Although higher than planned at the end of October, cash balances are forecast to be lower than planned by the end of March.

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High		78.6%	80.8%	79.0%	77.3%	77.1%	77.0%	77.8%	79.2%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause		96.9%	95.8%	86.9%	93.4%	88.4%	87.8%	88.5%	92.1%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		83.3%	79.3%	47.6%	32.1%	20.0%	48.4%	43.8%	39.1%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause		80.8%	89.2%	84.8%	85.5%	90.7%	88.2%	89.3%	89.8%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		4	12	14	11	10	12	2		
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	71.1%	63.0%	64.5%	75.7%	76.6%	53.5%	74.8%	75.4%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Improvement - High		100.0%		80.0%	100.0%	100.0%	83.3%	77.8%	100.0%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		76.9%	61.8%	72.4%	63.3%	65.5%	68.1%	65.7%	90.5%	
	Cancer: number of urgent cancer patients waiting over 62 days	Cancer		No Target	Common Cause			71	72	93	85	93	88	61	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		115.1%	102.8%	112.7%	113.8%	101.0%	114.9%	111.5%	109.0%	123.6%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		89.7%	90.3%	87.0%	84.7%	85.7%	86.8%	86.9%	87.4%	86.3%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Improvement - High		109.3%	104.3%	107.7%	107.4%	99.6%	100.0%	102.2%	103.4%	101.2%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Concern - Low	Yes	65.8%	71.4%	73.3%	72.7%	66.4%	65.8%	75.9%	62.9%	51.1%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		17.0%	12.2%	10.2%	10.5%	15.4%	18.7%	14.5%	18.8%	29.1%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		123.3%	119.5%	114.4%	111.5%	112.2%	113.5%	114.6%	120.3%	119.2%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		46.0%	45.0%	46.2%	46.9%	47.4%	46.1%	42.3%	44.3%	48.0%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause		54.9%	65.5%	68.8%	68.1%	66.4%	68.3%	67.6%	65.8%	65.8%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause	Yes	16.9%	12.2%	11.9%	11.7%	12.3%	12.4%	10.8%	12.5%	12.4%
	A&E - Time to treatment	Urgent and emergency care		No Target	Concern - Low		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care		No Target	Improvement - Low		1.7%	1.7%	1.8%	1.8%	2.0%	1.9%	1.9%	1.8%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		306	250	292	318	291	330	312	284	270
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		8.5%	8.1%	8.1%	7.8%	8.0%				

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		56.3%	55.4%	54.5%	55.6%	55.8%	55.7%	55.6%	55.1%	55.8%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		67.6%	68.3%	67.8%	68.2%	70.0%	70.3%	69.4%	69.5%	70.0%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		27256	27780	28130	28574	29179	28848	28708	28783	28761
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Common Cause	Yes	1287	1152	1171	1198	1285	1140	1169	987	865
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		16	9	6	13	15	14	14	9	4
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		1	0	1	2	3	1	3	2	1
	GP Referrals	Elective care		No Target	Common Cause	Yes	119.6%	134.4%	115.6%	102.9%	90.8%	102.0%	86.3%	93.2%	
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		116.0%	129.1%	112.9%	113.3%	110.3%	113.6%	114.1%	111.2%	116.6%
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Improvement - High	Yes	112.6%	83.4%	109.6%	105.7%	84.8%	114.6%	98.4%	82.9%	111.4%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		109.2%	123.8%	115.5%	117.9%	113.9%	119.2%	114.9%	110.0%	112.3%
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	120.0%	89.3%	112.8%	111.9%	88.0%	122.9%	106.6%	90.2%	114.7%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		106.5%	121.0%	112.4%	110.5%	99.1%	102.2%	104.9%	110.0%	107.4%
	Total Elective Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	112.6%	83.9%	119.0%	112.8%	86.2%	100.8%	91.3%	87.7%	104.4%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause		79.0%	79.8%	77.2%	77.9%	79.7%	76.9%	78.7%	80.2%	79.5%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		36	31	32	24	39	42	40	32	25
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Improvement - High		111.0%	107.5%	111.8%	126.5%	129.5%	104.0%	100.7%	118.0%	104.4%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Common Cause	Yes	150.3%	99.3%	130.4%	98.1%	76.6%	156.2%	126.9%	93.3%	91.4%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Improvement - High		95.3%	148.8%	120.5%	130.6%	119.2%	115.1%	111.1%	116.2%	113.6%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Improvement - Low		15.6%	21.5%	24.7%	24.8%	30.2%	30.0%	27.8%	17.2%	15.1%

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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		92.1%	93.8%	94.4%	93.9%	90.6%	95.5%	95.1%	88.9%	94.6%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause	Yes	24.3%	19.5%	19.0%	16.0%	16.3%	14.2%	16.3%	15.6%	16.2%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Common Cause	Yes	64.6%	62.9%	60.6%	55.5%	54.7%	54.8%	55.7%	55.3%	55.6%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Common Cause		88.2%	87.0%	85.5%	87.3%	86.3%	88.5%	88.1%	85.9%	87.8%
	Maternity Activity (Deliveries)	Elective care		No Target	Common Cause	Yes	115.0%	99.3%	99.2%	83.9%	113.8%	93.4%	85.6%	108.4%	92.9%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.2%	6.0%	6.3%	6.3%	6.6%	6.5%	7.8%	6.5%	5.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High		86.5%	87.0%	86.7%	88.0%	87.6%	88.8%	89.9%	89.3%	88.8%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		106.2%	121.5%	116.8%	120.2%	115.7%	121.9%	115.3%	109.4%	110.5%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Improvement - High	Yes	123.8%	92.3%	114.4%	115.0%	89.6%	127.0%	110.6%	93.9%	116.3%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Fail	Improvement - Low		19.8%	19.2%	20.2%	20.5%	19.5%	19.1%	19.5%	19.6%	19.2%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term		No Target	Improvement - Low	Yes	8.8%	6.3%	11.2%	5.3%	10.1%	6.5%	4.1%	7.4%	4.8%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	98.6%	99.8%	99.9%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		89.5%	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	Common Cause	Yes	65	74	54	99	84	70	134	204	348
	Patient ward moves emergency admissions (acute)	Safe, high quality care		No Target	Common Cause		10.1%	8.8%	8.5%	9.5%	8.9%	8.2%	7.4%	7.1%	
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		7	7	6	6	6	6	7	6	7
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause	Yes	3	3	3	2	3	3	3	3	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Concern - Low		21.4%	18.7%	18.8%	15.3%	14.1%	15.6%	17.1%	13.8%	15.5%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Common Cause	Yes	51.6%	50.1%	46.2%	42.6%	47.4%	48.9%	50.1%	47.5%	53.1%
	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%				

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Safe, high quality care	HSMR - Rolling 12 months	Safe, high quality care	<= 100	Variable	Common Cause	Yes	100								
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Improvement - Low		100	98	98	100	100				
	Never Events	Safe, high quality care	0	Variable	Common Cause	Yes	0	0	1	0	0	0	0	0	0
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Concern - Low		1	0	0	0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause	Yes	2	2	1	0	4	2	1	0	0
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care	44	Fail	Common Cause	Yes	3	2	6	6	5	9	10	6	2
	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		2	1	1	4	2	2	3	2	2
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Concern - Low		89.2%	89.3%	90.0%	88.7%	89.4%	88.5%	87.4%	88.2%	85.5%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Concern - Low	Yes		99.4%			98.0%			98.7%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Common Cause		66.7%	63.0%	64.4%	50.9%	63.2%	74.4%	73.9%	65.8%	
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause		60.0%	33.3%	0.0%	66.7%	20.0%	33.3%	0.0%	66.7%	
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause		78.0%	83.1%	77.8%	75.0%	78.7%	89.2%	87.5%	76.5%	
	Number of complaints	Safe, high quality care		No Target	Concern - High	Yes	29	38	45	31	30	29	20	31	47
	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	37.9%	35.3%	44.8%	39.4%	50.0%	53.8%	51.6%	50.0%	53.6%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		75.7%	81.2%	81.0%	81.1%	78.7%	79.3%	79.1%	74.5%	79.0%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Concern - Low		81.7%	88.6%	86.0%	82.7%	84.5%	80.7%	84.2%	83.2%	87.9%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		92.6%	91.3%	96.9%	85.7%	96.6%	94.4%	85.7%	90.2%	97.0%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Improvement - High		21.0%	20.0%	19.0%	19.0%	20.0%	18.0%	20.0%	18.0%	18.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		16.0%	17.0%	18.0%	16.0%	18.0%	15.0%	17.3%	15.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		23.0%	16.0%	28.0%	25.0%	24.0%	31.0%	32.0%	30.0%	28.0%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		8.1%	6.0%	5.5%	6.3%	5.5%	5.9%	5.8%	4.5%	4.1%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	71.8%	70.8%	75.9%	79.2%	80.3%	80.2%	80.3%	79.8%	80.1%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		88.8%	88.4%	89.2%	89.8%	89.7%	89.7%	89.5%	88.0%	88.3%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Improvement - Low		5.7%	4.0%	4.7%	4.6%	4.8%	5.1%	4.7%	5.0%	5.3%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		10.1%	10.4%	9.0%	9.2%	9.4%	9.5%	9.8%	9.7%	9.4%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%	3.9%	

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Concern - High	Yes	£9902k	(£9316k)	(£3387k)	(£3387k)	(£3387k)	(£4957k)	(£3686k)	£12576k	(£602k)
	I&E - Margin (%)	Finance		No Target	Concern - High	Yes	£0k	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)
	I&E - Variance from plan (£k)	Finance		No Target	Common Cause		(£3019k)	(£13529k)	(£410k)	(£469k)	(£524k)	(£1793k)	(£606k)	(£645k)	(£178k)
	I&E - Variance from Plan (%)	Finance		No Target	Common Cause		(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)
	CPIP - Variance from plan (£k)	Finance		No Target	Common Cause	Yes	(£830k)	£906k	(£433k)	(£580k)	(£566k)	(£844k)	(£811k)	£539k	(£498k)
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low		£1596k	£1127k	£1069k	£1027k	£1048k	£953k	£725k	£573k	£755k
	Agency - expenditure as % of total pay	Finance		No Target	Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance		No Target	Common Cause		(£689k)	(£1572k)	(£14k)	£178k	(£522k)	£785k	(£284k)	(£242k)	(£697k)
	Cash - Balance at end of month (£m)	Finance		No Target	Concern - High	Yes	£23k	£19k	£22k	£30k	£23k	£22k	£18k	£14k	£37k
	BPPC - Invoices paid <30 days (% value £k)	Finance		No Target	Common Cause		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance		No Target	Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**5.12.24**
Title of Report:	CNST Board Exception 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:	Click or tap here to enter text.

1. Purpose of the report

To provide Trust Board with an overview of performance against CNST Year 6 standards.

To request Board delegation of sign off for Saving Babies Lives Care Bundle V3 and overall CNST compliance to Quality Committee at the end of January 2025.

2. Recommendation(s)

Board is asked to approve the request for delegated sign off of SBLCBV3 and CNST.

3. Executive Director Opinion[1]

The position described in this update report is the assessment of the maternity service and local LMNS as of the end of November 2024. The work to progress the remaining standards is ongoing and is anticipated to achieve full compliance.

[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***

CNST Year 6 Progress Report

Executive Summary
Maternity services are reporting to Trust Board the compliance against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 6. The Board is asked to note progress against each of the 10 safety actions set out within the MIS standards.

Within this report, there are a number of requests made to Board for approval. These requests are clearly identified by **bold underlined text** in each of the relevant sections.

In order to comply with the scheme, and to be eligible for payment under the scheme, Trusts are required to submit their completed Board declaration form to NHSR by 12 noon on the 3rd March 2025. In line with the approach in 2022 and 2023, we are seeking LMNS support with quality assurance of each safety action again this year.

In view of the LMNS quality assurance requirement, and required sign off of Safety Action 6 by the LMNS Board in January and noting WVT Board meeting schedule **we request the delegation for sign off of CNST to Quality Committee, which will be held on the 30th January.**

Safety Action 1: Status - Compliant
The service is required to review all perinatal deaths above 22 weeks gestation, to a required standard using the national Perinatal Mortality Review Tool (PMRT). The qualifying period is deaths from 8th December 2023, and the service confirms there have been 13 deaths meeting the criteria in this time period. Under the technical guidance, Trusts are required to partner with another Trust to ensure learning can be taken from reviews conducted. There are clear requirements to notify MBRRACE within 7 working days and this has been achieved in 100% of the cases. Parent's views are required to be sought in at least 95% of cases and this has also been achieved. Reviews of deaths should be started within two months and completed and published within 6 months, this has also been achieved. To achieve this, the team have partnered with the team at Worcester Acute Hospital Trust on a monthly basis throughout this time period and are able to evidence through minutes and actions that this has been achieved. Additionally, where a woman who has received antenatal care with us and has a baby that dies in another Trust, we partner with that Trust to undertake a joint PMRT and ensure learning is taken. We have provided Quarterly reports on this details to Quality Committee and Board to evidence and comply with this standard.

Safety Action 2: Status - Compliant
The service is required to submit data to the Maternity Services Data Set (MSDS) to a required standard. This is an externally verified process and we have confirmed compliance with this standard.

Safety Action 3: Status – Compliant
The service is required to demonstrate that Transitional Care Services are in place to minimise separation of mothers and their babies. The pathways to Transitional Care are well established and meet the criteria as set out within this action. In addition, this year has required the team to identify themes from term admissions and undertake a quality improvement initiative. This has been completed and shared with Quality Committee previously and therefore no further sign off is required.

Safety Action 4: Status – Compliant
The service is required to demonstrate an effective system of clinical workforce planning to the required standard. This is separated into 4 subcategories:
a) Obstetric medical workforce

The Trust meets the standards set out within section 1, 2 and 4 of this standard with regard to employment of long and short term locums, and the presence of the Obstetric Consultant at specified clinical scenarios as outlined in the RCOG Roles and Responsibilities document. This is reported monthly within the PQSM report. However, the Trust is encouraged to implement the RCOG guidance for compensatory rest for Consultants on-call, however we are not currently able to achieve the standard set out. We are able to declare compliance without implementation, but wish to assure Board we remain committed to maintaining existing safety measures to ensure clinicians can continue to work safely and effectively.

b) Anaesthetic medical workforce – compliant

We meet, and can evidence the standards set out in this section.

c) Neonatal medical workforce – compliant

We meet, and can evidence the standards set out in this section.

d) Neonatal nursing workforce - compliant

The Neonatal nursing workforce does not currently comply with BAPM standards. In CNST Year 4 and 5 a report and action plan were submitted to Trust Board. The requirement in Year 6 is to share the progress against the action plan with Trust Board. This was shared in the November paper to Quality Committee and Trust Board.

Safety Action 5: Status – Compliant

This action requires the service to demonstrate an effective system of midwifery workforce planning to the required standard (i.e. in line with Birthrate Plus or other recognised tool). The element requires a staffing report to be submitted to Board every 6 months. Within this requirement we report on staffing every month within PQSM, and a more detailed report within with quarterly reports.

Safety Action 6: Status – Awaiting Confirmation

There are 6 elements within this years' Saving Babies Care Bundle and the team have divided the work amongst the specialist roles. The requirement to achieve CNST standards is full implementation of SBLCB. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. The LMNS are required to review the evidence and confirm compliance over 2 quarters. The first check has been undertaken and we are awaiting the result and feedback which we will share at the next Quality Committee. The team will continue to progress the work, with every effort being made to achieve compliance. Following the LMNS feedback, **Trust Board is asked to delegate sign off to the Executive and Non-Executive Safety Champion and Chair of Quality Committee.**

Safety Action 7: Status – Compliant

This action requires the service to demonstrate listening to women, parents and families using maternity and neonatal services and coproduce services with users. Our MVP service is running effectively in line with standards and the LMNS have a role in demonstrating compliance in this element.

Safety Action 8: Status - Compliant

This action is linked to the multi-disciplinary training compliance which is set to 90% across each professional group – to be achieved by 1st December. The training has been met at 90% compliance across all relevant elements of Fetal monitoring training; Multi-professional maternity emergencies training (PROMPT) and Neonatal Life Support Training (NLS) across each applicable staffing group.

Safety Action 9: Status – Awaiting LMNS confirmation

There are reporting requirements within the action that we believe have been met and this action is being submitted to the LMNS for an early peer review to determine compliance.

Safety Action 10: Status – Compliant

Services are required to report 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 8th December 2023 to 30th November 2024. We are fully compliant and this can be demonstrated in the table above.

Case date	Statutory Duty of Candour	Referred to HSIB/MNSI	Referred to NHS Resolution	Parents given information regarding NHS Resolution (letter sent)
October 2024	Yes, completed verbally and in writing.	Yes and accepted	N/A – not met criteria	N/A
November 2024	Yes, completed verbally and in writing.	Yes and accepted	N/A – not met criteria	N/A

The service is working at full pace to achieve 10/10 standards again this year.

The LMNS will peer review and sign off compliance with CNST in January. As there in no January Board meeting and February is a Foundation Group Board, **Trust Board are requested to delegate sign off to Quality Committee at the end of January.**

Report Ends

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Use of the Trust Seal
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Company Secretary
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authorities.

The Board is required to endorse the use of the Trust Seal.

Following completion of the Elective Surgical Hub in July 2024, the Trust is now in receipt of the collateral warranties associated with the various design elements of the building (M&E, Structural, SIPS panels, etc)

In line with the NHS ProCure23 process and the NEC4 Contract the use of the Trust Seal is required.

2. Recommendation(s)

The Board is asked to endorse the use of the Trust Seal as described above.

3. Executive Director Opinion[1]

[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	***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***	

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Perinatal Safety Report (Quarterly)
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Attached as appendices; • Perinatal Dashboard – Appendix 1

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 of the quarterly exception report and pursue any key lines of enquiry.

3. Executive Director Opinion[1]

This report and the further confidential detail has been provided to Quality Committee, the following key points are to be noted:

- The Insight report will be shared with Quality Committee when received
- Work is on track to achieve CNST compliance with support and review provided by LMNS colleagues
- The robust review of stillbirths and neonatal deaths is welcome with confirmation that lessons are learnt and associated Quality improvement projects in place.

[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 – November 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 the monthly reporting requirement data for October 2024 and the quarterly elements will cover Q2 (July-Sept 24). The report is shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board.

2. PERFORMANCE

2.1 **Activity**

There were 130 births in October, which is average for the service.

Midwife to birth ratio (<1:24)	1:23

The ratio in September rose to 1:27 which was the worst it has been for the year. Following the successful induction of the newly qualified midwives and a reduction in the vacancy and sickness rates, this has contributed to an improved position this month, and is expected to continue.

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 are recorded as:

	October
Delay in Induction >2hrs	0
Delay in Catagory 1 C-Section >30mins	1
Delay in administering medication	0
Delay in starting syntocinon/ARM >30mins	1
Delay in Suturing >60mins	0
Unable to provide 1:1 care in labour	0
Delay in Triage >30mins	0
Community midwives on call covering maternity unit	1
Any movement of midwifery staff from any area to provide midwifery cover	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

The red flag incident for delay in induction of labour has been reviewed and no issues were identified for either mother or baby. The women were offered fetal and maternal monitoring to ensure there were no emerging risks and their safety could be maintained. The case for the delay in Cat 1 CS was only identified whilst undertaking a review of the dashboard and has since been reported and will be subject to review.

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 October is noted as:

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	N/A	
Caesarean birth for women with BMI>50	0	N/A	
Caesarean birth <28/40	0	N/A	
Premature twins (<30/40)	0	N/A	
4th degree perineal tear repair	0	N/A	
Unexpected intrapartum stillbirth	0	N/A	
Eclampsia	0	N/A	
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%	Consultant attendance in both scenarios.

3. SAFETY

3.1 Incidents

To provide Board oversight and assurance, this report aligns to the PQSM Minimum Data Set requirement and provides detail on incidents graded moderate or above; including incidents reported to MNSI (formerly HSIB), NHS Resolution Early Notifications/Claims. Whilst we transition to improved ways of working under PSIRF, this report also provides detail on cases determined as a PSII and any cluster reviews under the PSIRF umbrella.

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee, a forum where scrutiny and assurance are gained, and is restricted to the 'private' section of Board.

3.1.2 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
October	1	1	1	0	0	0	0

Please note the 1 case in each category above relates to the same case.

3.2 Concerns and Complaints

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is potentially patient identifiable and is therefore not shared in public board but the detail is provided within the Minimum Data Set and shared with Quality Committee. The high level numbers are included here.

	Concerns	Complaints
October	0	4

3.2.1 One key note is that although the complaints have been raised in October, they relate to care provided over a broader range of time and there is no correlation to events that happened during October. A review of complaints year to date has been undertaken with the main themes being communication and clinical treatment. However, there are no links across the individual concerns and this is not limited to small number or one group of staff.

3.2.2 There is wider work underway with publishing the management plans to Badgernet so that women are able to see these records. We have also stopped the use of the pre-populated management plans

to ensure that management plans are individualised to the woman and remain up to date with the current situation at the time of her presentation.

3.2.3 We are working across the department to support staff attendance at the NHSE free Personalised Care training packages, and have rolled out BirthRights training for a number of staff who will be champions. We are also re-launching the BRAIN pneumonic which will support better informed decision making and this closely links with our findings from PMRT and incidents too.

3.2.4 We monitor and theme all feedback from women through debriefs and this is now collated within the debrief tracker. We also monitor feedback from Friends and Family testing which is largely positive at 95.45% for Delivery Suite and 100% for the Maternity Ward. Some reassurance should be taken from the Friends and Family feedback where staff attitudes and communication are in the top ten positives.

3.3 **PMRT (Perinatal Mortality Review Tool) / MBRRACE Performance**

Throughout 2024, there has been an increase Year to Date on the number of stillbirths and neonatal deaths in WVT compared with previous years.

	Stillbirths	Neonatal Death
2024 (Jan-Oct)	**6**	**2**
2023	3	1
2022	3	2

3.3.1 CNST requires the service to provide a quarterly PMRT summary of the reportable cases, specified by MBRRACE criteria:

- Late fetal loss (between 22+0 and 23+6 weeks)
- Stillbirths (24+0 onwards)
- Early neonatal death (from 20 weeks gestation within 7 days of birth)
- Late neonatal deaths (between 8-28 days of birth) or cases joint with another hospital

3.3.2 In line with CNST Safety Action 1, the report includes details of the deaths reviewed, highlights themes identified and the consequent action plans. The report evidences that the PMRT has been used to review eligible deaths and meets the required standards of a) notification of all eligible deaths, b) seeking parents' view of care and c) reviewing the death and completing a review within specified timeframes. This detail is discussed at quality committee and provided in the minimum data set yet not shared at public board due to the nature of the information that is potentially identifiable.

3.3.3 In summary, all cases have been appropriately reported to MBRRACE and managed within the appropriate timescales meeting the prescribed standards.

3.3.4 **Themes:**
Preterm Prediction / referral: 3 cases
GROW monitoring for OOA women: 2 cases
OOA / cross boundary: 3 cases

3.3.5 **Health Inequalities:**
Ethnicity / Non-English first language: 3 cases
Deprivation: 1 case
Smokers: 1 case

3.3.6 **Actions:**

In response to the findings a number of actions have been commenced.

Preterm Birth Prevention

Over Q1 the PMRT reviews identified issues where women should have been referred for the Preterm Pathway and were not appropriately referred; or there were issues with the monitoring of fetal growth. In some cases it was felt that missed opportunities contributed to the poor outcomes. The service has since devised an audit tool and began undertaking a thematic review of preterm births. This includes babies with poor outcomes, but also cases of pre-term birth for babies under our care whether they delivered in our Trust or were transferred out and delivered. This allows identification of key themes for improvement. The service has partially complete this with the newly appointed Consultant Midwife being the named lead for the QI project.

The series of actions have been broken down into 4 sections and the team are developing robust actions for each of the following:

Prediction – ensuring the pathway is fit and functional to ensure all women are appropriately and accurately identified where there is a risk of pre-term birth.

Prevention – ensuring that once women are identified (predicted) then they will be appropriately referred to the correct pathway where preterm clinic will ensure all aspects of care are delivered to prevent pre-term birth. This work includes a full review of the policy and guidelines and this is being supported by colleagues at Worcester Acute Hospitals Trust.

Pre-term Optimisation – ensuring when women present with threatened labour, that they are managed appropriately to birth in the most appropriate setting, and that the right treatments and pathways have been offered / delivered.

Peri-prem passport – this is the parent based passport to support the delivery of pre-term care and can only be launched once all other aspects of the preterm work are effective.

Out of Area GROW chart

We had noted a number of issues with the generation of GROW charts, particularly with women from Powys, where Badgernet is not in use. We have since signed data sharing agreements which have allowed appropriate sharing of this documentation. We are currently working to now share the learning across the team to ensure all professional groups understand how to access and use the charts for out of area women.

3.4 **TRIANGULATION**

3.4.1 The service uses all of its knowledge from safety information and service user feedback to determine key learning and actions. This informs the improvement initiatives taken across the service. All immediate actions reported in the previous report have been completed. The NHS CNST Year 6 document requires Trusts to review the data from the Claims Scorecard, alongside the Complaints / Incidents / PMRT to determine themes and identify relevant learning and subsequent actions. Below is the recommended National template and will be reported quarterly. This covers Q2 (Jul-Sept).

Claims Scorecard April 13 – March 23

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

Complaints Q2 24-25 (N=3)

Communication (3)
Clinical Treatment (3)
Consent (2)
Accuracy of records (1)
Inappropriate procedure (1)

Incidents/PMRT Q2 24-25

PPH > 1.5litres (20)
Missed OOA discharges from Gloucester (3)
Issues with Grow charts for OOA women (2)
Urine Retention Issues (1)
Blood administration / Anti D (2)

Themes Q2 24-25

- Prevention of Preterm Birth
- PPH management
- Discharge management / OOA practice
- GROW review for OOA women
- Blood administration / Anti D

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

NHS Wye Valley NHS Trust

Learning Q2 24-25

There are issues with referrals in to Preterm birth clinic
There are concerns with the management of PPH – this is improving but further work ongoing
Some Out of Area practices need improving including communication around discharges and GROW monitoring

Action Plan Q2 23-24 Not started | In progress | Completed

Work with clinical leads to improve ward round attendance	By 30.09.24 (EH)
PPH thematic review and subsequent action plan	By 30.09.24 (AS)
Devise a comms strategy with LMNS re: partners staying	By 30.12.24 (CL)
Book FREE Coms for Personalised Care Training all staff	By 30.09.24 (CL/EH)
Preterm birth action plan delivery	By 31.01.25 (CL/MC)
Review issues / improve process GROW charts OOA	By 30.12.24 (AM)
Share Movements Matter Campaign local and with Powys	By 31.08.24 (AS)
Review Bladder Policy specific to maternity / Urology input	By 30.12.24 (CL)
Review Discharge process with Gloucester	By 31.09.24 (AS)
Review / improve internal discharge process	By 14.12.24 (AM/MC)

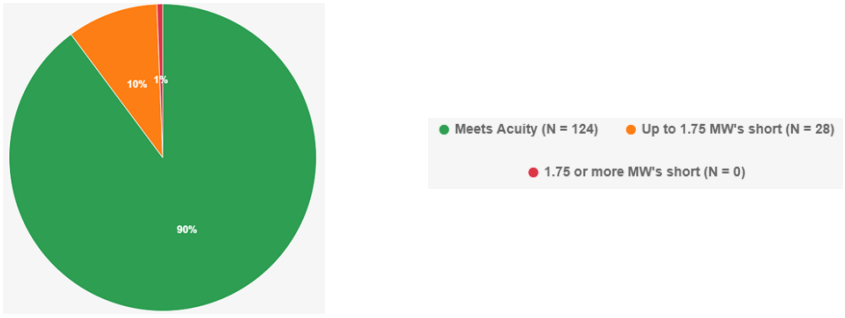
4. WORKFORCE

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 89.8% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 90% of the time. For 10% 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. The chart format within Birthrate Plus Acuity Tool has changed to a monthly overall chart as noted.



4.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 30 instances of staff being redeployed internally to cover acuity, for example from another clinical area

to Delivery Suite. In a small service, this is reasonable as it demonstrates flexibility within the service to meet acuity needs. There were 5 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 6 occasions where acuity was escalated to the manager on call for support.

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	30	65%
MA2	Redeploy from community	5	11%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	4	9%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	1	2%
MA10	Escalate to manager on call	6	13%
MA11	Maternity Unit on Divert	0	0%
TOTAL		46	

*The % is rounded to nearest whole number

4.1.3 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November 2023. The workforce has an improving position for the month of October with long term sickness within Maternity Triage and Antenatal Clinic being the most predominant factors, accounting for the increase in the midwife extra hours in these areas. Sickness has increased to 7.18% for midwives and reduced to 6.26% for support workers. The Management Team are supported well by HR colleagues to support and facilitate staff wellbeing and improved sickness rates.

	Fill Rate %					
	MW contracted	MW extra hrs	MW bank only	MSW contacted	MSW extra hrs	MSW bank only
AN clinic/DAU	86.96%	1.09%	0%	67.39%	8.70%	0%
Community	90.38%	5.84%	0%	85.14%	4.05%	0%
Delivery Suite	88.78%	3.06%	0.26%	82.26%	4.84%	8.06%
Maternity Ward	87.1%	4.03%	0.40%	66.13%	8.06%	11.69%
Triage	83.87%	6.85%	2.02%	16.13%	4.84%	50.00%

4.2 **Obstetric workforce**

4.2.1 The obstetric rotas have been covered throughout October as outlined below. The Obstetric workforce is in a positive place as a new Obstetric Consultant joined the team in September and has taken them to full complement. The Obstetric workforce has remained compliant with the RCOG standards for recruitment of Locums during the CNST year as no short-term locums have been recruited over the period.

	Substantive fill	Substantive fill rate%	Substantive extra fill	Sub. extra fill rate %	Locum fill	Locum fill rate%
Consultant: hot week	230/230 hrs	100%	0	0%	0	0%
Consultant: on call	537/537 hrs	100%	108/537 hrs (S Hobern support)	20%	0	0%
Consultant: cold week	88/104 hrs	85%	16/104 hrs	15%	0	0%
Consultant: antenatal clinic	72/72 hrs	100%	0	0%	0	0%
Middle Grade: delivery suite	202.5/207 hrs	98%	4.5/207 hrs	2%	0	0%
Middle Grade: antenatal clinic	144/198 hrs	73%	54/198 hrs	27%	0	0%

4.3 Neonatal Medical Workforce

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that the Neonatal Medical Workforce does not use locum support as they are fully funded and recruited to BAPM standards.

4.4 Anaesthetic workforce

4.4.1 The anaesthetic rotas have been covered throughout October 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	28	90%	20	65%
Anaesthetist extra days	3	10%	11	35%

Factors contributing to the rota gaps include long term sickness, and reduced duties due to pregnancy. The gaps are likely to be improved by December where an anaesthetist will join the team from theatres.

4.5 MDT ward rounds

4.5.1 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 October has fallen again following an improvement in September. This has been escalated to the CL and CD in anaesthetics. The Obstetric team have hit 100% for both day and night.

	08:30	20:30
Anaesthetist	97%	81%
Obstetric Consultant	100%	100%
Ward round completed	100%	100%

4.6 Neonatal Nursing

4.6.1 The Neonatal Nursing workforce is outlined as:

Nursing position	Budgeted WTE	Contracted WTE	Maternity leave	Long term sickness
Band 7	2.0	2.0	0	0
Band 6	5.2	5.13	0	0
Band 5	10.5	10.26	0.92	0
Neonatal Outreach	1.26	1.26	0	0

October 2024	QIS expected standard 70%	QIS against Neonatal Toolkit on shift	
	44%	95%	

5. COMPLIANCE

5.1 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. All staff who are out of compliance across each professional group, and across each programme of training has been booked onto the relevant training before 1st December. Although the data below is for October, we are already sighted that we have met the standards in November and we will be fully compliant with this safety action.

Training compliance in PROMPT: Midwives	96%
Training compliance in PROMPT: Obstetric Consultants	90%
Training compliance in PROMPT: Obstetric Middle Grades	92%
Training compliance in PROMPT: Anaesthetic Consultants	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%
Training compliance PROMPT: Maternity Support Workers	81%
Annual NLS update compliance: Paediatric Consultants	100%
Annual NLS update compliance: Paediatric Middle Grades	100%
Annual NLS update compliance: Paediatric Juniors	100%
Annual NLS update compliance: Midwives	96%
Annual NLS update compliance: Neonatal Nurses	84%
Fetal Wellbeing update day: Obstetrics	85%
Fetal Wellbeing update day: Midwives	91%
Midwifery update day (Core Competency): Midwives	94%
Midwifery update day (Core Competency): Support Staff	85%

5.2 **Saving Babies Lives v3**

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 assured by the LMNS on a quarterly basis.

The service has action plans to address each of the key areas. CNST year 6 requires full implementation by March 2024, however where this has not been met, compliance can still be achieved if the ICB confirms it is assured best endeavours and sufficient progress has been made. The LMNS have confirmed that they are satisfied with efforts and progress to date but do require an increase in trajectory in element 4 in order to be compliant with CNST. The next LMNS review of the full saving babies' lives data for Quarter 2 is planned for November where we hope to have seen improvements in all elements.

5.3 **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 5th November with the Non-Executive Director Safety Champion plus a peer Non-Executive Director present. The review looked at maternity triage which was found to be very clean and tidy, and staff reported positive experiences of the improvements that have been made, reporting women are also happy. There is work underway which will see the introduction of a medication trolley and new infographic boards for the wall. The service is also very proud to launch the new triage telephony system and updates will be provided in future reports.

Delivery Suite staff changing facilities are still not improved, however new lockers and storage is on order. The midwifery apprenticeship is up and running with one Maternity Support Worker currently undertaking the programme and is doing well. Staff morale was found to be positive and supportive across the unit.

The Safety Champions visited the Neonatal Unit and spoke with a family who had been admitted for 9 days and reported positively on her experiences. The artwork in the Neonatal Unit has also been installed and was positively received by staff, families and Safety Champions.

The team chatted to staff across the clinical area and no safety concerns were identified.

5.4 **CNST MIS Year 6**

5.4.1 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. An exception report is being shared with Board today.

5.5 LMNS Insight Visit

The LMNS undertook an insight visit on the 6th November. The visiting team consisted of members of the LMNS and the MNVP and the focus was on a mortality review and our progress against the Single Delivery Plan. The initial feedback is summarised below and we will share the more formal feedback once it is received.

SCBU:

- The visiting team felt that SCBU had a really strong 'family feel' amongst staff, really welcoming and comfortable environment
- There was a case of excellent student support with feedback direct from a student in the area
- Elaine as manager was recognised by all staff, her leadership and skills were described as pivotal to the service
- There was apparent empathy shown across the workforce and to staff

MATERNITY:

- Lovely environment, clean and welcoming
- A strong sense of cohesive team was recognised, lots of close connections and working together well
- Good opportunities for growth and development were described by staff in the midwifery and support staff group, not just promotion but to develop
- Matron and Senior Leadership Team recognised for being really cohesive, motivated and working well together delivering really positive work streams
- All Band 7's were noted to be approachable and all staff felt able to escalate, discuss issues etc and confident they would be well supported in doing so
- They spoke with 2 families and they reported:
    - Significant improvements in experience compared to previous child 4 years ago, noticeably more staff and better environment
    - BF support has been outstanding, time, patience and care shown to women
    - Good pain relief
- It was very apparent that all staff have a good awareness of domestic abuse and work hard to facilitate safe environments for women to have these discussions
- They were impressed with the Blood Loss trollies and are going to pinch with pride this idea
- There is strong evidence of an awareness of Health Inequalities, most importantly as a theme through governance, and with service delivery to address and reduce this although Continuity of Care models cannot be funded at this time
- The ADoM and governance team prepared and presented a review of perinatal mortality across 2024 to date and this was well received, good assurance that we are learning from cases and themes are identified and significant QI work in progress; notable that themes from previous years are resolved. Learning from WVT approach was well received with plans by the LMNS to now request this biannually across the system thus strengthening oversight and assurance closer to real time that MBRRACE reporting.

AREAS FOR FOCUS:

- There is a proactive approach to work together as a perinatal team, however Trust structures limit this, particularly with governance and therefore not true perinatal approach
- Relationships between teams and professional groups
- Engagement in some MDT forums
- They would like to see Obstetrics attending the 08:15 scuddle (recognised this would be a 15 min adjustment to start time)
- There was one midwife who had some feedback around roster structures
- Second Obstetric Theatre – request for review and mitigations to Region as national review of theatre provision has been underway and WVT outlier in Midlands. The current estate and set-up presents a risk to elective work when cases are delayed or deferred. (The national approach and review has been indicated on the back of the National MBRRACE report and learning from perinatal mortality). This risk is mitigated and features on the risk register.

Overall, the service were pleased with the feedback. There were no surprises as we are sighted on the issues raised, but will ensure the feedback is used as an opportunity to further improve.

REPORT ENDS

APPENDIX 1 – PQSM Dashboard

Indicator Description	May	June	July	August	September	October
Total bookings	132	139	154	122	135	147
Women who were booked before 12 + 6 weeks	124	126	147	116	120	139
% Women who were booked before 12 + 6 weeks (target 90%)	93.9%	90.6%	95.5%	95.1%	88.9%	94.6%
Women who were booked after 12 + 6 weeks	8	13	7	6	15	8
% Women who were booked after 12 + 6 weeks	6.1%	9.4%	4.5%	4.9%	11.1%	5.4%
Midwife led care at booking	19	16	27	24	18	27
% Midwife led care at booking	14.4%	11.5%	17.5%	19.7%	13.3%	18.4%
Women with BMI of 30 and over at booking	41	39	40	40	38	43
% Women with BMI of 30 and over at booking	31.1%	28.1%	26.0%	32.8%	28.1%	29.3%
% Antenatal Personalised Care Plan completed	97.6%	95.9%	97.1%	100.0%	98.4%	98.40%
% Intrapartum Personalised Care Plan completed	63.2%	61.5%	61.0%	68.5%	63.1%	63.1%
% Portal Access Consent	99.2%	100.0%	100.0%	98.4%	99.3%	99.3%
% Portal Access - Women who registered and logged in	88.5%	83.5%	82.5%	80.8%	79.9%	79.5%
% Contacts were place of birth suitability was recorded	13.7%	65.3%	65.4%	65.3%	69.5%	69.5%
% High risk women assigned a named Consultant - within 7 days	50.7%	56.6%	62.7%	58.40%	59.00%	59.00%
% High risk women assigned a named Consultant - at any time	79.7%	83.5%	86.0%	88.5%	84.2%	84.2%
% Antenatal contacts with a reviewed / authorised risk assessment	30.7%	56.3%	77.1%	72.9%	84.2%	84.2%
% Antenatal contacts with a risk assessment form completed	92.9%	94.3%	91.1%	91.7%	96.8%	96.8%
Recorded Smoking Status at Booking - Yes	7	14	10	5	9	11
Recorded Smoking Status at Booking - No	125	125	144	117	126	136
Recorded Smoking Status at Booking - Unknown	0	0	0	0	0	0
% of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Women who were current smokers at booking	7	14	10	5	9	11
% Women who were current smokers at booking	5.3%	10.1%	6.5%	4.1%	6.7%	7.5%
Smokers who were referred to smoking cessation services	7	14	9	5	9	11
% Smokers who were referred to smoking cessation services	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%
Smokers who accepted CO screening at booking	7	14	10	5	9	11
% Smokers who accepted CO screening at booking	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Women who were screened for CO at booking	126	133	149	113	130	136
% Women who were screened for CO at booking (of total bookings)	95.5%	95.7%	91.4%	92.6%	96.3%	92.5%
Women with CO reading of 4 ppm or more at booking	9	14	6	5	10	7
% Women with CO reading of 4 ppm or more at booking (of total bookings)	6.8%	10.1%	3.9%	4.1%	7.4%	4.8%
Total births (deliveries)	135	148	128	125	142	130
Home Births	2	3	0	0	3	2
BBA's	0	1	0	1	1	1
Vaginal births (deliveries)	62	68	47	43	58	57
% Vaginal births (deliveries)	45.9%	45.9%	36.7%	34.4%	40.8%	43.8%
Ventouse & forceps births (deliveries)	22	16	17	13	21	19
% Ventouse & forceps births (deliveries)	16.3%	10.8%	13.3%	10.4%	14.8%	14.6%
RG*1 having a caesarean section with no previous births	3	5	2	2	3	3
RG*1 Deliveries	26	22	17	15	16	16
RG*1 % C-section deliveries	11.5%	22.7%	11.8%	13.3%	18.8%	18.75%
RG*2 having a caesarean section with no previous births	15	16	20	25	14	14
RG*2 Deliveries	36	30	36	31	31	31
RG*2 % C-section deliveries	41.7%	53.3%	55.6%	80.6%	45.2%	45.16%
RG*5 having a caesarean section with at least one previous birth	19	17	18	21	21	21
RG*5 Deliveries	20	21	19	23	27	27
RG*5 % C-section deliveries	95.0%	81.0%	94.7%	91.3%	77.8%	77.78%
Total Elective C-Sections	23	19	27	22	28	21
Total Emergency C-Sections	28	45	36	46	34	33
Total Caesarean births (deliveries)	51	64	63	68	62	54
% Total Caesarean births (deliveries)	37.8%	43.2%	49.2%	54.4%	43.7%	41.5%
% Grade 1 C-Sections within 30 minutes	71.4%	62.5%	75.0%	75.0%	87.5%	87.5%
% Grade 2 C-Sections within 75 minutes	80.9%	84.8%	84.6%	100.0%	90.9%	90.9%
Midwife led (low risk care) births	33	31	29	29	26	30
% Midwife led (low risk care) births	24.4%	20.9%	22.7%	23.2%	18.3%	22.9%
Home births (deliveries) - midwife led only	0	2	0	0	1	1
% Home births (deliveries)	0.0%	1.4%	0.0%	0.0%	0.7%	0.8%
Total number of babies born	136	150	131	128	144	132
Babies born preterm (singletons born 36+6 or less)	9	10	17	11	16	13
% Babies born preterm (singletons born 36+6 or less)	6.62%	6.67%	13.0%	8.6%	11.1%	9.8%
Singleton babies born 26+6 or less	1	0	0	1	0	1
% Singleton babies born 26+6 or less	1%	0%	0.00%	0.83%	0.00%	0.77%
Babies (multiples) born 27+6 or less	0	0	0	0	0	0
% Babies (multiples) born 27+6 or less	0%	0%	0.00%	0.00%	0.00%	0.00%
Stillbirths	1	0	2	2	0	0
% Stillbirths	0.7%	0.0%	1.5%	1.6%	0.0%	0.0%
Stillbirths rate per 1,000	0.136	0	0.3	0.3	0.0	0.0

Live births where breastfeeding initiated (first feed = breastmilk)	114	119	102	105	108	107
% Live births where breastfeeding initiated (first feed = breastmilk)	85.7%	80.4%	81.0%	86.1%	76.6%	82.3%
Women who were current smokers at booking (delivered mothers)	9	16	7	11	8	8
% Women who were current smokers at booking (delivered mothers)	6.7%	10.8%	5.5%	8.8%	5.6%	6.1%
Women who were current smokers at birth (delivery)	7	13	8	12	9	6
% Women who were current smokers at birth (delivery)	5.2%	8.8%	6.4%	9.6%	6.3%	4.6%
% Women with CO measured at 36 weeks	98.4%	99.3%	100.0%	100.0%	100.0%	100.0%
% CO >= 4ppm at booking and below 4 ppm at 36 weeks	7.3%	10.4%	2.7%	7.2%	4.8%	3.5%
Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0	1	0	0
% (as a % of all singleton births)		0.00%				0.00%
% Detection rate for FGR (below 3rd centile)	15%	13%	10%	20.0%	22.2%	0.0%
Women who had a PPH of 1,500ml or more	11	8	6	5	9	4
% Women who had a PPH of 1,500ml or more	8.1%	5.4%	4.7%	4.0%	5.0%	3.1%
Women who sustained a 3rd or 4th degree tear	1	2	1	0	0	0
% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.2%	2.4%	1.5%	0.00%	0.00%	0.00%
% Induction of labour rate (of all births)	34.8%	36.5%	34.4%	39.2%	34.5%	32.3%
Routine Enquiry Domestic Violence - Asked	87	92	84	78	100	80
Routine Enquiry Domestic Violence - Unable to ask	45	54	43	47	41	51
Routine Enquiry Domestic Violence - Unknown	3	2	1	0	1	0
% routine enquiry domestic violence	97.8%	98.6%	99.2%	100.0%	99.3%	100.0%
Midwife to birth ratio	1:25	1:26	1:22	1:21	1:27	1:23
Delay in Induction >2hrs	0	8	0	0	2	0
Delay in Catagory 1 C-Section >30mins	1	3	0	2	0	1
Delay in administering medication	0	0	0	1	0	0
Delay in starting syntocinon/ARM >30mins	0	2	0	0	0	1
Delay in Suturing >60mins	0	0	0	0	0	0
Unable to provide 1:1 care in labour	0	0	0	0	0	0
Delay in Triage >30mins	0	0	0	0	1	0
Community midwives on call covering maternity unit	0	8	0	3	2	1
Any movement of midwifery staff from any area to provide midwifery cover	0	2	1	0	2	0
Delayed recognition of and action on abnormal vital signs	0	1	0	0	0	0
DSC lost - supernumerary status	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	*	*	0	0	0	0
Delay of more than 30 minutes in providing pain relief	*	*	0	0	0	0
Number of women presenting to service with reduced fetal movements	174	199	220	199	203	211
Number of women presenting with RFM who are recorded as having a CTG	172	197	218	197	200	211
% of women presenting with RFM who received CTG	98.9%	99.0%	99.1%	99.0%	98.5%	100.0%
Total admissions to neonatal care	5	13	12	6	15	17
Unexpected admissions of full-term babies to neonatal care	1	7	3	2	4	7
% Unexpected admissions of full-term babies to neonatal care	0.8%	5.0%	2.7%	1.7%	3.1%	5.9%
Eligible Babies	2	3	1	0	2	3
% taken within hour	50.0%	100.0%	100.0%	n/a	100.0%	66.6%
Adm temp <36.5 degrees	0	0	0	0	0	0
Eligible Babies	9	17	22	12	19	16
% taken within hour	89.0%	82.3%	86.3%	75.0%	94.0%	87.5%
Adm temp <36.5 degrees	0	0	3	1	0	1
Babies born with an APGAR score between 0 and 6 (at 5 minutes)	3	3	3	3	6	5
Neonatal deaths	0	0	0	0	1	1
% Neonatal deaths	n/a	n/a	0.0%	0.8%	0.7%	0.8%
Neonatal mortality per 1,000 births	0	0	0	0.128	0.144	0.132
Neonatal transfers for therapeutic hypothermia	0	0	0	0	0	0
% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a	n/a	n/a	n/a
Neonatal brain injuries	0	0	0	0	0	0
% Neonatal brain injuries	n/a	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	3	1	1	2	2
Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	3	3	2	2	2	2
% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	66.7%	100.0%	50.0%	50.0%	100.0%	100.0%
Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0	0	0
Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	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	n/a
Obstetrics admissions to ITU	0	0	1	0	0	0
Maternal deaths	0	0	0	0	0	0
% Postnatal Personalised Care Plan completed	97.0%	97.7%	98.4%	97.7%	97.5%	97.5%
Postnatal readmissions within 28 days (mothers)	9	4	10	13	2	8
Postnatal readmissions within 28 days (babies)	6	7	5	7	7	4
Number of times Maternity Services Suspended per month	0	1	0	1	0	0
Number of hrs Maternity Services suspended	0	8	0	9	0	0
Number of times Home Birth services suspended per month	0	0	0	0	1	0
Number of hrs Home Birth services suspended	0	0	0	0	12	0
Number of times SCBU suspended per month	0	0	0	0	1	0
Number of hrs SCBU suspended per month	0	0	0	0	0	0

Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0	0	0	0	1
New HSIB SI referrals accepted	0	0	0	0	0	1
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust		0	0	0	0	0
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	160	0	0	0	0	0
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	150	4.5	0	0	0	0
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	4	0	0	0	0	0
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	0	4	3	2	2	0
Vacancy rate for midwives (black = over establishment, red = under establishment	4.8	0.06wte	0.06wte	2.4wte	2.4wte	4wte
Inphase related to workforce (service provision/staffing)	0	11	0	3	4	
MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Service User feedback: Number of Compliments (formal)	0	4	7	5	6	4
Service User feedback: Number of Complaints (formal)	0	4	1	0	1	4
Staff feedback from frontline champions and walk-abouts (number of themes)	2	0	0	0	0	0
Progress in achievement of CNST /10	On Track	On Track	On Track	On Track	On track	On track
Training compliance in PROMPT: Midwives	96%	98%	93%	93%	96%	96%
Training compliance in PROMPT: Obstetric Consultants	100%	100%	100%	100%	100%	90%
Training compliance in PROMPT: Obstetric Middle Grades	93%	87%	93%	93%	92%	92%
Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%	100%	100%	100%	100%
Training compliance PROMPT: Maternity Support Workers	67%	67%	65%	62%	73%	81%
Annual NLS update compliance: Paediatric Consultants	100%	100%	100%	100%	100%	100%
Annual NLS update compliance: Paediatric Middle Grades	100%	100%	100%	80%	100%	100%
Annual NLS update compliance: Paediatric Juniors	*	90%	91%	90%	100%	100%
Annual NLS update compliance: Midwives	96%	98%	93%	93%	96%	96%
Annual NLS update compliance: Neonatal Nurses	94%	98%	100%	100%	100%	84%
Fetal Wellbeing update day: Obstetrics	100%	89%	89%	95%	84%	85%
Fetal Wellbeing update day: Midwives	98%	98%	94%	95%	92%	91%
Midwifery update day (Core Competency): Midwives	97%	97%	98%	98%	94%	94%
Midwifery update day (Core Competency): Support Staff	88%	88%	79%	77%	81%	85%

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Patient Experience Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Associate Director of Quality Governance
Documents covered by this report:	

1. Purpose of the report

To update the Board on the progress in key areas for improving patient experience, supporting the delivery of the updated Trust quality priority for 2024-25; *Improve responsiveness to patient experience data*.

2. Recommendation(s)

The Board is asked to note;

- Family friends data not available at the time of reporting
- National Inpatient Survey headlines - Key areas for improvement identified and projects are underway, not an outlier in comparison to members of the Foundation Group, yet some opportunities for shared learning
- Analysis of complaint comebacks identified clear issues prompting further communication from patients
- Trust is not an outlier for Parliamentary and health service ombudsman cases in Group comparison
- Patient advice and liaison service (PALS) remains fragile but well supported by clinical teams
- Volunteer Steering Group established

The Patient Experience team would like to extend their thanks and appreciation to clinical teams who have supported the PALS service whilst recruitment continues to address gaps in the team. This has ensured patient, family and carer concerns remain at the forefront of our efforts to resolve issues as they arise.

3. Executive Director Opinion[1]

The improvement in response times, notably in medicine is to be commended, although there is clearly more work to do in this area. The rising number of comebacks requires attention and the increase in complaints for October is a cause for concern; there may be a correlation between this increase and the reduced PALs service, with more individuals opting for a formal route.

Divisions have been asked to report actions being taken in relation to themes identified from the October deep dive – these will feature in the divisional reports to Quality Committee.

The 4 key priorities identified following the 2023 inpatient survey (published in 2024) are anticipated to drive improvements for the 2024 survey.

The launch of the volunteer steering group is a positive next step in progressing our volunteer strategy.

1

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.

Patient Experience Report

Introduction

The report provides an update on patient experience key metrics and areas of improvement in support of the Trust Quality priority for patient experience.

Headlines

- FFT data not available at time of reporting
- National Inpatient Survey results- Trust not an outlier in the Group, areas for improvement identified and projects underway
- Analysis of complaint comebacks identified clear issues prompting further communication from patients
- Trust not an outlier for PHSO cases in Group comparison
- PALS service remains fragile but well supported by clinical teams
- Volunteer Steering Group established

Quality Priority 2024-25- Improve responsiveness to patient experience data

For the year ahead this report will provide a quarterly update on patient experience metrics and in addition will highlight improvement work underway to deliver the quality priority. The aim being to see an improvement in the following areas;

- Evidence use of FFT feedback to generate improvement (projects/ case studies)
- Improvement in national patient survey results
- Evidence use of survey feedback to generate improvement (projects/ case studies)
- Reduction in complaints and concerns
- Improved response times to complaints and concerns
- Reduction in overdue responses to complaints and concerns
- Reduction in comebacks or re-opened cases
- Increased patient engagement and collaboration on improvement projects

Surveys

National Inpatient Survey

The results of the survey were reported to Quality Committee in October 2024. In summary;

- Overall, position has remained relatively stable with the majority of responses 'about the same' as other Trusts.
- Quality of food, waiting list times and discharge communication remain a challenge
- Patient comments in relation to staff are predominantly positive
- Scores for kindness and compassion as well as dignity and respect remain high
- Good results for first questions related to patient experience on the virtual ward

Group wide benchmarking has been undertaken and scores across the group are similar for most questions. Opportunities for possible shared learning to aid improvement at WVT identified for:

- Information whilst waiting for admission
- Discussions around support post discharge
- Feedback during hospital stay

Actions for improvement are being monitored by Patient Experience Committee and four trust-wide initiatives have commenced;

1. Food quality and safety- joint working group with Sodexo
2. Communications regarding medicines on discharge
3. Identifying health and social care support on discharge (work with care navigator team)
4. Learning from SWFT- communication about waiting times when on a waiting list

Urgent and Emergency Care Survey

Results were published 21st November 2024 and will be presented at Quality Committee in December 2024.

Complaints

This section of the report provides;

- Performance data update
- Analysis of complaints position by Division
- Deep dive – comebacks (dissatisfied with original response)
- Deep dive- complaints increase in October 2024
- PHSO cases- group comparison 2023-24

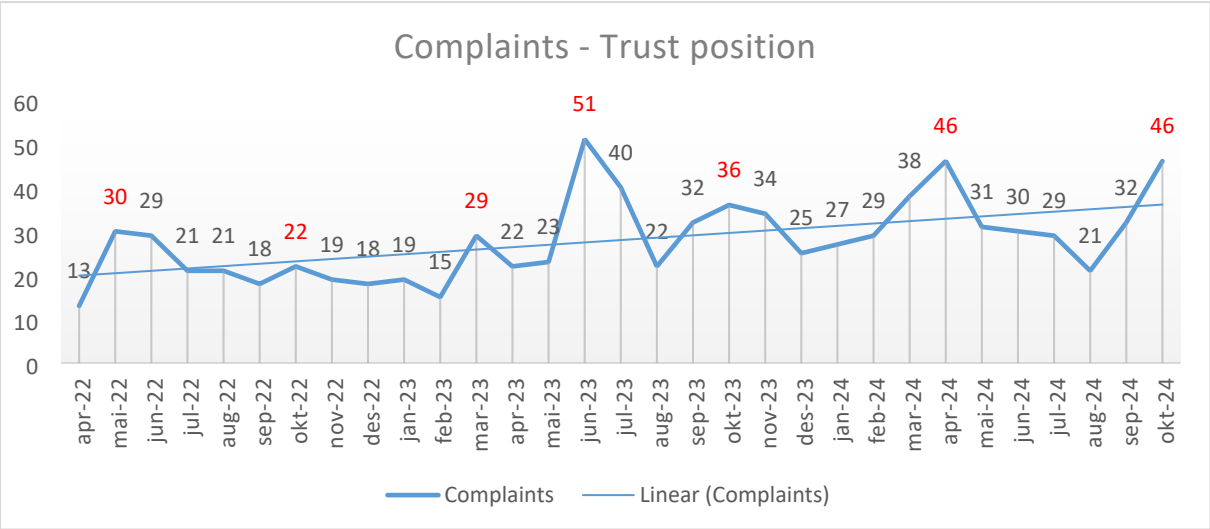
Complaints position

(New complaints only)

KPI	Jul	Aug	Sept	Oct	Total Q1	Total Q2	Total Apr-Oct (inc)
Number of complaints **2023**	40	22	32	36	96	94	226
Number of complaints **2024**	29 ↓27%	21 ↓4%	32	46 ↑28%	107 ↑11%	82 ↓13%	189 ↓16%

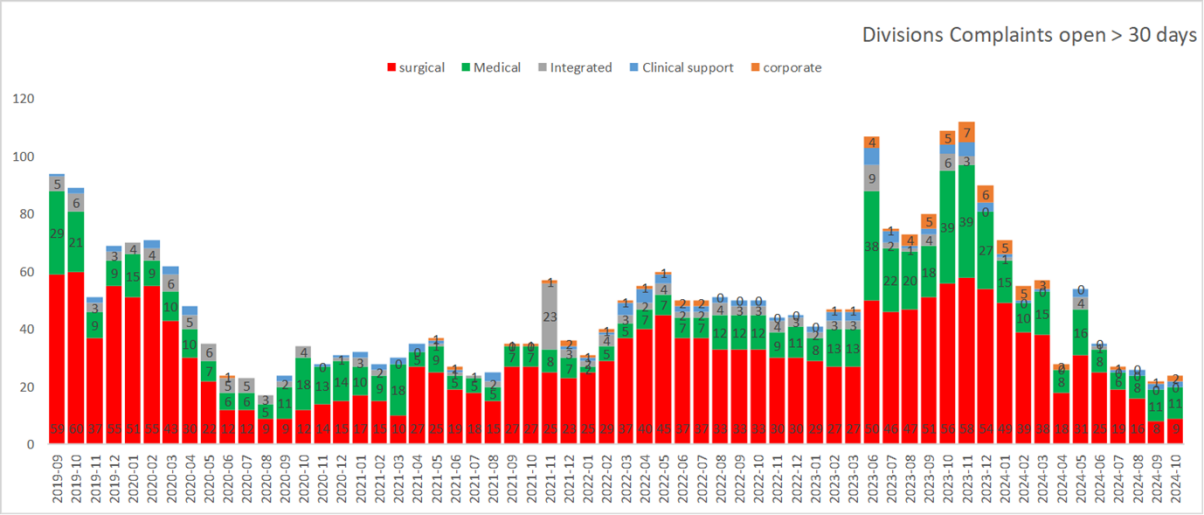
A comparison of data between 2023 and 2024 shows an overall decrease of 16% in complaints received in 2024 to date. There was a noticeable increase in April resulting in higher Q1 figures in 2024, and again in October. This trend can be seen over time with similar increases in or around these months.

There has been an overall slight increasing trend in the total number of new complaints received since April 2022.

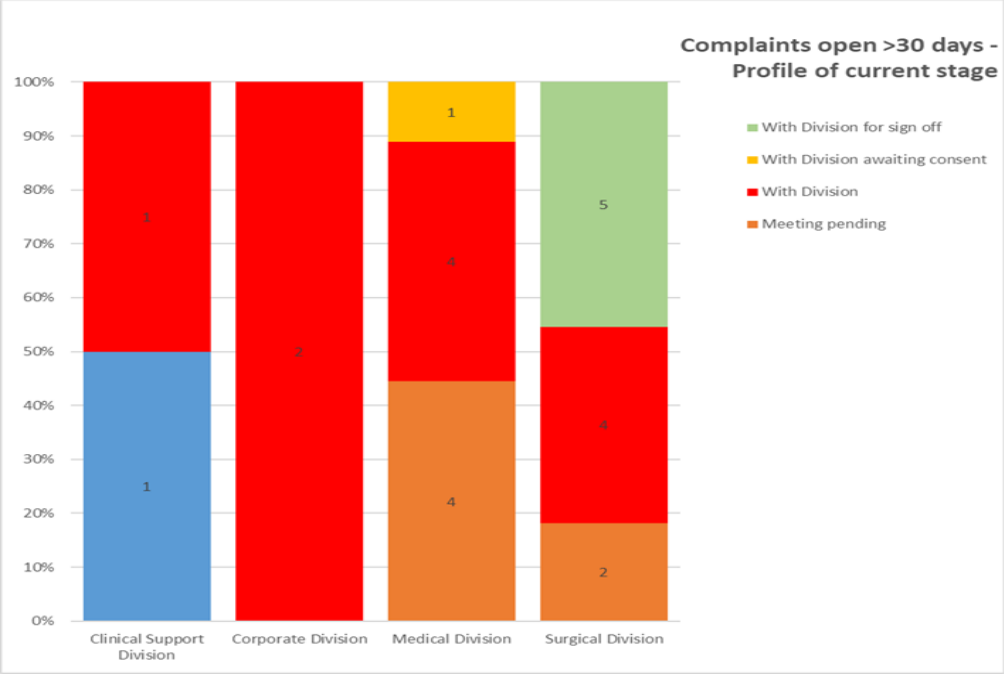


Complaint response times

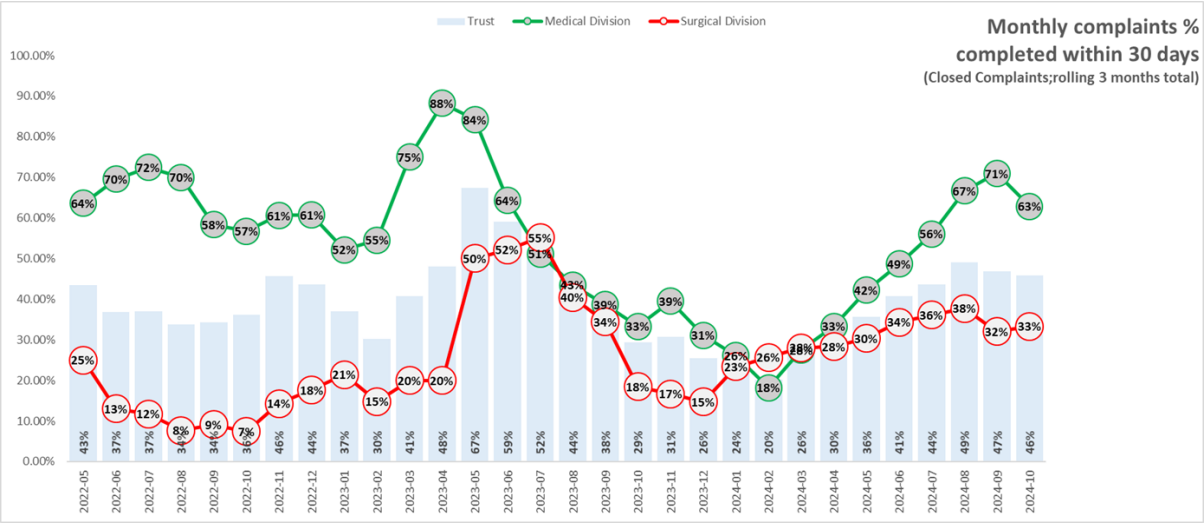
The chart below highlights the current number of complaints open over 30 days by division. These figures will include any complaints where an agreed timeframe has been applied. Despite this, overall there is a much improved trend of 'overdue' complaints, with Q2 having the lowest total overdue complaints since 2021.



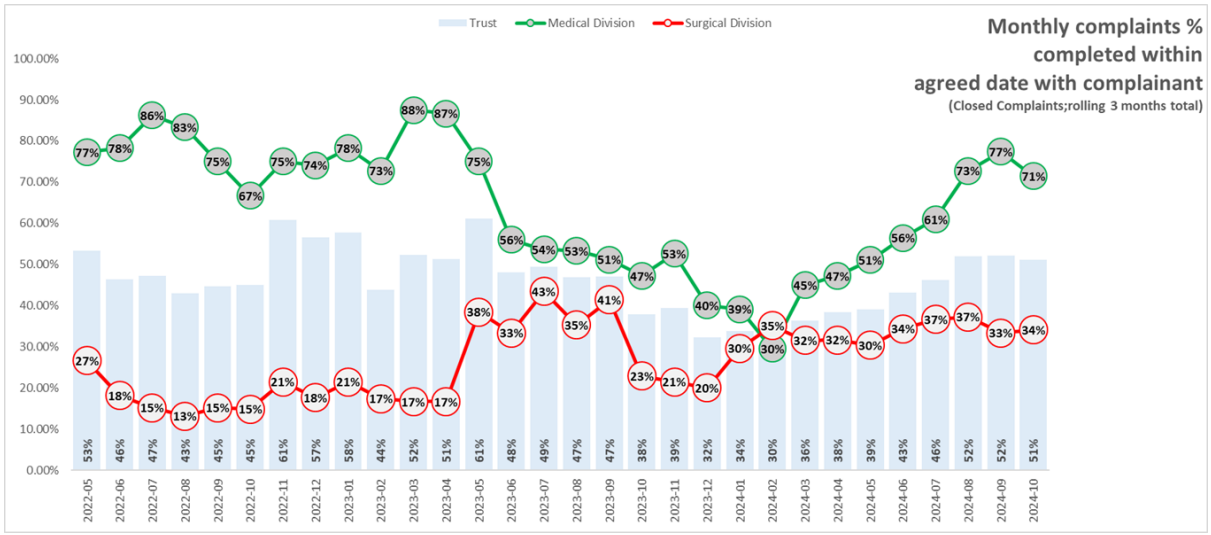
When reviewing the stage of current complaints open for more than 30 days, we can see that a significant number reflect that a meeting has been requested and is pending, or are with the Division for amendment and sign off.



The chart below shows the percentage of complaints being resolved within the 30 day timeframe (rolling 3 month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers.



Often complaints are complex in nature and require multiple services to input to the investigation and response. Where this is the case, early engagement with the complainant should be undertaken to agree a timeframe for the response to be provided. The chart below highlights performance for these cases where a timeframe is agreed that is greater than our specified 30 day target.

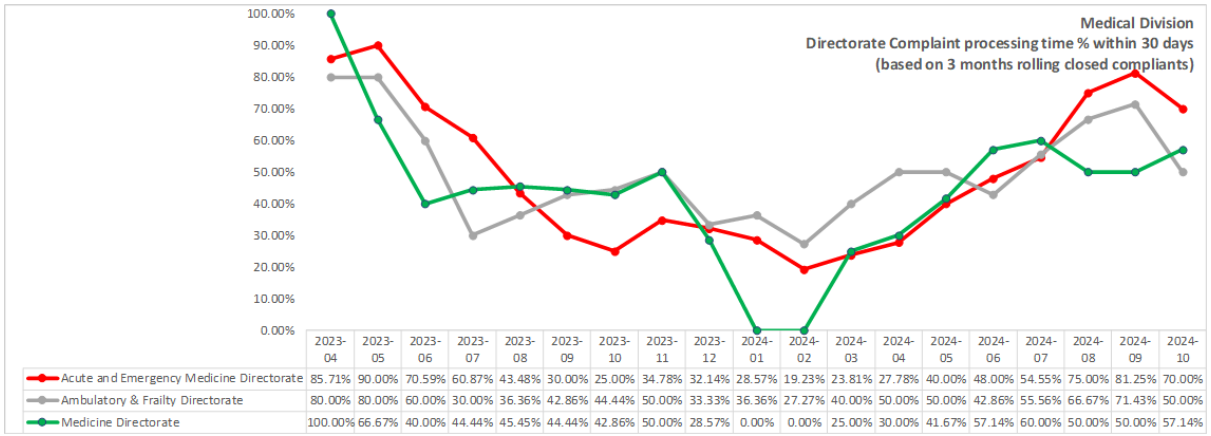


These charts demonstrate that whilst there is a small improvement when agreeing the timescale to respond with complainants, we are only meeting any agreed deadlines 50% of the time.

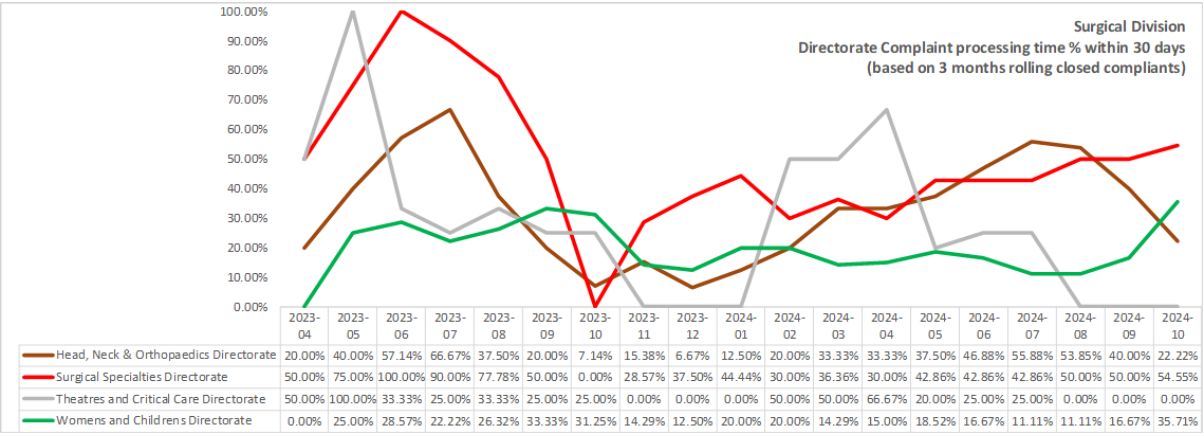
On further analysis, there are improvements that can be made to data accuracy which is likely to show an improved picture. The agreed date with the complainant data point is taken from the 'extension date' in the complaint chain and it is apparent that when a meeting is pending, the complaint chain isn't always being updated to reflect this extension.

When breaking down these figures to directorate level, it shows that Medical directorates have largely similar response rates whereas Surgery have differing results per directorate, with Women and Children's in particular having prolonged response times over a sustained period.

In Q2, Surgical directorates have shown an improving trend in processing times except for Head, Neck and Orthopaedics.



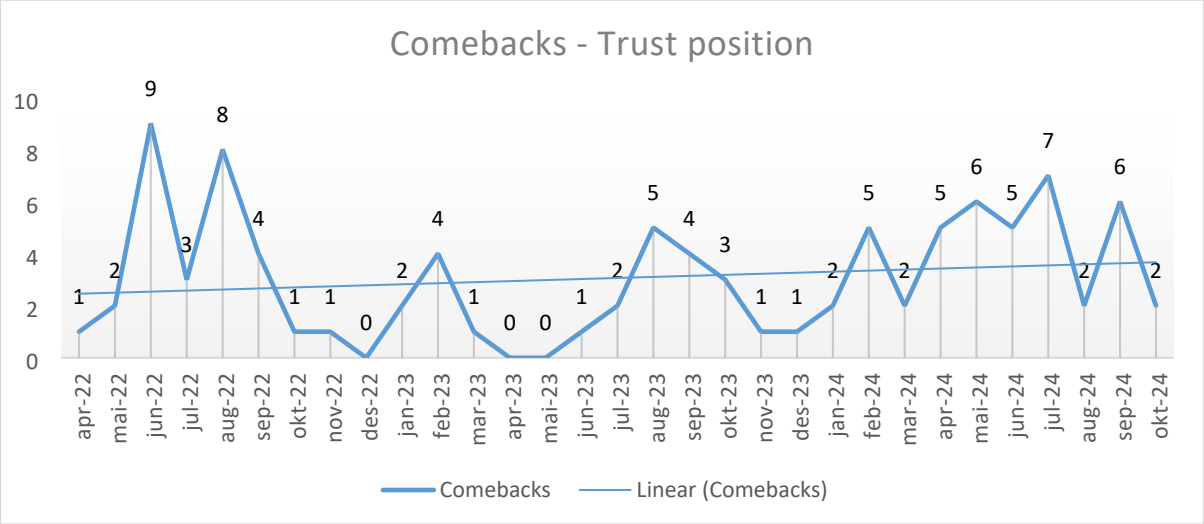
	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Acute and Emergency Medicine Directorate	85.71%	90.00%	70.59%	60.87%	43.48%	30.00%	25.00%	34.78%	32.14%	28.57%	19.23%	23.81%	27.78%	40.00%	48.00%	54.55%	75.00%	81.25%	70.00%
Ambulatory & Frailty Directorate	80.00%	80.00%	60.00%	30.00%	36.36%	42.86%	44.44%	50.00%	33.33%	36.36%	27.27%	40.00%	50.00%	50.00%	42.86%	55.56%	66.67%	71.43%	50.00%
Medicine Directorate	100.00%	66.67%	40.00%	44.44%	45.45%	44.44%	42.86%	50.00%	28.57%	0.00%	0.00%	25.00%	30.00%	41.67%	57.14%	60.00%	50.00%	50.00%	57.14%



	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Head, Neck & Orthopaedics Directorate	20.00%	40.00%	57.14%	66.67%	37.50%	20.00%	7.14%	15.38%	6.67%	12.50%	20.00%	33.33%	33.33%	37.50%	46.88%	55.88%	53.85%	40.00%	22.22%
Surgical Specialties Directorate	50.00%	75.00%	100.00%	90.00%	77.78%	50.00%	0.00%	28.57%	37.50%	44.44%	30.00%	36.36%	30.00%	42.86%	42.86%	42.86%	50.00%	50.00%	54.55%
Theatres and Critical Care Directorate	50.00%	100.00%	33.33%	25.00%	33.33%	25.00%	25.00%	0.00%	0.00%	0.00%	50.00%	50.00%	66.67%	20.00%	25.00%	25.00%	0.00%	0.00%	0.00%
Womens and Childrens Directorate	0.00%	25.00%	28.57%	22.22%	26.32%	33.33%	31.25%	14.29%	12.50%	20.00%	20.00%	14.29%	15.00%	18.52%	16.67%	11.11%	11.11%	16.67%	35.71%

Comebacks- Deep dive

When also considering the number of complaints that are reopened ('comebacks') that Divisions also need to respond to, this increases the total number of complaint responses required.



Number of comebacks 2022	36
Number of comebacks 2023	25
Number of comebacks 2024 (Apr-Oct inc)	33

The number of comebacks received year to date shows a deteriorating position.

When broken down by Division, there has been an increase in comebacks for the Surgical Division this year, with no comebacks received for Clinical Support or Integrated Care.

As a result of the increase, a deep dive of all 33 comebacks received year to date has been undertaken to understand whether complainants are dissatisfied with their initial complaint responses, and if so, why.

Analysis of the comebacks received year to date shows us that 27% of initial complaint responses either did not answer all of the questions raised in their original complaint, or that the response had factual inaccuracies.

The majority of comebacks that had outstanding or unanswered questions were due to the following:

- Investigating officers engaging with complainants where verbal questions were raised but not included in the response. When responses are approved and signed off by Divisions and Executives, they would be unaware that this additional information was agreed.

The majority of comebacks that were requesting further explanation were due to the following:

- Closing letters that confirm the issue has been resolved following a conversation/meeting but does not summarise the discussion (sometimes despite the complainant agreeing to this approach).
- New information provided in the complaint response that the complainant was unaware of.

Factual inaccuracies were errors in dates/times/names.

The issues identified were discussed at Patient Experience Committee, and will be shared with colleagues in all divisions for learning and remedial action where possible.

Complaints increase October 2024- deep dive

In October, a higher number of new complaints were received by the Trust, with the hotspots that have shown an above average number of complaints in month highlighted.

Division	**Directorate**	**Number of complaints received 1st October 2024 to 31st October 2024**	**Total for division**
Clinical Support Division	Patient Access	1	2
	Diagnostic Services	1	
Integrated Care Division	Integrated Services Directorate	1	2
	Acute & Countywide	1	
Medical Division	Acute & Emergency	4	16
	Ambulatory & Frailty	7	
	Medicine	5	
Surgical Division	Head, Neck & Orthopaedics	5	26
	Surgical Specialties	8	
	Theatres & Critical Care	1	
	Women's & Children's	11	
		Total	**46**

The below table details the themes and issues raised by complainants related to the highlighted services - Ambulatory & Frailty, Surgical Specialties and Women's and Children's.

Division/Directorate	No	Themes identified
Medical Ambulatory & Frailty	7	**Communication** Informed decision making, information sharing with families **Patient care** Support at meal times/ food choice Support with mobilisation and personal care Infection prevention and control practices
Surgical Surgical Specialties	8	**Communication** Provision of information particularly aftercare at discharge Availability of information at clinic appointments Staff attitude – empathy and compassion Limited interaction with patients during treatment Pain management
Surgical – Women's & Children's	11	**Communication** Limited information in relation to discharge planning Information provision during or prior to a procedure Difficulty contacting department Contradictory advice provided between teams Patient's history and concerns not listened to **Clinical treatment** Concerns about the procedure and examination Expected procedure not booked/completed Incorrect medication prescribed on discharge

Parliamentary and Health Service Ombudsman (PHSO) Cases- Group comparison 2023-24

This year the Trust has seen a sharp increase in-year of cases being reviewed by the PHSO.

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

The PHSO publishes outcomes of all cases referred to them each year. The table below shows how WVT compare to our foundation group peers for 2023-24.

	Cases referred to PHSO					Decided following detailed investigation						
Organisation	Complaints Received	Complaints Resolved by mediation	Decided following primary investigation	Resolved with agreement of the complainant at Initial checks or Primary Investigation	Complaints accepted for Detailed Investigation	Detailed Investigations fully upheld	Detailed Investigations partly upheld	Detailed Investigations not upheld	Detailed Investigations Resolved with the agreement of the complainant	Detailed Investigations discontinued	Uphold rate (only upholds)	Uphold rate (upheld or partly upheld)
GEH	29	0	10	2	3	1	1	1	0	0	33%	67%
SWFT	29	0	9	0	0	0	0	1	0	0	0%	0%
WAT	51	0	19	0	2	0	3	2	0	1	0%	50%
WVT	23	1	12	0	1	0	1	0	0	0	0%	100%

Wye Valley had the lowest number of cases referred to the PHSO in the year across the group (23) with 52% (12) subject to primary investigation. 44% (10) were not considered for review by the PHSO. Of the 12 reviewed, one case went on for full investigation and was partially upheld. One case was resolved through mediation prior to investigation.

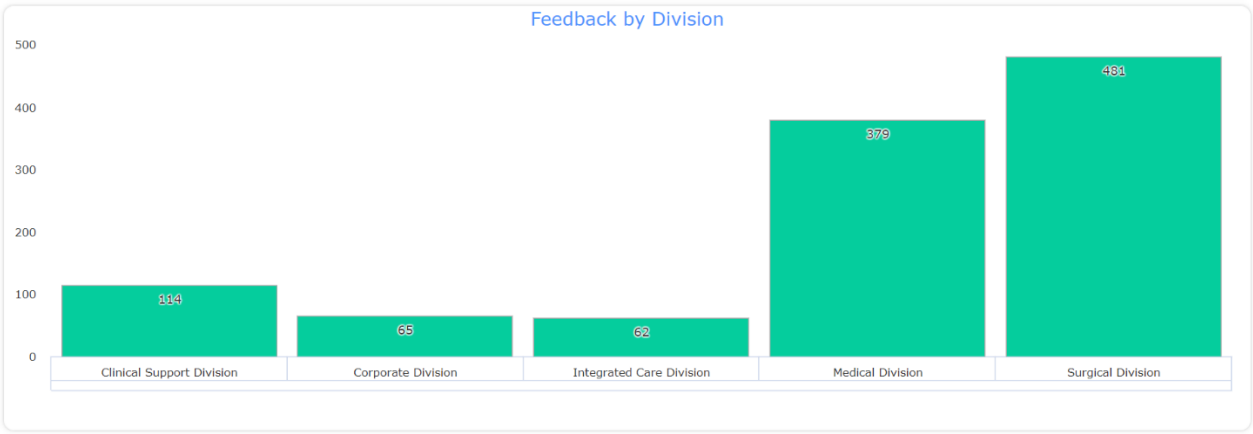
All Trusts had a similar number of cases accepted for full investigation, with SWFT having no cases investigated following primary review. It is difficult to draw any further conclusions due to small numbers but can summarise that our PHSO case rates are not an outlier within the Foundation Group for 2023-24.

Concerns

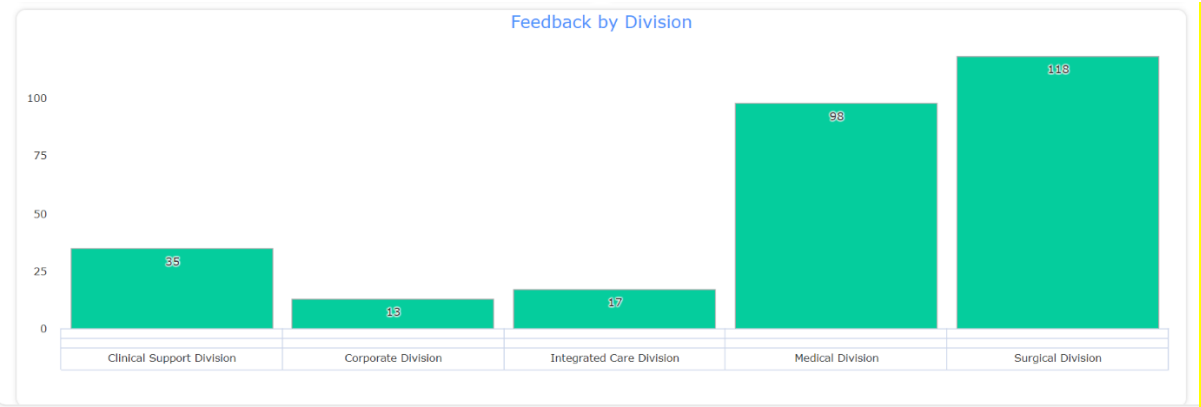
The number of concerns reported over time and for this year are shown in the chart below.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25	106	97	93	105	83	93						
2023-24	13	68	103	96	85	95	97	94	71	116	100	87
2022-23	69	63	79	71	88	76	99	79	63	55	86	82
2021-22	93	88	83	92	86	85	68	86	65	66	69	71
2020-21	66	76	72	80	73	102	94	84	79	78	84	79

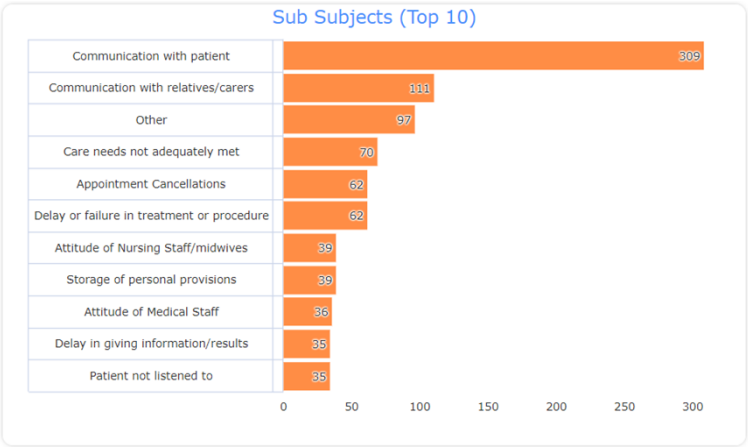
Over the last 12 months concerns have been reported for each division as follows;



The data for Q2 mirrors this distribution with the majority of concerns relate to medical and surgical division.



Communication with patient remains the highest reported theme in concerns however there has been some reduction in concerns in relation to communication in general. A reduction has also been noted in relation to care needs not met and appointment cancellations. Some themes have dropped out the top ten, including concerns in relation waits for procedures/ operations and attitudes of nursing staff/midwives. However, themes of patient not listened to and attitudes of medical staff have moved into the top ten. This correlates with themes noted in the deep dive into October complaints.



Patient Advice and Liaison service (PALS)

The PALS service remains in a fragile position due to ongoing vacancies. However 1.0 wte PALS administrator role has now been recruited to with the new team member commencing employment on 4 November 2024. The restructure process for the remaining team is ongoing.

A temporary process for managing concerns has been agreed to ensure provision of a minimum level of service provision during this challenging time. The situation is being constantly monitored and engagement is ongoing with clinical teams to try to mitigate the impact on service users.

During this period of fragility, the PALS service have signposted patients and carers directly to services to raise their concerns for resolution. This means that not all contacts with the Trust are being logged as concerns.

Patient Experience Committee

The committee has two core sub-groups now established and embedding to support the quality priority and wider Trust objectives; Patient Engagement Group and Volunteer Steering Group.

Patient Engagement Group

The Trust re-established the Patient Engagement Group earlier this year with attendance and membership increasing month on month. Members are engaged with a number of Trust initiatives; PLACE, PLACE Lite, 15 Steps, improvement projects in response to survey results and supporting transformation work streams. The group have welcomed representative organisation from Herefordshire and Powys who support carers and individuals with learning disabilities and autism. Feedback from Credu (Carer's Powys);

"Thanks for inviting me to a fantastic meeting today- great to hear citizens' voices so clearly"

The group are collaborating with the patient experience manager to co-produce recruitment materials and plans to reach out to more members and expand the membership to be more representative of the population we serve.

Volunteer Steering Group

In Q3 the Volunteer Steering Group was established and held its first meeting. The group will report into Patient Experience Committee for assurance that the volunteer service is meeting the Trust objectives.

Key discussions focussed on streamlining the volunteer application and recruitment process. The current process has the potential to delay on-boarding of volunteers and delay new roles and projects being implemented to meet Trust needs.

The Group approved to pilot of the volunteer contact centre aiming to reduce do not Attend (DNA) for appointments after receiving a presentation on the model being used at GEH. The WVT pilot will commence with Ophthalmology.

Conclusion

When reviewing the data against our quality priority measures we are seeing progress and improvement in a number of areas, however recognise there is more work to do to deliver the quality priority in full.

Measure	Update August 2024	Update October 2024
Evidence use of FFT feedback to generate improvement (projects/ case studies)	Defined projects based solely on FFT in some areas. Other areas are triangulating and using data for improvement projects. This is reported to PEC by divisions.	Next update in Q4
Improvement in national patient survey results	Final data awaited.	Mixed results with some areas of improvement and good practice but other areas of deterioration.
Evidence use of survey feedback to generate improvement (projects/ case studies)	Whilst final data not verified. Initial results confirmed internal concerns in two areas; food quality and communication about medicines on discharge. Improvement work underway for both.	Improvement projects established to tackle the areas of concern noted in the survey as presented to QC in October.
Reduction in complaints and concerns	Number of complaints increasing however a downward trend in recent months for concerns.	Complaints continue to increase along with comebacks and cases referred to the PHSO.
Improved response times to complaints and concerns	There is month on month improvement since February 2024 in response times to complaints.	
Reduction in overdue responses to complaints and concerns.	Tis a downward trend in number of overdue complaints with August 2024 showing the lowest number since February 2021.	
Reduction in comebacks or re-opened cases.	There has been an increase in re-opened cases and comebacks year to date.	Reduction seen in Q2 but YTD still high. Issues known and discussion at PEC to seek support from divisions to remedy the issues.
Increased patient engagement and collaboration on improvement projects	The Patient Engagement Group is meeting regularly again with new and increased membership. The members are participating in a wide range of improvement work including; projects based on survey results. PLACE and PLACE lite, 15 steps and stakeholder engagement.	Continued and increased engagement at the Group, participating in more projects and seeking to increase membership more representative of the patient population.

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	EPRR Core Standards Report 2024-2025
Status of report:	☐**Approval** ☒**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Emergency Planning Committee
Lead Executive Director:	**Chief Operating Officer**
Author:	WVT Emergency Planning Officer
Documents covered by this report:	NHSE EPRR Core Standards Assurance Programme 2024-2025 - WVT Action Plan

1. Purpose of the report

The purpose of this report is to provide notification to the Trusts Board of Wye Valley NHSE Trust current position in meeting its statutory duties and obligations in relation to Emergency Planning, Resilience and Response (EPRR) as laid out in:

- Health and Social Care Act (2012)
- Civil Contingencies Act (2004)
- NHS Core Standards for EPRR 2023
- NHS England Business Continuity Management Framework
- NHS Standard Contract

All NHS organisations are required to undertake a self-assessment against the NHS Core Standards Assurance Programme relevant to their organisation. The Core Standards consists of 10 domains divided into 66 individual standards, which organisations are required to meet across the EPRR continuum based on their service provision.

62 standards apply to Wye Valley NHS Trust.

The 10 domains contained within the EPRR Core Standards follow:

1. Governance.
2. Duty to Risk Assess
3. Duty to Maintain Plans
4. Command and Control
5. Training and Exercise
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10 Chemical, Biological, Radiological and Nuclear (CBRN).

Wye Valley NHS Trust were assessed by NHSE/ ICB to be fully compliant with 51 standards, and partially compliant with 11. In addition to the Core Standards, NHS England conducted a 'deep dive' exercise focused on Cyber for 2024-2025.

Organisationally the Trust achieved an overall position of partial compliance with a score of 82%.

Areas where Wye Valley NHS Trust were found to be non-compliant follow (numbering relates to the Core Standard):

12. Maintain Plans - Infectious Disease.
14. Maintain Plans – Countermeasures.
28. Response -Management of business continuity incidents
33. Warning and Informing - Communications planning and activity with the organisation's EPRR.
37. Cooperation - LHRP Engagement.
46. Business Continuity - Business Impact Analysis/Assessment (BIA).
47. Business Continuity - Business Continuity Plans (BCP).
51. Business Continuity – Business Continuity Audit.

52. Business Continuity - Business Continuity Management Strategy (BCMS) Continuous Improvement
53. Business Continuity – Suppliers and Providers assurance.
59. Chemical, Biological, Radiological & Nuclear – Decontamination capability availability 24 /7

Core Standards Challenge - Governance of Trust board policies sign off is delegated to the WVT Policies Review Group.

- Core Standard 2 – EPRR Policy Statement (EPRR Trust Wide Policy).
- Core Standard 44 – BC Policy Statement (Business Continuity Management Strategy Policy).

Previous scores: 2023-2024 =78% achieving partial compliance; 2022-2023 = 76% achieved a non-compliance position.

WVT 2024-2025 Action Plan

Action Plan focus areas:

- Infection Prevention:
  - High Consequence Infectious Disease – Being finalised.
  - New and Emerging Pandemic – Pandemic Influenza to be merged.
- Maintaining Plans
  - Countermeasures – Finalised and awaiting approval.
- Communications
  - Senior Managers On-Call guidance updated.
  - On-Call Communications Presentation – Covering templates and staff cascades for out of hours.
- Business Continuity
  - Business Continuity Management Strategy key performance indicators to be modified to include Suppliers and Providers and reflect the new assurance cycle. .
  - Business Continuity audit programme and annual report.
  - Extensive Business Continuity Plan testing across all divisions.
  - Assurance of suppliers and providers Business Continuity arrangements.
- Chemical, Biological, Radiological and Nuclear
  - Decontamination capability availability 24 /7 – Sufficient staff trained to enable 24/7 coverage, Allocate electronic rotas denoting CBRN trained being put in place.

2. Recommendation(s)

Approve for submission to Emergency planning Committee - Public Board - Annual Trust report

3. Executive Director Opinion[1]

Further progress has been made this year with our core compliance to NHS EPRR standards.

There continues to be area of focus that need improvement for 24/25 that are highlighted in the attached action plan ahead of core compliance assurance submission for 2025.

The rest of the Integrated Care System [ICS] have also made significant progress towards substantial compliance with the EPPR core standards. We continue to work with the Integrated Care Board and our NHS provider partners, and other system partners such as Herefordshire Council, across the ICS to learn and share best practice in order to improve our position next year.

[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 2024/5 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***

EPRR Core standards - 2024-2025 Action Plan

Ser	Domain	Ref	Core Standard	Completed Actions	Status/ Actions Due	% Complete	Responsible	Due by
1	Domain 3 - Duty to maintain plans	12	Infection Disease – High Consequence Infectious Disease Policy	• Plan developed aligned to guidance, completed IPT team review. Circulated for consultation.	In Progressed.	95%	Infection Prevention	Q2 2025
2		14	Countermeasures Plan	• Plan developed following NHSE CS C&C further observations thave been adopted and currently plan with Pharmacy under review.	In Progress	80%	EPO/ Pharmacy	Q2 2025
3	Response	28	Management of business continuity incidents	• Development of overarching organisational business continuity plan.	Being initiated	20%	EPO/ Divisions	Q2 2025
4	Warning and Informing	33	Warning and Informing	• Training required for Level 3 & 4 for Comm's handling to provide 24/7 coverage. • Senior Managers On-Call On-Duty Guidance reviewed EPC awaiting.	In Progress	50%	EPO/ Comms Team	Q2 2025
5	Cooperation	37	LHRP Representation	• AEO or deputy attending the LHRP.	In Progress	15%	AEO/ Deputies	Ongoing
6	Business Continuity Business Continuity	46	Business Continuity Impact Analysis (BIA)	• Divisions review and approval required annually.	In Progress	75%	EPO/ Divisions	Q2 2025
7		47	Business Continuity Plans	• No Corporate Overarching Plan/ BC status report unclear.	In Progress	60%	EPO	Q2 2025
8		48	Testing and Exercise	• No Corporate Plan or testing/ Testing of Plans required for input into BCP report	In Progress	50%	EPO/ Divsions	Q2 2025
9		51	Business Continuity Audit	• No Annual Audit report linked to KPIs.	To be progressed.	30%	EPO/ Divisions	Q2 2025
10		52	KPI reporting (Trust Board)	• KPIs established require addition of Supplier and Providers input	In Progress	80%	EPO/ Divisions	Q2 2025

11		**53**	**Supplier and Providers BC arrangements**	• Further traction required to obtain all 73 Suppliers BC arrangement. EPO has list of suppliers provided by Shared Services.	In Progress	15%	EPO/ Contract Managers	Q3 2025
12	**Hazmat/ CBRN**	**57**	**Decontamination capability availability 24 /7**	• Allocate now being put in place therefore this action to be closed 2025	In Process	95%	Medical Division	Q1 2025

Ser	Domain	Ref	Core Standard	Completed Actions	Status/ Actions Due	% Complete	Responsible	Due by
1	**Deep Dive**	**2**	**Cyber Security & IT related incident response arrangements**	• IT Services Plan updated and awaiting approval by EPC. Introducing Cyber testing in Divisional BCP.	**In Progress**	95%	EPO/ IMT	Q1 2025
2	**Deep Dive**	**9**	**Business Impact Assessments**	• IT Services Plan updated and awaiting approval by EPC.	**In Progress**	95%	EPO/ IMT	Q1 2025
3	**Deep Dive**	**11**	**Business Impact Assessments**	• Linked to Deep Dive D 9 IT Services Plan updated and awaiting approval by EPC.	**In Progress**	95%	EPO/ IMT	Q1 2025

11 partials (excluding 2 & 44) out of 62, which is 82%.

- Partial: 12,14,37,59,28,33,46,47,51,52,53
- Deep dive partial: DD2, DD9, DD11

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Board Assurance Framework (BAF) and Operational Very High Risk Report
Status of report:	**☐Approval ☐Position statement ☐Information ☒Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Associate Director of Corporate Governance / Company Secretary
Documents covered by this report:	1) BAF Review 2) BAF 3) Very High Risks 15+

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).
This quarter, as requested by the Board, a heat map and a risk score tracker for the life of each BAF risk are included in the report.

2. Recommendation(s)

The Trust Board is invited to consider:

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

3. 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***

Board Assurance Framework Review December 2024

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

The BAF is presented to the Trust Board 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.

Since the last review:

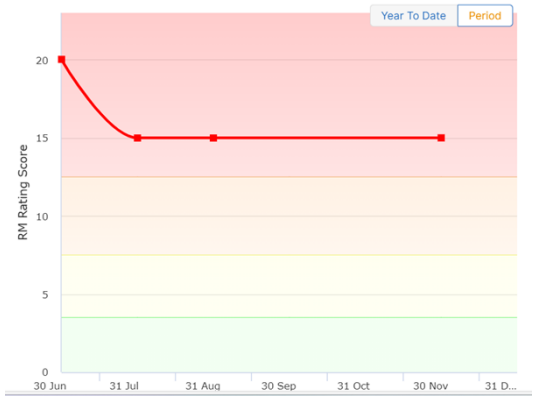
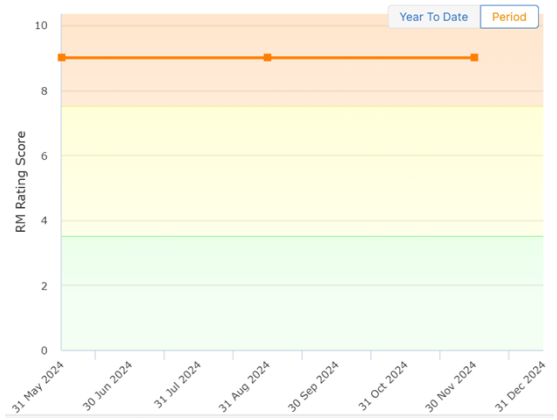
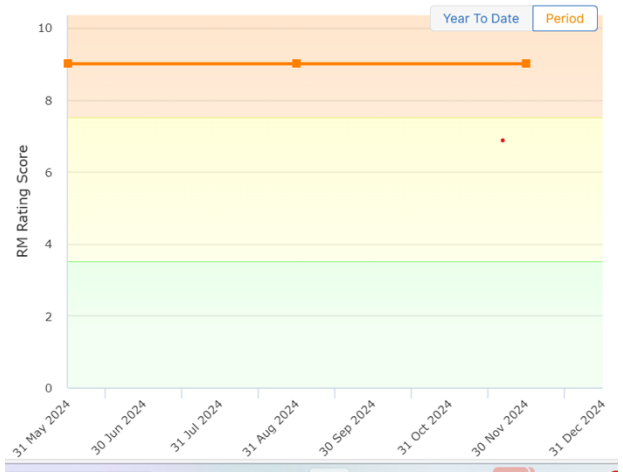
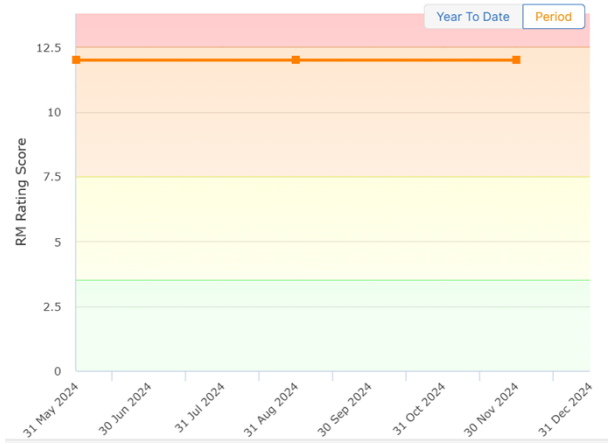
- No new BAF risks have been put on the framework since the last review
- One BAF risk (0423) will be closed shortly as this is no longer a risk following substantive recruitment
- No risk scores have increased since the last review
- Two BAF risk scores have decreased since the last review
    - 066 *Risks to productivity and operational capacity plans and delivery*: score decreased to 10 due to additional controls in place
    - 1688 *Delivery of Academic Programme to improve our Research Profile*: score decreased to 6 due to increased staffing levels (recruitment of Research Manager).

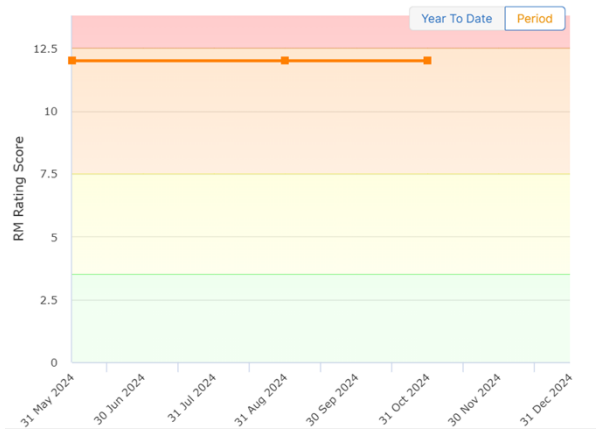
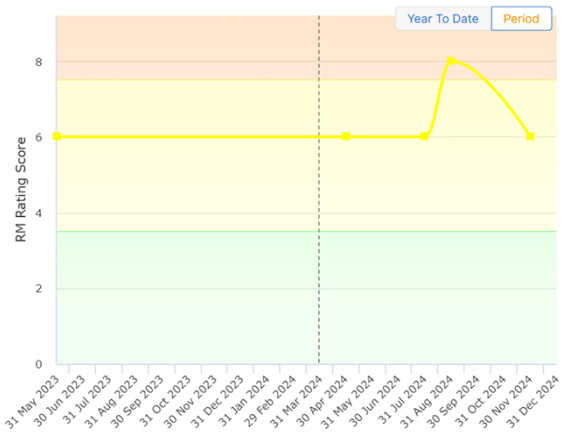
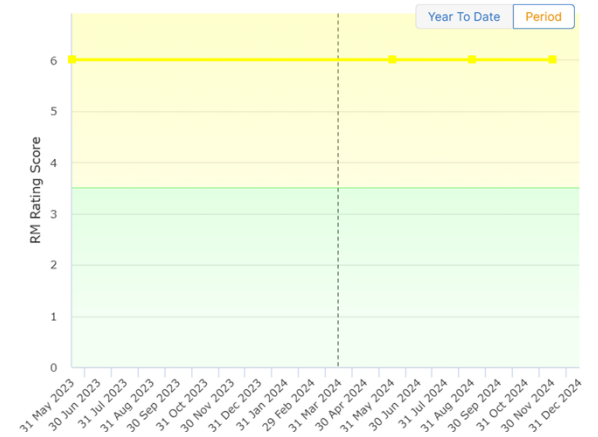
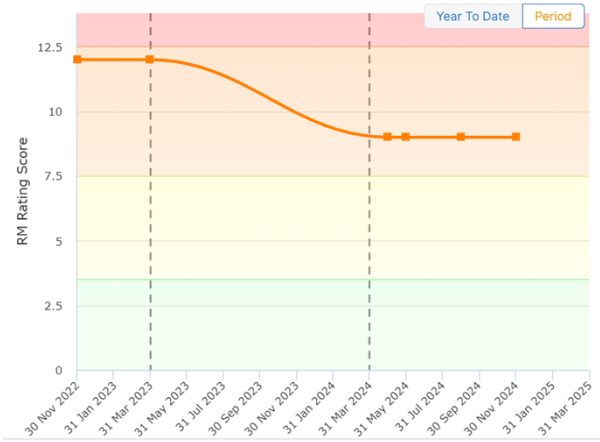
BAF Risk Heat Map

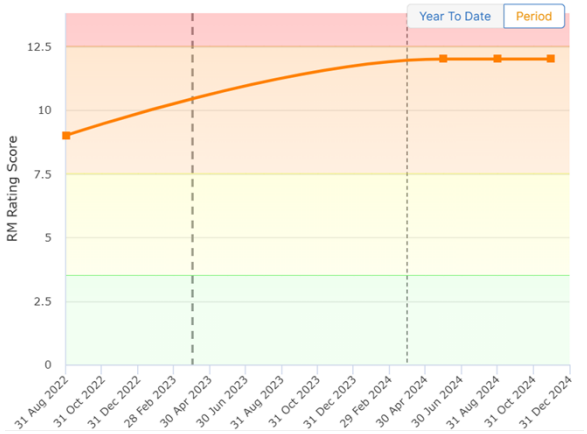
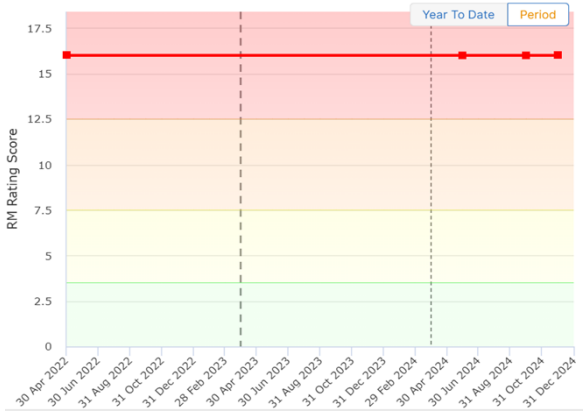
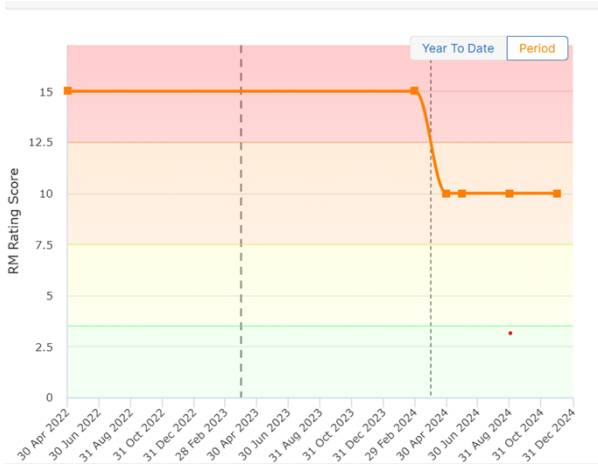
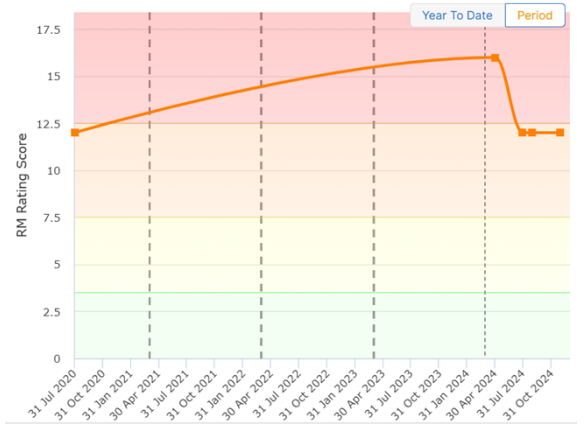
The heat map demonstrates the degree of strategic risk the Trust is currently carrying.

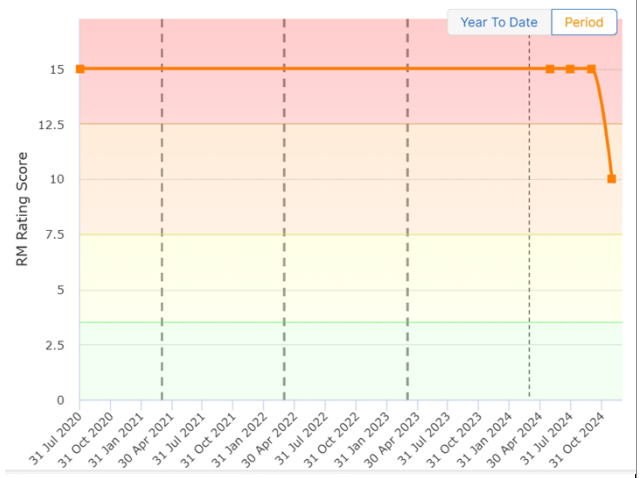
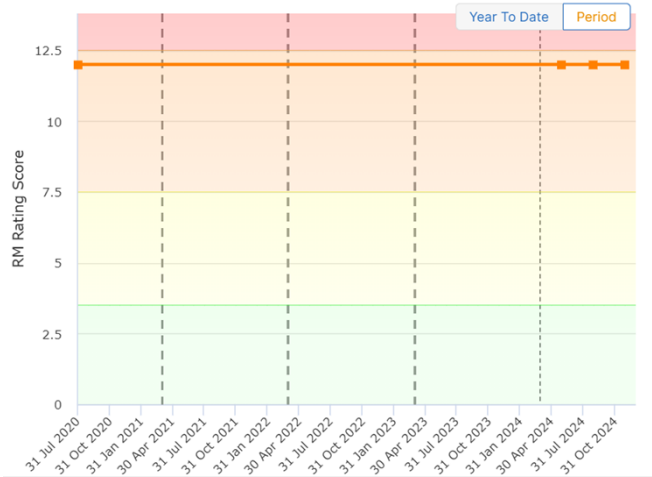
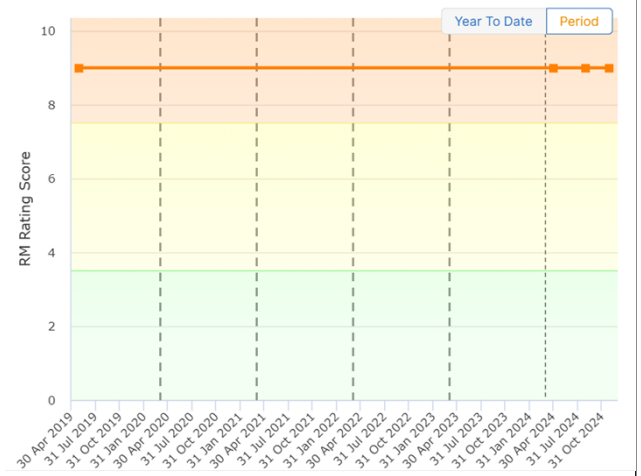
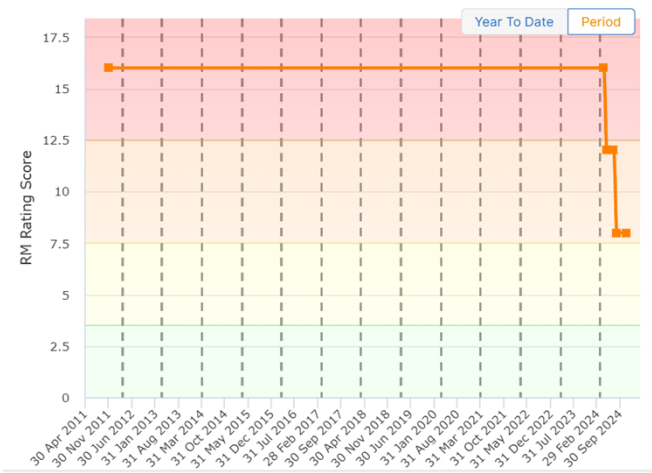
CONSEQUENCE					
LIKELIHOOD	**1: Rare**	**2: Unlikely**	**3: Possible**	**4: Likely**	**5: Almost Certain**
5: Catastrophic					
4: Major			**1933 / 0056**	**0054**	
3: Moderate		**1688**	**1931 / 1932 / 0002 /0827**	**1934 / 0058 / 0059**	**1945**
2: Minor			**1687**	**0756**	**0423 / 066**
1: Negligible					

Risk Score Tracking

Risk	Date of Entry*	Risk Score Over Time	Risk	Date of Entry*	Risk Score Over Time
1945 Cyber Security	June 24		1931 Failure to gain system support for agreed Herefordshire Integrated Care Model	May 24	
1932 Inability to fund the required resource to achieve maximum functionality of EMIS	May 24		1933 Inability to identify resource to 'left shift' and/or maintain financial flow into Herefordshire	May 24	

1934 Local children's services	May 24		1688 Delivery of Academic Programme to improve our Research Profile	May 23	
1687 One Herefordshire delivery of responsibilities contained within the MOU	May 23		0002 Difficulties in delivering on the Equality, Diversity and Inclusion agenda	Nov 22	

0056 Availability of Capital Funds to meet Trust's Strategic Objectives	Aug 22		0054 Ability of system to manage flow across the urgent and emergency care pathway	Apr 22	
0423 Fragility of Haematology service	Apr 22		0059 Delivery of the Digital Strategy	Jul 20	

0066 Risks to productivity and operational capacity plans and delivery	Jul 20		0058 Clinical and support staff recruitment and retention	Jul 20	
0827 Fragility of Medical cover for Stroke pathway	May 19		0756 Fragility of Histopathology Service	Nov 11	

*Date of entry may be entry on Trust Risk Register or Board Assurance Framework

Legacy ID	Risk Title	Risk detail	Risk Owner	Initial Risk Rating	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
54	**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	16	8	•Trust Capacity meetings allowing visibility of the issues and escalation. •Escalation and Surge Plans in place •System wide silver meetings • Winter Plan 2024/25 - Discharge to Assess Board - Valuing Patient Time Board - ICS Urgent and Emergency Care Board - Robust vaccination programme for staff and high risk patients - Implementation of the community referral hub and single point of access	•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 temporary escalation spaces on acute wards to maintain flow	18-Nov-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. - ICS Urgent and Emergency Care 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. Investment in additional ward discharge coordinator capacity / medical and nursing for ED / opening of 11 additional beds in old day surgery unit	System oversight of discharge delays and capacity within pathway 1-3 care settings across Herefordshire and Powys	
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	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	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	12-Nov-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	
56	**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	Alan Dawson	15	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 •Capital funding provided is not sufficient to meet whole requirement	08-Nov-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	

58	**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	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 - Recruitment events in December 2024 for HCAs - Exploring feasibility of finding staff to fill	•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.	18-Nov-24	•HR Directors weekly ICS meeting. •F&PE reports •E-rostering project board to deliver against plan. •JNCC and Equalities group receive quarterly update on workforce issues. •Staff recruitment and retention working group. •Integrated Performance Report to Board •MARP and NARP (reinstated in August 2022). •Weekly MD-led vacancy review panel - reviews all non-clinical recruitment. •Health and Wellbeing Group to review and assess effectiveness of health and wellbeing initiatives to support recruitment and retention.	• Limited assurance that the master vendor contract will meet required agency fill rates which leads to use of higher cost tiers within the contract and other agencies - due to ongoing National shortage of clinical staff. • Expediency of ICS-wide initiatives.	
59	**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	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.	12-Nov-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	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	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	19-Nov-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	12	8			29-Oct-24	- Internal: Childrens and Young People Committee meeting - SEND - Strategic partnership meeting / imminent inspection - Children and Young People Partnership - under review LA meeting - Quality Committee - One Herefordshire Partnership - Children an	#NAME?	
66	**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	10	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. - 24/25 H2 plan in place to stretch activity plan for the remainder of the year and attract additional	- 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 - Vacancies, absences and other workforce challenges could result in activity levels not being delivered or being delivered at additional premium cost	18-Nov-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	

423	** 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	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	•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-Nov-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 - Monthly Fragile Services meeting with Worcester Acute - One of the locums now acting as Clinical Lead providing additional stability	• ICB options not agreed • National shortage of qualified staff	
2	** 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	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.	18-Nov-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.	
827	**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. The service is currently led by locum consultant who could leave at short notice leading to a lack of local service	Chizo Agwu	15	9	3	1. Stroke locums have been with WVT long term and have indicated willingness to stay 2. Locum consultants providing virtual ward rounds at weekends 3. On-call for thrombolysis out of hours is provided by Worcestershire Acute. 4. Trust Registrar covered by Frailty Registrar 5. ACP appointed Jan '24 6. Clinical Senate review of the future of stroke services has taken place September 2024	1. Locums can choose to leave at very short notice d 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	13-Nov-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	Jon Barnes	9	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	19-Nov-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	Jon Barnes	9	9	3	Project support identified to scope the potential for improvement and resources required	No dedicated IT support identified	19-Nov-24	One Herefordshire Partnership Trust Board - work programme updates for information	Unclear at present extent of opportunities / issues with EMIS and MAXIMS	
756	**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	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	•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	13-Nov-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 - attendance at cancer PTL	Staff availability for Monitoring - availability of backlog resource	***Due to Close***

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	Jon Barnes	9	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	19-Nov-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 remains in place until 2024/25 version agreed.	None	
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	6	4	Project oversight in place: Executive lead; Research and development lead; Associate CMO for Research Narrowed scope in place focusing on the research strategy Research strategy was approved at TMB and Quality Committee - Scope agreed Following workshop in April 2024 - a draft MOU with the 3 Counties has been commenced - now signed off	1) Pause recruitment to some studies due to staff shortages 2) Current SLA with Worcester does not cover the academic programme but the newly appointed Research Manager has the programme in their job description	13-Nov-24	Reviewed under normal research meetings Quality Committee Trust Management Board	None	

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Audit Committee Summary Report 19 September 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 19 September 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 – 5 Dec 2024
Summary of Audit Committee (AC) meetings held on 19th Sept 2024

MATTERS FOR PARTICULAR ATTENTION

InPhase - Lynne Carpenter, Quality & Safety Matron provided an update on the InPhase dashboard, providing assurance that the system was working effectively and was growing in terms of operational coverage and in terms of how it can now provide the information needed to support our risk management processes. For information InPhase has been rebranded as Ideagen.

Consultant Job Planning - The Chief Medical Officer (CMO) provided an update. The CMO has agreed with T&O that job planning would not proceed and start afresh in January for next year, which will allow work in October/November to be completed. A review of the templates will include business planning and demand and capacity planning will be completed in November/December. It was confirmed that the productivity gains have been realized as CIP savings is part of a step change in job planning for H2.

Internal Auditors - RSM presented 3 reports. It was pleasing to see the Mortuary Review – Follow up of Human Tissue Authority Actions was assessed as Substantial Assurance and reflects the time and effort that has been applied since the HTA report in 2023. Data Quality - Emergency Department report resulted in a Reasonable Assurance outcome & Medical/ Surgical Junior Doctor's Rota Management was presented at draft stage with a Partial Assurance result to be finalised at the next Audit Committee. The Internal Audit Annual 2023/24 (final) report was received and approved.

External Auditors - Deloitte's provided a verbal update confirming that the final External Audit report 2023/24 would shortly be issued, that no additional significant weaknesses were identified and that they would be starting this the 23/24 audit very shortly.

OTHER MATTERS

Report	Discussion / Recommendation
Hutted Wards	Post Project Evaluation. Key learns reviewed & confirmation was received that the report has now been submitted to NHSE;
Lionel Green Business Case	It was confirmed by the Chief Strategy and Planning Officer that proper governance was followed and approval received for the transfer of funds from the One Public Estate scheme;
Local Counter Fraud Services (LCFS)	It was noted that there is still a need for more staff to complete the fraud & bribery questionnaire and an enhanced awareness programme was agreed.

Due to the number of internal reports and governance items, the agenda was sufficiently large that a follow up meeting was arranged for October 24, allowing for the new Company Secretary to join the meeting. The outcome of this meeting will be summarised as part of the next full board report.

Prepared by:-
Nicola Twigg, Chair of Audit Committee

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 19 September 2024 at
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
In attendance:		
Chizo Agwu	CA	Chief Medical Officer (for agenda items 5.4 and 6.1)
Lynne Carpenter	LC	Quality & Safety Matron (for agenda item 5.1)
Mark Coton	MC	RSM Risk Assurance Services LLP, Assistant Manager, Internal Audit
Alan Dawson	AD	Chief Strategy & Planning Officer (for agenda items 5.2 and 5.3)
Geoffrey Etule	GE	Chief People Officer (for agenda item 6.2)
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)
Asam Hussain	AH	Risk Assurance Director, RSM Risk Assurance Services LLP
Kieran Lappin	KL	Associate Non-Executive Director
Heather Moreton	HM	Associate Chief Finance Officer
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer (for agenda item 6.3)
Lauren Parsons	LP	Senior Manager, Audit & Assurance, Deloitte LLP
Jo Rouse	JR	Non-Executive Director (NED)
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
Shona Wilcox	SW	Risk Advisory Team, Deloittes LLP

Minute		**Action**
AC001/09.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Ian Howse, Partner, Risk Advisory Team, Deloittes LLP and Ian James, Non-Executive Director. Due to the amount of items on the agenda it was agreed that an additional meeting would be held in October to carry agenda items over for discussion and approval. The Audit Committee thanked Erica Hermon, Associate Director of Governance/Company Secretary (EH) and wished her well on her retirement. Gwenny Scott will be taking over the role from the 1 October 2024 and will attend the next Audit Committee meeting.	
AC002/09.24	**QUORUM & DECLARATIONS OF INTEREST**	
	The meeting was quorate.	
AC003/09.24	**MINUTES OF THE MEETING HELD ON THE 25 JUNE 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.	
AC004/09.24	**MATTERS ARISING AND ACTIONS**	
	The complete actions were noted as completed on the action log.	

	AC05.5/09.23 – Contract Management – A joint workshop with the Board to be held by Procurement on the effectiveness of the Atamis tool. Workshop to be arranged in the new year with the Foundation Group on 'Contract Management & Atamis'. Agreed that an update is provided at the December Audit Committee. **ACTION**	**KO**
	AC03.6/06.23 – DHCS Gateway 5 Review Report (Hutted Wards) – The lessons learnt report to be presented at the September agenda. **ACTION CLOSED**	
	AC004/06.24 – Matters Arising and Actions – Mrs Twigg (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 (Chair) will discuss further with new Company Secretary when she commences in post. **ACTION**	**NT**
	AC004/06.24 – Matters Arising and Actions – To discuss with Foundation Group colleagues around whether they have a Financial Reporting Risk Report which we can benchmark ourselves against. Agreed to be presented at the October meeting. **ACTION**	**HM**
	AC004.2/06.24 – Review of WVT Annual Accounts – A footnote to be included in the External Auditors report to clarify the audit fee. Mr Lappin, Associate Non-Executive Director to confirm if addition had been included in the final WVT Annual Accounts. **ACTION**	**KL**
	The ADoCG confirmed that the AGM Annual Report and Annual Accounts were being published to the public on the WVT website and on Admin Control.	
	AC005/06.24 – External Audit – The Chief Executive Officer to provide an update on the governance levels as part of the outcomes framework. **ACTION COMPLETED**	
	AC06.7/04.24 – Internal Audit Strategy & Internal Plan 2023/24 – Internal Audit to link the actions from the second HTA visit at the Mortuary to the first visit in 2022. Picked up as part of the Mortuary audit undertaken in July 2024 and presented as part of the papers for this meeting. **ACTION CLOSED**	
	Resolved – that action log to be discussed at the next meeting.	
AC005/09.24	**GOVERNANCE**	
AC005.1/09.24	**INPHASE DASHBOARD UPDATE**	
	Lynne Carpenter, Quality & Safety Matron provided an update on the InPhase dashboard and the following points were noted:- • The InPhase dashboard presentation slides were taken as read and a brief overview was provided; • A Mortality module has been added to the seven original purchased modules within InPhase, the digital risk management system; • InPhase has been taken over and rebranded by Ideagen. Business as usual noted with no interruptions or issues identified and continuity with team continues. The team is developing an enhanced training suite which will provide benefits; • A learning from patient safety events system which allows serious incidents to be reported digitally by patients and members of the public to feed data directly to NHSE. Question fields and reporting detail are currently being changed, with no news of the implementation date as	

	there is a delay with NHSE. InPhase is ready and a request for WVT to pilot the system has been submitted; • The ImPrivata single sign on option will be provided, which will be beneficial for clinical users (tap in tap out function) and will be implemented as part of the roll out; • South Warwickshire Foundation Trust (SWFT) have given notice to DATIX and will implement InPhase, WVT are fully supporting the implementation with SWFT. <u>Discussion</u> • Worcestershire Acute Hospitals Trust (WAHT) are still using DATIX, EH confirmed that the Quality & Safety Matron's details had been sent to WAHT as a contact for InPhase; • Constant tweaks are still being undertaken to the system, especially the risk module; • The Audit Committee's thanks were given to the team, InPhase has now been embedded in the culture of the Trust; • Mrs Twigg (Chair) requested that when the Non-Executive Directors are on walkabouts they question how staff are managing the system; • Flexibility within the system has provided the most benefit, with the ability to now build our own reports; • The IA questioned if InPhase would be subject to a post project implementation review to provide assurance that the benefits have been delivered. EH requested that the InPhase dashboard update is presented to the Trust Management Board (TMB) to provide assurance.	
	<u>Resolved</u> – that the InPhase dashboard update was received and noted.	
AC005.2/09.24	**<u>DHCS GATEWAY 5 REVIEW REPORT (HUTTED WARDS)</u>**	
	The Chief of Strategy & Planning (AD) presented the Hutted Ward Replacement Post Project Evaluation and the following points were noted:- • The report was taken as read and confirmation was received that the report has now been submitted to NHSE; • The Gateway Review by the Department of Health, which took place last year provided a green rating on the cost of a 72 bed three storey Frailty block; • The Hutted wards were opened in the midst of COVID with some benefits noted following the reconfiguration of the wards there were far fewer medical outliers and the opportunity to ring fenced elective beds, which have been maintained; • Another benefit was the attractiveness of the building to geriatricians, which enabled the recruitment of five Consultants; • The delivery of 18 additional beds plus a 16 bed decant ward, providing the 34 extra beds should have dealt with the demand over the next five years. Looking at the assumptions, there has been an increase in demand and a significant increase in number of transfers of care; • Lessons learnt shows the importance of having critical success factors and objectives for each of the projects; • The Trust was advised to keep the business case under £15 million by the NHSE; • A plan was worked up to include derogations, driven by the need to keep costs down, the Trust worked up a plan and NHSE would not accept the derogations;	

	• The business case financials were developed in an incremental way without a whole zero based analysis, this was a mistake which has meant it has been difficult to evaluate the finances; • Capital was all spent and not overspent; • The delay to the scheme, which involved a flood in the building, took place before the handover to the Trust. <u>Discussion</u> • Mrs Hill (NED) commented that given the overspend on the works and building costs is there any way we can outsource the risk of overspend, for example fixed cost projects. AD responded that in this case the Trust contracted directly with the modular contractor, with a view to keeping costs down and chose not to go down a structured procurement route. If the Trust had gone down the Procure 23 route, which is a national procurement standard and contract, the risk would have been transferred. There is a higher overall cost using this method but it avoids difficult discussions and negotiations and has worked well in other projects; • Mr Lappin (ANED) highlighted on page 28, the increase in rates as a cost and questioned if this is more of a resource transfer from NHS funding to the Council. The Trust has given the Council between £10 million to £20 million of resource when their cost has reduced due to the Council servicing one site instead of three; • Mr Lappin (ANED) commented on PDC dividends and questioned if PDC dividends are paid on net relevant assets. The Trust's losses may be significantly reducing the net relevant assets. The External Auditors (EA's) have stated that the Trust has £45 million of new loans, which would increase the PDC. It was agreed that Mr Lappin (ANED) and the Chief Finance Officer (KO) would discuss the issue outside of the meeting. **ACTION**	**KL/KO**
	<u>Resolved</u> – that: **A) The Hutted Ward Replacement Post Project Evaluation update was received and noted.** **B) Mr Lappin (ANED) and the Chief Finance Officer to discuss the PDC Dividends outside of the meeting and provide an update at the next meeting.**	
AC005.3/09.24	**<u>BUSINESS CASE EVALUATION – LIONEL GREEN</u>**	
	The Chief of Strategy & Planning (AD) presented a verbal update on the business case evaluation – Lionel Green and the following points were noted:- • The Lionel Green building has been derelict for some time. The Estates team had tried to convert the building into offices but had been unable to obtain capital for a non-clinical building; • Money received from Cancer Alliance has been utilised for a new multi-disciplinary cancer meeting room; • Money has been received for increasing outpatient capacity and the ED SDEC scheme for the refurbishment of ED in the Lionel Green building. The feasibility of the work has been completed with One Public Estates money, monies overseen by the Council bid which is Cabinet Office money available to turn derelict buildings back to use; • The scheme was created for Cancer MDT room offices and virtual Outpatient rooms. There were some issues with fire protection, which incurred increased costs, but the scheme was delivered on budget;	

	• The plan for the first floor is to be an expansion of the Education service with a proposal that when the Education centre is developed, Speller Metcalfe will develop the second floor of the building. Discussion • It was confirmed by AD that proper governance was followed and approval received for the transfer of funds from the One Public Estate scheme; • Mr Lappin (ANED) questioned the £1.1 million mentioned on ED transformation. AD confirmed that this was the ED transformation scheme budget used to house the staffing in the building.	
	Resolved – that the update on the business case evaluation – Lionel Green be received and noted.	
AC007/09.24	**LCFS**	
AC007.1/09.24	**PROGRESS REPORT**	
	The Local Counter Fraud Services (LCFS) provided a verbal update on the progress report and the following points were noted:- • The progress report was taken as read; • Approval received for the national procurement and the car parking local proactive exercises to commence; • The delivery of the quarterly fraud, bribery, and cyber awareness session will take place on the 6th November 2024, invites have been issued. Discussion • Mrs Hill (NED) commented on the responses awaited on the alerts and questioned the prioritisation on the responses and if additional support was required. The IA confirmed outstanding alerts are chased on a bi-weekly basis. KO was assured that the teams are reviewing and actioning the alerts. The Deputy Chief Finance Officer (HM) confirmed that the Shared Service team will be contacted to chase up outstanding alerts relating to invoices.	
	Resolved – that the update on the LCFS progress report be received and noted.	
AC007.2/09.24	**BENCHMARKING REPORT**	
	The Local Counter Fraud Services (LCFS) provided a verbal update on the benchmarking report and the following points were noted:- • The Benchmarking report was taken as read; • Within the 2023/24 report, there has been an increase in referrals, which has doubled since the 2021/22 report, which is a positive. This demonstrates that staff feel confident in reporting concerns. Discussion • Mrs Twigg (NED & Chair) commented on staff completing the fraud & bribery questionnaire. KO confirmed that the questionnaire appeared in Trust Talk and KO sent out to each Associate Chief Operating Officer to encourage completion within their Divisions. The LCFS confirmed that only two responses had been received. A regular update will be available at each Audit Committee. LCFS will re-issue the questionnaire and confirmed that there will be a big push in November in Fraud Awareness week;	

	• Mrs Hill (NED) commented that the Trust is only referring in six out of 33 referral types. Some of the high volume referrals e.g. failure to work contracted hours and timesheet fraud and questioned if the Trust was missing something. The IA confirmed that a review had taken place relating to timesheet fraud and controls had been strengthened. Confirmation was received that the referrals will be outlined in the LCFS presentations during the tailored Fraud Awareness sessions; • Mrs Hill queried whether there were any concerns given that a couple of the central function teams were not showing any referral data. The CFO provided reassurance in that the areas are encouraged to make referrals directly rather than refer into a central team for the fraud referrals to be raised, demonstrating accountability and ownership throughout the Trust; • KO stated that it is the increase in referral by topic and volume which is important rather than who it is being reported by; • This aligns with Freedom to Speak Up (FTSU), which shows that people are coming forward.	
	Resolved – that the benchmarking report update be received and noted.	
AC008/09.24	**EXTERNAL AUDIT**	
	The External Auditors (EA) provided a verbal update and the following points were noted:- • Confirmation was received that the final External Audit report 2023/24 will shortly be issued, no additional significant weaknesses were identified; • The EA will be commencing next year's audit and will make contact with HM regarding timescales; • KO commented that it would be advantageous as part of the audit planning process to maximise the work before Year End.	
	Resolved – that the External Audit verbal update be received and noted.	
AC006/09.24	**INTERNAL AUDIT**	
AC006.3/09.24	**WVT DATA QUALITY – ED PATHWAYS AUDIT (FINAL)**	
	The Internal Auditors (IA) presented the WVT Data Quality – ED Pathways Audit report for final approval. The Chief Operating Officer (AP) was in attendance to answer any questions relating to the report. The following points were noted:- • The review was led by an Internal Audit Clinical Consultant and resulted in an overall positive opinion. The arrival, booking and triage times were all accurately captured; • The intention is to roll out Maxims within ED, subject to business case; • Three high and five medium priority actions were identified following a review, one of which was to review the current triage process of the patients and to conduct a review of the neutropenic sepsis guidance; • The Chief Operating Officer (AP) commented on the report and confirmed that the audit provided assurance that every patient is being triaged which is being recorded; • The ED is embedding the Nurse Navigator posts. The Nurse business case was approved at Trust Board, this will ensure that the non-clinical streaming at the reception area is put in place; • The report identifies the leadership within ED and recognised the Estates constraints taking into account the ED decant;	

	• Confirmation was received by AP that many of the actions have been picked up through the Valuing Patient Time Board. KO commented on action 10 relating to Symphony to Maxims and the move to a single EPR, subject to the business case being approved, this is to be placed on the action tracker. **ACTION**	**IA**
	Resolved – that **A) The WVT Data Quality – ED Pathways audit be received and APPROVED.** **B) The IA to add action 10 relating to Symphony to Maxims and the move to a single EPR to the action tracker.**	
AC006.1/09.24	**MORTUARY REVIEW (FINAL)**	
	The Internal Auditors (IA) presented the Mortuary review for final approval. The Chief Medical Officer (CA) was also in attendance to answer any questions relating to the agenda item. The following points were noted:- • The report was given a substantial assurance rating; • A review took place by the Human Tissue Authority (HTA) in November 2022 regarding the Trust's compliance. The actions were completed and the evidence was sent to the HTA. A newly appointed designated individual was appointed which raised some actions. The majority of the actions have been completed, with some local minor actions outstanding. The audits have been planned; • The Chief Medical Officer commented that the Mortuary had undergone a 360 degree change in its governance and functioning and new processes have been embedded; • It was confirmed that any actions will be discussed at Quality Committee.	
	Resolved – that the Mortuary Review report be received and APPROVED.	
AC006.2/09.24	**MEDICAL/SURGICAL JUNIOR DOCTORS ROTA MANAGEMENT (DRAFT)**	
	The Internal Auditors, (IA) presented the draft Medical/Surgical Junior Doctors Rota Management. The Chief of People (GE) and Chief Medical Officer (CA) were also in attendance to answer any questions pertaining to the report. The following points were noted:- • The report has identified gaps and issues with housekeeping and GE confirmed that rota management has been devolved to Divisions over the last few years, the report has highlighted gaps in policies and protocols. GE and CA are working with the Associate Medical Directors and General Managers to address concerns specified in the report. Discussion • CA highlighted that the move to electronic rostering is the way forward; • The report will be discussed at the Education and Workforce Committee from a governance perspective and Mrs Twigg (NED & Chair) and Mrs Rouse (ANED) who attend the meeting will be present to hear the outcome;	

	• GE confirmed that within the next three to six months the position will be improved; • Mr Lappin (ANED) congratulated IA on the quality of the reports and Mrs Twigg (NED & Chair) thanked the Executive team for their involvement and ownership.	
	Resolved – that the draft Medical/Surgical Junior Doctors Rota Management report be received and noted.	
AC005.4/09.24	**CONSULTANT JOB PLANNING**	
	The Chief Medical Officer (CA) provided a verbal update on Consultant Job Planning and the following points were noted:- • The report was taken as read; • CA commented that work had been undertaken collaboratively with the General Manager, Clinical Leads and Consultants. Confirmation was received that 71% of job plans had been signed off; • With regard to productivity gains, transparency was the biggest gain. The next step is to align to capacity and planning and embed good practice in job planning avoiding overlaps; • A workshop with key stakeholder is taking place in October to identify lessons learnt and share good practice; • There is a need to explore theatre capacity to deliver a sensible job plan for T&O. The Associate Chief Operating Officer in Surgery is reviewing a theatre template to identify tha job plans are meeting the needs of the Division as a whole. Discussion • CA had agreed with T&O that job planning would not proceed and start afresh in January for next year, which will allow work in October/November to be completed. A review of the templates to include business planning and demand and capacity planning will be completed in November/December; • CA commented that without the data it is difficult, work needs to be completed by the operational team; • It was confirmed that the productivity gains have been realized as CIP savings and is part of a step change in job planning for H2.	
	Resolved – that the update on Consultant Job Planning be received and noted.	
AC006.4/09.24	**IA PROGRESS REPORT**	
	The Internal Auditors (IA) provided a verbal update on the IA Progress report and the following points were noted:- • The key messages were summarized and confirmation received that three reports had been finalized. The Data Quality review around VTE and Elective process for the Pre- Op theatres report are currently in draft and likely to be presented at the October meeting; • The Medical job planning review will begin in October and work is being scoped for the Key Financial Controls audit which commences in December; • IA confirmed that the Digital Nurse noting to transition on to digital noting has been agreed with KO with a period of embedding and implementation noted. This is still in this year's plan and will be picked up in February;	

	• Appendix C – KPI's issuing reports within 10 days and receipt of management responses has slipped, this has been impacted by the holiday season and IA reported that this will be brought back in line with targets.	
	Resolved – that the update on the IA Progress report be received and noted.	
AC006.5/09.24	**RECOMMENDATION TRACKER**	
	The Internal Auditors (IA) provided a verbal update on the Recommendation Tracker and the following points were noted:- • Of the 53 actions on the recommendation tracker, 23 have been closed as implemented or superseded, 19 were not yet due, 11 were work in progress and revised dates were requested. The actions have been reviewed and agreed by KO; • A number of the actions relate to policies, which will be closed once ratified at Policy Group.	
	Resolved – that the Recommendation Tracker update be received and noted.	
AC006.6/09.24	**INTERNAL AUDIT ANNUAL 2023/24 (FINAL) REPORT**	
	The Internal Audit Annual 2023/24 (final) report was received.	
	Resolved – that the Internal Audit Annual 2023/24 (Final) be received and APPROVED.	
AC009/09.24	**ANY OTHER BUSINESS**	
	EH thanked the Audit Committee and Internal Audit.	
AC011/09.24	**DATE OF THE NEXT MEETING** **Monday 21 October 2024 – 12:00 p.m. – 2:30 p.m. via TEAMS**	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 November 2024 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present:

Russell Hardy	(RH)	Group Chair
Chizo Agwu	(CAg)	Chief Medical Officer WVT
Varadarajan Baskar	(VB)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Acting Chief Medical Officer WAHT (present from Minute 24.086)
Glen Burley	(GB)	Group Chief Executive
Stephen Collman	(SC)	Managing Director WAHT
Neil Cook	(NC)	Chief Finance Officer WAHT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Catherine Free	(CF)	Managing Director GEH
Phil Gilbert	(PG)	NED SWFT
Sophie Gilkes	(SG)	Acting Managing Director SWFT
Paramjit Gill	(PGi)	Nominated NED SWFT
Natalie Green	(NG)	Chief Nursing Officer GEH
Sharon Hill	(SH)	NED WVT
Julie Houlder	(JH)	NED and Vice Chair GEH
Colin Horwath	(CH)	NED WAHT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Kim Li	(KLi)	Chief Finance Officer SWFT
Anil Majithia	(AMa)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Simon Page	(SP)	NED and Vice Chair SWFT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Acting Chief Medical Officer WAHT
Ellie Ward	(EW)	Acting Chief Nursing Officer SWFT
Robert White	(RW)	NED SWFT
Umar Zamman	(UZ)	NED GEH

In attendance:

Jennie Bannon	(JBa)	Acting Chief Strategy Officer SWFT
Rebecca Bourne	(RB)	Head of Communications WAHT
Rebecca Brown	(RBr)	Chief Information Officer WAHT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 November 2024 at 1.30pm via Microsoft Teams

In attendance (continued)

John Burnett	(JBu)	Head of Communications WVT
Paul Capener	(PC)	ANED GEH
Oliver Cofler	(OC)	ANED SWFT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Catherine Driscoll	(CDr)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Jack Foster	(JF)	Associate Chief Operating Officer SWFT (deputising for Chief Operating Officer SWFT)
Oli Hiscoe	(OH)	ANED SWFT
Emma King	(EK)	Deputy Director of Estates and Facilities WAHT (deputising for Chief Strategy Officer WAHT)
Rosie Kneafsey	(RK)	ANED GEH
Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Suzi Joberns	(SJ)	Deputy Chief Finance Officer WVT (deputising for Chief Finance Officer WVT)
Kieran Lappin	(KLa)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Sara MacLeod	(SMa)	Interim Chief People Officer GEH/SWFT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Bharti Patel	(BP)	ANED SWFT
Mary Powell	(MP)	Head of Strategic Communications SWFT
Jackie Richards	(JR)	ANED GEH
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Sue Sinclair	(SSi)	ANED WAHT (present from Minute 24.085)
Robin Snead	(RS)	Chief Operating Officer GEH
Vidhya Sumesh	(VS)	Group Business Information Specialist (observing)
James Turner	(JT)	Head of Communications GEH
Sue Whelan Tracy	(SWT)	NED SWFT (non-voting)

There were four SWFT Governors also in attendance.

MINUTE		ACTION
24.079	**APOLOGIES FOR ABSENCE** Apologies for absence were received from: Fiona Burton, Chief Nursing Officer SWFT; Tony Bramley, NED WAHT; Adam Carson, Managing Director SWFT; Richard Haynes, Director of Communications WAHT; Lucy Flanagan, Chief Nursing Officer WVT; Harkamal Heran, Chief Operating Officer SWFT; Simone Jordan, NED GEH; Helen Lancaster, Chief Operating Officer WAHT; Zoe Mayhew, Chief Commissioning Officer (Health and Care) SWFT; David Moon, Group Strategic Financial Advisor, Dame Julie Moore, NED WAHT; Alex Moran, ANED WAHT; Jo Newton, Chief Strategy Officer WAHT; and Katie Osmond, Chief Finance Officer WVT.	

MINUTE		ACTION
	Resolved – that the position be noted.	
24.080	**DECLARATIONS OF INTEREST** The Acting Chief Nursing Officer for SWFT declared that she was married to a Consultant Anaethetist at SWFT. The Chief Finance Officer for SWFT declared that she had recently been appointed as Chair of the Management Board for 360 Assurance which was the Trust's Internal Audit Service. Simon Murphy, NED and Deputy Chair WAHT, declared that he had been appointed as a Trustee of the Regional Advisory Board in the West Midlands for the Canal and River Trust. Bharti Patel, AED SWFT, declared that she recently accepted a role as NED for Castleman Healthcare Limited. The Group Chair declared that he had stepped down as Chair of Cherished UK. **Resolved – that the position be noted.**	
24.081	**PUBLIC MINUTES OF THE MEETING HELD ON 7 AUGUST 2024** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 7 August 2024 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
24.082	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.082.01	Foundation Group Performance Report (Minutes 23.058, 23.080.01, 24.007.02, 24.035.01 and 24.061.01 refers) The Managing Director for GEH informed the Foundation Group Boards that GEH had completed an audit on data collection to understand why GEH were showing as outliers for Cancer diagnoses from Emergency Department (ED) attendance. The report had identified that there was an inaccuracy in the GEH data collection process. This led to a revised process being implemented and the subsequent outcomes would be monitored through the GEH Cancer Board as a standing assurance item and would go quarterly through their Operational Quality and Safety Group and the Trust's Quality Assurance Committee. **Resolved – that the position be noted.**	
24.083	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP**	

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 November 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	The Group Chair provided an overview of the key discussions at the Foundation Group Boards Workshop earlier that day, focusing particularly on the Foundation Groups 'Big Moves' on Carbon Reduction and Home First. There were also sessions on Sustainability, led by Richard Spencer from E-On Energy Solutions, and Su Rollason the Chief Finance Officer at University Hospitals Coventry and Warwickshire NHS Trust (UHCW), where she shared a presentation on the learnings from their Electronic Patient Records (EPR) system. **Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.**	
24.084	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director for WVT provided an overview of WVT's performance. She explained that the Trust's area of concern remained around the congestion within ED, however there was also challenges with Productivity. The Trust had made good progress with the utilisation of outpatient clinics, which had gone from under 80% to 90%, however Patient Initiated Follow Ups (PIFU) remained challenged. The Managing Director for WVT explained that at the end of November 2024, there was going to be a significant change to the Trust's EPR which would result in more specialities being able to offer PIFU and therefore improvement in this area. The Managing Director for WVT informed the Foundation Group Boards that Theatre productivity had improved, with the Trust hitting 80% utilisation, however more importantly the cases per list had also improved from 3.2 patients per list on average to 3.8 patients per list on average. She highlighted that the number of patients waiting over 52-weeks for surgery had halved in the last twelve months and was on track to half again by the end of 2024/25 to five-hundred patients. It was important to note that this was still a lot of patients, however was a significant improvement. The Managing Director for WVT explained that WVT had seen some solid performance around Cancer, with September 2024 data showing the Trust at 78% for both the 62-day pathways and the 28-day Faster Diagnosis Standard (FDS). She highlighted that WVT Cancer 62-day pathways used to be 85%, however was now only 70% whilst everything continued to recover from Covid-19. WVT was well above the 70% target for 2024/25 and would now continue to aim to get back 85%. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive assured the Foundation Group Boards that he and the Managing Director for WVT had discussed the increase in Elective capacity and the use of WVT's core capacity through fewer cancellations which had been making a big impact on reducing the waiting list. He explained that hopefully there would come a point in the future that a point of equilibrium be reached, which would then lead to the reduction of independent sector usage. The Deputy Chief Finance Officer for WVT, added that she had also started	

MINUTE		ACTION
	having conversations with the Integrated Care Board (ICB) about utilisation and the development of a 2–3-year programme to move away from independent sector usage. The Acting Managing Director for SWFT presented SWFT performance data to the Foundation Group Boards. She highlighted that SWFT's 52-week waits were steadily reducing, however it was important to note the Orthodontics challenges that the Trust continued to face. The Acting Managing Director for SWFT explained that the Trust was working with the ICB and the West Midlands Commissioning Unit to identify alternative Orthodontics providers, and a regional review was about to commence for the service as more medium to long term plans were needed. She highlighted that the Trust had also informed Healthwatch to ensure that they understood the position and could inform any residence who might speak to them. The Acting Managing Director for SWFT informed the Foundation Group Boards that SWFT's Cancer performance continued to be a challenge, especially around 62-day targets, however the 28-day FDS and the 31-day target were on track to be met. She continued that SWFT had done further improvement work around Urology and Gynaecology pathways and therefore expected additional improvement in the targets through November 2024 and December 2024. The Acting Managing Director for SWFT noted that Pathology Services and Diagnostics continued to be the Trust's main concerns. She concluded by celebrating Theatres utilisation, which had hit 86.4%, ranking SWFT fifth nationally. The Acting Managing Director expressed her thanks to Nicola Mills, General Manager for the Elective Division, for the work she had done on Theatre utilisation. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive recommended that the Diagnostic wait times that were linked to Pathology be discussed in more detail at SWFT Board of Directors in December 2024. He also informed the Foundation Group Boards that he had reached out to Professor Tim Briggs, National Lead for Elective Recovery, who had put the Trust in touch with the National Dental Lead for Getting it Right First Time (GiRFT), to see if there was anything he could do to help with an Orthodontics solution. Paul Capener (ANED GEH) noted the significant improvement in late starts in Theatres and queried whether there was any learning that could be shared across the Foundation Group. The Acting Managing Director for SWFT explained that the team responsible for overseeing that improvement would be presenting at SWFT Improvement Board, and she would share the invitation to that session to the wider Foundation Group. The Managing Director for GEH presented an overview of GEH's performance to the Foundation Group Boards. She started by explaining that ED four-hour standard remains at 74.6%, however what we did see in September 2024 was that there was a slight increase in the twelve-hour decision to admit delay. The	**SG** **SG**

MINUTE		ACTION

Managing Director for GEH also informed the Foundation Group Boards that ambulance turnaround time had also increased. She explained that later in the meeting there would be a report on the use of temporary escalation spaces (Minute 24.085 refers) and she emphasised the importance of the report to help with the flow through ED. The Managing Director for GEH provided an update on GEH's Cancer performance, with the 28-day FDS being at 76.7% with the Trust continuing to aim for 80% or above. She highlighted GEH's improvement around 62-day performance, going from bottom in the region, to now being sixth. The Managing Director for GEH added that another area of improvement included the Trust successfully achieving no patients waiting longer than 65-weeks for treatment, which was a target that had to be achieved by September 2024. The Managing Director for GEH gave an overview on Elective performance, highlighting those inpatient operations being at 175% in comparison to 2019/20. She explained that the Trust was behind on their day cases at 95% but that was in part due to focusing on clearing the patients waiting longer then 65-weeks. GEH was at 109% on outpatients first appointments which continued to improve, and Theatre productivity had dipped but this was due to flooding in two of the Trust's new theatres. The Managing Director for GEH concluded by explaining that GEH was looking into their Referral to Treatment (RTT) performance to try and understand why waiting lists were not reducing despite more operations being delivered. She added that RTT was likely to become a national area of interest in the future as well.

The Managing Director for WAHT presented WAHT's performance, highlighting ED being the Trust's biggest area of concern. He continued that ambulance handover delays, and admission delays was a focus area, however part of this was an impact of the work taking place in ED. The Managing Director for WAHT explained that one of his biggest concerns was the Trust's long length of stay (LoS) for patients over 21-days. This was currently sitting at 150 patients, whereas previously it was fifty and related to patients mainly Medically Fit for Discharge (MFFD). The Chief Nursing Officer for WAHT and Acting Chief Medical Officer for WAHT were working with the system to try and reduce this. The Managing Director for WAHT highlighted the improvement that WAHT had made around Cancer performance and the Trust was hoping to be removed from the tiering arrangements in place as a result of that work. He also noted the RTT and Productivity improvements that had been made, with the Trust running at around 125% and the teams had also been following a 'right site, right surgery' methodology, however driving those improvements was the maximising of the Alexandra and Kidderminster Hospital sites. The Managing Director for WAHT concluded by highlighting the financial figures on insourcing, which was significant, and the Trust had also been able to illuminate most of their insourcing work.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chief Executive appreciated the Managing Director for WAHT addressing the Trust's long LoS concern, however he also noted that the short

MINUTE		ACTION
	LoS presented a potential opportunity to use the Same Day Emergency Care (SDEC) areas more for shorter stay patients to clear some of the ward areas. The Managing Director for WAHT explained that the Trust recently bought the SDECs together and they were starting to push them on their acuity, and as part of the Winter Plan they should hopefully start to free up some of those spaces. The Chief Nursing Officer for WAHT added that the Acting Chief Operating Officer for WAHT was going to reach out to the Clinical Leads across the Foundation Group for advice on SDEC, especially Surgical Leads, due to the push back experienced at WAHT. Frances Martin (NED and Vice Chair WVT) emphasised the importance of patients not being in an acute setting if they could be in less clinical settings. This was for several reasons including flow, but also was better for patients. The Group Chair took the time to thank WAHT colleagues and express how impressed he was with the pace of progress and improvements that they had achieved. He emphasised how quickly with the right leadership, challenged organisations could turn things around. **Resolved – that** **A) the Foundation Group Performance Report be received and noted;** **B) the Acting Managing Director for SWFT ensure that SWFT's Diagnostic Wait Times that related to Pathology be discussed in more detail at the SWFT Board of Directors in December 2024, and**	**SG**
	C) the Acting Managing Director for SWFT ensure the SWFT Improvement Board meeting information be shared with the wider Foundation Group, for the session on Theatre start time improvements.	**SG**
24.085	**WINTER PREPAREDNESS UPDATE AND USE OF TEMPORARY ESCALATION SPACES (TES)** The Group Chair highlighted to the public the importance of flow throughout the hospital. He explained that if Trusts were experiencing bed blocking with long LoS because patients were unable to get home or into a more appropriate setting, it resulted in ED becoming congested. He continued that this congestion had resulted in Trusts having to open surge capacity which could be in locations not equipped for patient care. The Chief Operating Officer for WVT introduced the Winter Preparedness element of the presentation. He explained that ED attendances were always considered as part of the Foundation Group's winter plans. Looking back on data it showed a year-on-year increase in ED activity levels, and this was predicted to increase again in the 2024/25 winter months. The Chief Operating for WVT explained that whilst it was natural to see an increase during winter months, what had been happening over the past few winters was that the activity was remaining high post winter throughout the year, and then increasing again the following winter. He continued that the overall plan for winter was to	

MINUTE		ACTION

improve patient flow, reduce demand on hospital inpatient capacity, work collaboratively with partners to maximise their input in the safer management of patients and improve the pre 8am decision to admits (DTAs) waiting for a bed.

The Chief Operating Officer for WVT provided an overview of the different elements that would enable the Trusts to deliver the overall winter plan, this included reviewing site capacity processes, site capacity digitalisation at SWFT, adopt the SAFER patient flow as part of board rounds, ensuring a criteria led discharge focus, developing a Frailty SDEC, introducing new Virtual Wards, promoting and continuing Call before Convey with West Midlands Ambulance Service (WMAS), improve Discharge to Assess (D2A), and ensure a single point of access was in place.

The Chief Operating Officer for WVT informed the Foundation Group Boards of the pathway challenges that were being faced heading into winter 2024/25. He explained that Emergency activity continued to be challenged, however there was also an increase in acuity. MFFD patients in inpatient beds continued to be a problem as well as community capacity transparency. The Chief Operating Officer for WVT added that it was important to note most Trusts were heading into winter with a demoralised workforce, with most teams not having had a break from pressures since before Covid-19 which understandably was having an effect on staff morale. The Chief Operating Officer for WVT informed the Foundation Group Boards that there was also a specific risk around the 45-minute rapid ambulance offload requirements, so there was a need to ensure ED and escalation processes were in place.

The Chief Operating Officer for WVT concluded by presenting what had been put in place for each Trust, including a point prevalence audit to ensure the right patient was in the right bed, and also looking at learning across the system to inform plans going forward. All plans also included the aim to reduce the need for TES as much as possible.

The Chief Nursing Officer for GEH provided the Foundation Group Boards with the presentation on TES across the Foundation Group. She explained that the Foundation Group's priority was to reduce the amount of TES and corridor care. The Chief Nursing Officer for GEH explained that over the past few years there had been a large increase in demand and the requirement to use every space possible, which had resulted in sub-optimal care, and this had been depicted in the media and on television shows such as Dispatches. In response to that, NHS England (NHSE) set out principles for providing safe and good quality care in TES, however TES should not be normalised and not counted as standard practice. The Chief Nursing Officer for GEH emphasised that TES were not the same as escalation beds, which were planned and had the designated resource areas, equipment and were used generally during winter demands. The Chief Nursing Officer for GEH presented the six principles to the Foundation Group Boards in relation to TES to ensure patient safety and patient experience were met. These included assessment of risk, escalation, quality of

MINUTE		ACTION
	care, raising concerns, data collection and measuring harm, and de-escalation. She assured the Foundation Group Boards that all Trusts within the Foundation Group pulled together everything in place against each of the principles to support staff and offer assurance that the quality of care in TES was being monitored. The Chief Operating Officer for GEH concluded the presentation by presenting the potential other implications of using TES. This included financial impact due to an increase in demand on staff, which subsequently effected staff morale, retention and sickness, therefore increasing Bank and Agency costs. The Chief Operating Officer for GEH also highlighted the pressures on quality and safety and psychological implications on staff that TES could cause. He explained that following winter, the Trusts would be facing the result of the increased demand, this would mean additional pressures would remain including Elective Recovery and the risks of not meeting financial targets. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive thanked the Chief Operating Officers and Chief Nursing Officers for a comprehensive report. He explained that it was good to see the shared ownership of risk and flow, and how well that was being managed. The Group Chief Executive added that the 45-minute protocol would bring another level of judgement against risk, so it was important to be mindful to not allow all that risk to be around the front door but looked at as a system. The Managing Director for GEH expressed that the presentation was built around the guidance that was sent out for the use of TES, which was imperative to keep patients safe when they were not in the right spaces for care. She explained that one of the recommendations was for Board members to understand and talk to patients about the delays they were facing within the Emergency pathway, and she encouraged Board colleagues to do this. In terms of the 45-minute handover protocol for ambulances, she expressed how Trusts were experiencing extremely overcrowded EDs and were then having to take additional patients into that setting which was really ratcheting up the level of risk of the ED. She added that the focus had to be on pathway Zero to ensure patients that could go home without support were being discharged. She emphasised that improvement in flow out of the hospital was imperative. Sarah Raistrick (NED GEH) echoed the importance of not allowing TES to become business as usual, and noted the need to keep Primary Care Network (PCN) colleagues up to date with the position Trusts were in. The Group Chief Executive highlighted that it would be interesting to do financial benchmarking across the Foundation Groups EDs particularly around the financial benchmarking. He explained that ED teams had been increased to accommodate patients waiting longer in A&E departments, however he	**COOs/CNOs/CFOs**

MINUTE		ACTION
	queried whether that funding could be used for admission avoidance or improved discharges. The Group Chair took the time to thank all front-line staff for working through incredibly challenged times. He also apologised to patients who were experiencing unacceptable delays. **Resolved – that** **A) the Winter Preparedness Update and Use of TES be received and noted, and** **B) the Chief Operating Officers, Chief Nursing Officers and Chief Finance Officers do a piece of work around ED benchmarking across the Foundation Group.**	**COOs/ CNOs/ CFOs**
24.086	**DEEP DIVE INTO WORKFORCE PRODUCTIVITY** The Chief People Officer for WAHT informed the Foundation Group Boards that the data set the Chief People Officers looked into spanned back eighteen months. One of the key focus areas was the reduction in agency spend, which had improved in comparison to eighteen months ago, however there was a significant improvement that was still needed to achieve anywhere near the level of reduction that systems needed to get to which was 3.2%. The Chief People Officer for WAHT explained that the West Midlands had developed a Medical Agency Cluster which was made up of a group of organisations working together to tackle some of the rate cards and agency rates, especially around medical locums. The Chief People Officer for WAHT explained that it was pleasing to see a slight decline in turnover over the past eighteen months, meaning less staff were leaving. The NHS Long-Term Workforce Plan provided a rough overview of suspected pressures that Trusts could face in the coming years. It recommended that Trusts should be moving towards the 7.4% - 8.2% rate of turnover, and therefore work needed to continue to take place into the flexible options. The Chief People Officer for WAHT added that vacancy rates had also improved, however this had not necessarily aligned to the reduction in temporary staffing due to the increase in demand and extra capacity that had to be created. One of the main contributing factors to that temporary staffing cost was staff sickness, and this had not really improved the way Trusts would have hoped over the past eighteen months, with psychiatric illnesses now being one of the main reasons for absence. The Chief People Officer for WAHT explained that NHS time to hire looked fairly lengthy, however the NHS had a set of standards and requirements that had to be completed and could not be compromised despite potential delays the checks could cause. The Chief People Officer for WAHT explained that WAHT had seen a reduction in agency spend especially around nursing agency spend, and the Trust was now focusing on medical agency reduction. She added that the Trust had recently decided to invest further into the Occupational Health resource, to try and support improved wellbeing and attendance, recognising the change in demand.	

MINUTE		ACTION

The Interim Chief People Officer for GEH/SWFT presented the GEH themes, achievements and actions. She highlighted that one of the things GEH was proud of was the work they had done to reduce agency usage, with no off-framework agency usage in over eighteen months. She explained that there had also been a continuous reduction in staff turnover, but this remained higher than the other Trusts within the Foundation Group and work was being completed to improve this. The Interim Chief People Officer for GEH/SWFT added that GEH's overall vacancy rates had reduced, with successful recruitment into key posts such as Opthalmology and Paediatrics. Sickness rates remained above the target but was comparable nationally for sickness. The Interim Chief People Officer for GEH/SWFT explained that GEH had implemented a regional agency rate card for medical staff, and were working with NHS Professionals to stop all agency usage above the price cap. She acknowledged that GEH's time to hire was longer in comparison to other Trusts within the Foundation Group and this was in the process of being reviewed to try and reduce this.

The Interim Chief People Officer for GEH/SWFT presented the SWFT themes, achievements and actions. There had been a continuous reduction in turnover which was well below the target, agency spend had also significantly reduced from previous years, but was still above the NHSE ceiling of 3.2%. Sickness absence remained an area of concern at SWFT and the Trust was in the process of reviewing the Sickness Absence Management Policy as this had not been reviewed since before Covid-19. The Interim Chief People Officer for GEH/SWFT explained that similarly to GEH, SWFT had introduced the agency rate card for medical staff, had a People Promise Manager action plan to promote flexible working and work was taking place to benchmark and review internal bank rates for all staff groups.

The Chief People Officer for WVT presented the WVT themes, achievements and actions. He explained that WVT was taking similar actions to WAHT, GEH and SWFT to continue driving down agency spend, improving vacancy rates and reducing staff turnover. In relation to agency spend, the Chief Medical Officer for WVT and Chief Nursing Officer for WVT were running agency reduction programmes alongside the Chief People Officers. He added that WVT would be taking part in a national story focusing on sickness within the NHS, this would be commencing in January 2025 and last twelve months. The Chief People Officer for WVT informed the Foundation Group Boards that the Trust was conducting reviews of its Key Performance Indicators (KPIs), taking learning from SWFT and also ensuring they aligned to NHS wider KPIs. On top of this, staff engagement work was taking place, especially around the Freedom to Speak up agenda.

The Group Chair invited questions and perspectives and of particular note were the following points.

MINUTE		ACTION
	The Group Chief Executive thanked the Chief People Officers for an informative presentation, and the work they were all doing to push the NHS Staff Survey in the background. He expressed that it felt like Nurse agency reduction had made improvement, but that there was a need to focus on the medical reduction. The Group Chief Executive also noted that a lot of work was being done around improving staff support, but felt there could be a group opportunity to further strengthen that. **Resolved – that the Deep Dive into Workforce Productivity be received and noted.**	
24.087	**GENDER PAY GAP UPDATE** The Interim Chief People Officer for GEH/SWFT informed the Foundation Group Boards that all NHS Trusts were required to publish an annual Gender Pay Gap report, and this was based on the pay indicator set out by the Government's Equalities Office. She explained that out of all four Trust's in the Foundation Group, the workforce was predominantly female, with just over 80% however when broken down by pay quartile, for most Trusts females were generally in the lower quartile compared to the upper quartile. This meant that women were more likely to be employed in the lower banding roles opposed to those higher banded positions. The Interim Chief People Officer for GEH/SWFT continued that when looking at the mean figure, overall men earned a higher percentage of pay then women. It was important to note that the report was not an equal pay report. This meant that the data was not suggesting men were receiving the same rate of pay for doing the same role, however it did indicate that men were more likely to be in the higher paid positions. The Interim Chief People Officer for GEH/SWFT explained the actions being put in place at GEH to address the gender pay gap included developing the leadership programme encouraging more women to attend to progress into senior roles, developing the levelling up programme to support international nurse recruits into more senior roles and working with staff networks to promote opportunities available for all colleagues. She explained that at SWFT the pay gap was closing but work was still needed, this included working with staff networks and international nurses and promoting flexible working opportunities. The Chief People Officer for WAHT presented the actions put in place at WAHT which included promoting flexible working offers, apprenticeships and including career conversations as part of annual development reviews. The Chief People Officer for WVT echoed the other actions taking place across the Foundation Group including working with Integrated Care System (ICS) partners on launching an online platform for coaching and mentoring opportunities, improving recruitment practices through gender diverse recruitment and would also start to report on the gender pay gap in consideration of equality. **Resolved – that the Gender Pay Gap Update be received and noted.**	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 November 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
24.088	**FOUNDATION GROUP BOARDS 2025/26 CALENDAR OF MEETINGS FOR APPROVAL** The Group Chair presented this report for approval. There were no comments or questions raised. **Resolved – that the Foundation Group Boards 2025/26 Calendar of Meetings be approved and ratified.**	
24.089	**ANY OTHER BUSINESS** No further business was discussed. **Resolved – that the position be noted.**	
24.090	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
24.090.01	Question from a SWFT Public Governor (West Stratford and Borders) The following question was submitted by the Public Governor in advance of the meeting: *'Whilst mention has been made of Intelligent Conveyancing, there is no mention of the risk associated with the implementation of the 45-minute protocol. How is it intended to mitigate this risk?'* The Associate Chief Operating Officer for SWFT explained that it represented a large risk for SWFT and other members of the Foundation Group, however the performance turnaround was 30-minutes which therefore already mitigated some of that risk. In terms of mitigations, this had been discussed in detailed throughout this meeting as part of flow, because if a Trust had flow right then it should have the capacity to off-load the ambulances. He added that these risks were also discussed on a daily basis at the Trust's operational calls, including using the escalation spaces. **Resolved – that the position be noted.**	
24.090.02	Question from a SWFT Public Governor (West Stratford and Borders) The following question was submitted by the Public Governor in advance of the meeting: *'With Covid-19 still circulating in the community, what is the prevalence of Long Covid in the community and how is this being addressed?'* The Associate Chief Operating Officer explained that he had reached out to Duncan Vernon, Public Health Consultant, regarding prevalence. There was not much in place within the community at the moment, however at SWFT the	

MINUTE		ACTION
	Trust continued to run a bi-weekly post Covid-19 Multi-disciplinary Team (MDT), where they could then access a range of professionals to provide the support they needed. Referrals had reduced significantly into that team since 2021/22; however, the team were doing a lot of work around educational training with PCNs to ensure the referral pathway was known and offered to patients within the community. **Resolved – that the position be noted.**	
24.090.03	Question from WAHT Patient Forum The following question was submitted by the member of Patient Forum in advance of the meeting: *'Why is the information on the TV screens in Worcestershire Acute Hospital Emergency Department waiting room not up to date and not giving real information? There are three columns, one for General Practitioner wait times, one for waiting room times and the third one is blank. What is it for? During, a 7-hour wait the waiting room column was static at 16 patients only changing to 15 patients at the end of 7-hours despite more patients arriving in the waiting room.'* The Chief Technology Officer for WAHT assured the Foundation Group Boards that they had checked the screens and they were accurate, however it could have been that the data was delayed, or people in the waiting rooms were people with patients or patients waiting to be admitted. **Resolved – that the position be noted.**	
24.090.04	Question from a Member of the Public A member of public had submitted a detailed question in advance of the meeting around WAHT's complaints system, complaints policy, whether the quality of service to complainants had been compromised and whether the Trust complied with NHS Complaints Standards Summary of Expectations 2022. The Group Chair agreed that due to the nature of this question, it was more appropriate to be handled under the Freedom of Information process and also discussed in more detail at the WAHT Trust Board meeting in December 2024. **Resolved – that the Associate Director of Corporate Governance/Company Secretary WAHT/WVT ensure the question be handled under the Freedom of Information process and discussed in more detail at the WAHT Trust Boad meeting in December 2024.** Question from a Member of the Public	**GS** **GS**

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 November 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
24.090.05	A member of public had submitted a detailed question in advance of the meeting around WAHT's mortality data, Learning from Deaths policy and the report of such information to the WAHT public Board meeting on a quarterly basis. The Group Chair agreed that due to the nature of this question, it was more appropriate to be handled under the Freedom of Information process and also discussed in more detail at the WAHT Trust Board meeting in December 2024.	**GS**
	Resolved – that the Associate Director of Corporate Governance/Company Secretary WAHT/WVT ensure the question be handled under the Freedom of Information process and discussed in more detail at the WAHT Trust Boad meeting in December 2024.	**GS**
24.091	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
24.092	**CONFIDENTIAL APOLOGIES FOR ABSENCE**	
24.093	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
24.094	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 7 AUGUST 2024**	
24.095	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.096	**ANY OTHER CONFIDENTIAL BUSINESS**	
24.097	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 5 February 2025 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chair) Date: 5 February 2025
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 5 FEBRUARY 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
24.084 (06.11.24) Foundation Group Performance Report	The Acting Managing Director for SWFT ensure that SWFT's Diagnostic Wait Times that related to Pathology be discussed in more detail at the SWFT Board of Directors in December 2024. The Acting Managing Director for SWFT ensure the SWFT Improvement Board meeting information be shared with the wider Foundation Group, for the session on Theatre start time improvements.	S Gilkes S Gilkes	To be included in the Integrated Performance Report.
24.085 (06.11.24) Winter Preparedness Update and Use of Temporary Escalation Spaces	The Chief Operating Officers, Chief Nursing Officers and Chief Finance Officers do a piece of work around Emergency Department (ED) benchmarking across the Foundation Group.	Chief Strategy Officers / Chief Nursing Officers / Chief Finance Officers	
24.090.04/24.090.05 Questions from Members of the Public and SWFT Governors	The Associate Director of Corporate Governance/Company Secretary for WAHT/WVT ensure the questions from the members of the public relating to WAHT complaints policy and WAHT mortality data reporting be discussed at WAHT Trust Board in December 2024.	G Scott	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Quality Committee August 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 August 2024

1. Purpose of the report

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

To consider the summary report and minutes and to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

N/A

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

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***

☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***

☒ ***Work with partners to deliver the improvement plan for Children's services***

Digital

☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***

☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***

☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***

Productivity

☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***

☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***

☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***

Sustainability

☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***

☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***

☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***

Workforce

☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***

☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***

☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***

Research

☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***

☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Matters for Noting

1. **Patient Safety Panel – Admissions, Discharges and Transfers** – This has been agreed as a quality priority due to the identification of a range of issues from the patient survey and complaints and incidents linked to patient moves. Committee agreed that the priority is presently too broad in scope and requires more focus, and will consider again following further analysis

2. **Ward Accreditation** – There is agreement to pursue ward accreditation across the Foundation Group. WVT has an Accreditation Group and is running a pilot on Dinmore ward. The Trusts approach is to progress this ambition by developing a programme of peer review visits. Full accreditation is a long-term goal and would need to be resourced. Committee agreed that the peer reviews will allow assessment of what we would need as well as being very beneficial in themselves.

3. **Mortality Report** – Committee welcomed the SHMI death rate remaining below 100, but noted the outlier alert from the Healthcare Quality Improvement Partnership regarding fractured neck of femur. This is a known concern and Committee was assured that work is already in train to assess how the pathway can be improved, with a workshop planned in October.

   Sepsis is another outlier and Committee was assured that a thematic audit will be carried out to identify learning.

4. **Colposcopy Report** – Committee noted the problems in meeting 2 week and 6 week waits but was assured that these reflected staffing shortfalls in Q4 of last year and Q1 this year and that these issues were now resolved and with patients again being seen within these timescales.

   Following discussion of the last colposcopy report Committee also received an audit of patients who had opted for conservative treatment at CIN2 stage and were assured of the outcomes in these cases and that they were in line with those from other trusts.

5. **Boarding Report** – We continue to see high numbers of boarded patients and the focus on improved flow of patients into, through and out from the hospital continues. To strengthen this further a new Flow Facilitator post has been created. Work is also underway to move the Discharge Lounge to a better and location with better environment and facilities.

6. **Perinatal Safety Quarterly Report** – Across a comprehensive report, Committee focussed on 1) findings from a cluster review of higher than average post-partum haemorrhage and the setting up of a task and finish group to work on this; 2) work with Powys midwives to review cases concerning reduced foetal movements and 3) work to improve Gloucestershire discharges

7. **Deep Dive Emergency Department CQC Action Plan Update -** – Quality Committee continues to scrutinise progress on the actions to address CQC concerns but used this opportunity to review some key areas in more depth including:

   - Focus on the patient pathway including need for assurance that patients are triaged;
   - Management of pain;
   - Need for access to resuscitation training;
   - Risk of patients falling between our Symphony and Maxims IT systems;

   While challenges remain, overall Quality Committee was assured by the clear focus on these as well as the considerable progress made in response to the CQC report.

8. **Infection Prevention Quarterly Report** – Quality Committee noted concerns about the higher-than-expected levels of C-Diff cases so far this year and was assured that a summit id being held to review these. The CPE outbreak at Ross has been the area of greatest focus and we are working with the ICS and with NHSE on the response to this.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 29 August 2024 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED) (left meeting for 30 minutes during item 11)
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Rachael Hebbert	RH	Associate Director Nursing (ADN)
Jane Ives	JI	Managing Director (MD)
Frances Martin	FM	Non-Executive Director (NED)
Grace Quantock	GQ	Non-Executive Director (NED)
In attendance:		
Sadia Akhtar	SA	Consultant Obstetrics and Gynaecology
Chris Beaumont	CB	Mortality Project Manager (MPM) - For item 8
Lynn Carpenter	LC	Quality and Safety Matron (QSM)
Jo Clutterbuck	JC	Associate Chief Operating Officer– Medical Division (ACOO)
Rosemary Gardiner	RG	GIRFT Out Patient Delivery Lead
Helen Harris	HH	Integrated Care Boards (ICB) Representative
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 (DCMO)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Natalie Simcock	NS	Lead Nurse, MacMillan Renton Unit
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division
Amie Symes	AS	Associate Director Midwifery (ADOM) (for item 12)
Emma Wales	EW	Associate Chief Medical Officer (ACMO), Medical Division
Laura Weston	LW	Lead Infection Prevention Nurse

QC001/08.24	**APOLOGIES FOR ABSENCE**	
	Chizo Agwu (Chief Medical Officer), Dan Harding (Associate Director Diagnostic Programmes), Sharon Hill (Non-Executive Director), Sarah Holliehead (Associate Chief Nursing Officer), Natasha Owen (Associate Director of Quality Governance) and Nicola Twigg (Non-Executive Director)	
QC002/08.24	**QUORUM**	
	The meeting was quorate.	
QC003/08.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC004/08.24	**MINUTES OF THE MEETING HELD ON 25 JULY 2024**	
	Resolved – that the minutes of the meeting held on 25 July 2024 be received and approved.	

QC005/08.24	**ACTION LOG AND MATTERS ARISING**	
	The actions were reviewed and updated: QC06.3/07.24 – ICB Representative to escalate children looked after dental check-ups via the dental commissioning quality route – HH to discuss with BH-T and email the response. CQ015/06.24 – There is a risk on the register regarding medication and the time to get critical drugs in ED due to Symphony and EPMA not linking. Work is ongoing to mitigate this risk. Further, the integration of EPMA and Maxims should be another standalone risk on the register and will be discussed and an update provided as part of the deep dive into ED and any other divisional concerns - The risk is on the register re medication and time to critical drugs in ED due to Symphony and EPMA and work is ongoing to mitigate. The remaining actions are due to be reported at the September meeting	
	Resolved – that: the Action Log be received and updated.	
	BUSINESS SECTION	
QC006/0.24	**PATIENT SAFETY PANEL – ADMISSIONS, DISCHARGES AND TRANSFERS**	
	The Quality and Safety Matron (QSM) gave an update on the patient safety priority admissions and discharges relating to the movement of patients and delays to follow up. The priority had been discussed at patient safety committee where it was identified that: • The priority is too broad, preventing the collection of meaningful information and has likely led to under reporting. • There is an inadvertent overlap with another priority – delays to assessment, diagnosis and treatment. It was acknowledged that the patient safety incident response plan (PSIRP) is still in the embedding phase and therefore open to further refinement and review including the processes to capture the data more effectively. This work would be reported at the next meeting. The Chair asked for clarity on what the overall aim and objective of this work was. The ACMO also asked if the movement of dementia patients was monitored as part of the safety priority. In response, the CNO explained that when developing the PSIRP, information was triangulated from a variety of sources; this triangulation identified problems relating to the admission and discharge of patients which in itself a very broad category. There was also a specific issue with the movement of patients, especially overnight, and with delays to follow up, these were highly likely to present ongoing concerns.	

	The CNO explained that the ability to capture this data had also been impacted by system changes and this was being reviewed. Therefore, the next set of data would enable greater analysis to determine if this remains a priority moving forward or whether there is a more narrow focus. The CNO confirmed that we used to count the number of patient moves after 22.00 hrs and will see if we can capture this along with those who have a dementia diagnosis. **ACTION** The ICB Representative noted that a deep dive on safety would be taking place across systems and could feed in that learning.	**LF**
	Resolved – that: **A. The patient safety panel – Admissions, Discharges and Transfers update be received and noted** **B. The CNO will ask informatics to see if patient moves and those with a dementia diagnosis can be captured from maxims as a BAU performance indicator**	**LF**
QC007/08.24	**WARD ACCREDITATION**	
	The CNO explained that ward accreditation was initially set as a Foundation Group objective in 2022, reporting at that time through the Foundation Group Strategy Committee. It was subsequently agreed to become BAU reporting into each organisation at Quality Committee. The ADN presented a slide set and highlighted the following points: • It is key to note that ward accreditation is not an inspection, but around sharing best practice and gaining assurance in terms of quality. It brings together important quality indicators and is an opportunity to review how wards are performing against each other and to share best practice and innovation. • There had been an ambition to have a joint Foundation Group standard operating procedure (SOP) for ward accreditation and all four trusts had met to look at how this would work. However, given the differences in trust sizes and the resources available, partners were already at different stages of the journey and it was decided therefore not to pursue this as a wider group. • The WVT Ward Accreditation Working Group has been established and a pilot of the approach was run on Dinmore Ward. This data informed a methodology for future visits.	

	• As part of the next steps it is planned to implement the peer review part of the process and expand the pilot to one surgical, one medical and one community ward. The visiting team would include the ADN, QSM and a Ward Manager from a different ward and would look at the methodology and determine what is needed going forward. The final stage would be to have conducted peer review visits for all wards areas within the next six months. As part of peer review visits there will be an opportunity for the Ward Manger to share a short presentation on what they are proud of and any quality improvement projects. The CNO explained that the national evidence regarding full accreditation processes can extend to a large amount of work, requiring an infrastructure to support and that accreditation can take up to5 years. It was agreed that the peer review visits would give sufficient intelligence to share best practice and introduce quality improvement initiatives. Further, undertaking peer reviews in pilot areas will be helpful and a half day will be spent in each area to observe and talk to staff as a useful exercise to identify best practice for sharing and areas for focus. Overall, the committee agreed that the peer review process is valuable although disappointing that it had not been possible to carry out the process as a Foundation Group, It was also noted that there should be some consideration given to how this is communicated to ward staff including whether to use the term 'ward accreditation'.	
	Resolved – that the Ward Accreditation report be received and noted	
QC008/08.24	**MORTALITY REPORT**	
	The MPM presented the mortality report and highlighted the following: • The provisional SHMI shows further reduction and is now below 98. • Crude mortality equated to 66 deaths, which is another positive trend. • Perinatal mortality also remains very low. • An outlier alert was received from The Healthcare Quality Improvement Partnership regarding fractured neck of femur. A thematic audit took place of all deaths over a period of 12 months which showed they were predominantly frail, palliative, co-morbidity patients. A workshop will be held in October with key stakeholders to see if that pathway can be improved. • Pneumonia, the biggest cohort of deaths, has seen a significant drop to 94.	

	• New legislation for medical examiners has been passed and goes live 9 September 2024. This will provide a more streamlined service and all deaths will be reviewed by the Medical Examiner Service. WVT has also taken some helpful advice from Worcestershire Acute Hospitals Trust (WAHT) who are further ahead in the process. • A piece of work has been instigated with the Clinical Coding and Surgery Teams to investigate the reason for a dip in depth of coding. The Chair acknowledged the huge progress made in the last two years and asked how we would respond to the outlier alert regarding fractured neck of femur. The MPM confirmed that a letter was sent which outlined what has been done and what the plans are moving forward. The pathway has been broken down into many steps and we are able to see the barriers. A further action plan is due mid-October The MD had been concerned that SDEC reporting may cause a data issue but it did not appear to have been the case so far. The MPM responded that data may be varied for a few months and would need to be reviewed over the coming months. He noted that WAHT had done a piece of work around how this may impact. The ICB Representative noted that septicaemia had not been noted as a mortality outlier group and asked if there was anything to add. The MPM confirmed that another thematic audit would take place to identify anything cross divisional and noted that every sepsis death will have a mortality review at Learning from Deaths Committee.	
	Resolved – that the Mortality Report be received and noted.	
QC009/08.24	**COLPOSCOPY REPORT**	
	The GIFT Out-patient Delivery Lead, presented the colposcopy report. • The considerable backlog for two and six week waits reflects the difficulties experienced in Q4 of last year and Q1 of this year. This is predominantly due to workforce shortfalls. • There were also some admin errors with four patients incorrectly entered on Maxims. Training has since been given to mitigate any future errors • A Nurse Colposcopist is now in post and is progressing in her training. • A job planning process has been completed for lead roles with three objectives identified for each lead role.	

	• The number of colposcopy sessions has been increased from 12 to 14 which has showed a great improvement and patients are being seen within six week / two week targets. • The service is currently very reactive and there are some concerns around the high number of admin vacancies which may result in delays with appointments / sending results to patients. Admin support is under review to strengthen cover at times of absence. • The Fail Safe Officer vacancy has been successfully recruited though there remains a risk during the time of transition. • The CIN2 audit has been completed and presented at Programme Board. The Consultant Obstetrician and Gynaecologist presented the key conclusions from the CIN2 audit. • The audit was completed from 2020-2022. Over the three years, CIN2 and CIN3 changes were measured using BSCCP UK and National screening programme standards • Of 126 patients, 84 underwent the conservative management pathway. 73 patients underwent regression and were discharged. • The rest of the findings were reassuring and development of guidelines to inform on care of all patients is underway. Suitability for conservative pathway will depend on age and only those patients under the age of 50 will be offered conservative pathway. • All patients will be discussed at multi-disciplinary team meeting (MDT) to ensure all are in agreement with the proposed treatment options. • The outcomes of conservative treatment were in line with those from other trusts. The conservative pathway is also part of national guidance. It was agreed that it would be useful to have shared information across the group therefore the DCMO will reach out to other trusts across the Foundation Group. **ACTION**	**TM-J**
	<u>Resolved</u> – that: **A. The colposcopy report be received and noted.** **B. The DCMO will reach out to other trusts across the group to obtain any information which might be shared.**	**TM-J**

QC010/08.24	**BOARDING REPORT**	
	The Associate Chief Medical Officer (ACMO), Medical Division presented the monthly boarding report. • Although a slight reduction was seen in July, the number of boarding patients remains high. • The average number of patients in the discharge lounge has been fairly stable, however the total percentage of all discharges using the lounge has decreased. • There has been a significant influx of quality and safety incidents from Wye Ward, mostly around infrastructure and the high number of boarding patients on the ward. • ED attendances remain high. • The ward moves completed in July are now embedding and have increased the medical bed base to reduce the number outliers and reduce length of stay. • New Patient Flow Facilitator post has been advertised for a trial basis. The main aim is to improve flow, focussing on discharge processes. They will also take over management of Discharge Lounge. • It is planned for the Discharge Lounge to move to an improved space with natural day light and increased capacity. Several options have been identified but will depend on the costs involved. • An audit of decision to admit is also being undertaken given the rising number of admissions we are seeing equating to on average an extra 5 per day. The Chair asked if there was a target for percentage of patients who use the Discharge Lounge. It was confirmed that there are no national figures to compare to so no target has been set but that there is some resistance from wards to use the current discharge lounge. The CNO noted that there had been some anxiety at F&PE around the ED decant and that the pressure may increase boarding numbers due to the loss of frailty SDEC capacity and will need to identify patients to go to community hospital beds.	

	<u>Resolved</u> – that the Boarding Report be received and noted.	
QC011/08.24	**<u>PERINATAL SAFETY QUARTERLY REPORT</u>**	
	The ADM presented the perinatal safety report. • There were 154 births in July. There were two red flag incidents which were both related to the same incident and two instances in July where a Consultant was required. • Cluster review reported higher than average post-partum haemorrhage. A task and finish group has been put together to work on this and will continue to report in future. • PMRT compliance – There were three incidences where patients received midwifery care in Powys and came to WVT reporting reduced foetal movements. Some learnings have been taken and all meetings have been jointly attended with Powys. • Over Q1 there were incidences where patients had either not been appropriately referred on the preterm pathway or had not received the appropriate monitoring. The grading of these cases is a cause for concern and indicates there could have been a different outcome for these cases. This is very sad for the families involved and is a key area of focus moving forward. • Consultant Midwife to commence in October and will be the nominated lead for Quality Improvement projects. • The Perinatal Quad have participated in the NHSE work to roll out the SCORE survey, this was supported by external facilitators and a number of sessions held for staff. • The trust is required to review data from the claims scorecard alongside complaints to determine themes and identify relevant learning. This will be reported on a quarterly basis. • The workforce position remains positive and continues to be stable. There has been no agency usage since November 2023. There is an increase in demand for support staff. • There have been some issues in the obstetric workforce due to sickness and holiday clashes. Anaesthesia rotas have deteriorated slightly due to sickness of a member of staff. • Training is on track and maintain high numbers • Attain data remains under the national average and some quality improvement work is underway to review those cases. • Good feedback was received from the Safety Champions visit in July. Noted to be clean and there were no safety concerns.	

	The Chair noted that the cluster reviews in the main report are really important and had been struck by the MDT figures at 100% and noted that those figures had been very low a short time ago which signifies improvement. The Chair also noted that post-partum haemorrhage cluster review work had flagged an issue whether doctors were called in the right circumstances and asked if this had now changed. An error was noted in the report. The MBRRACE report Grading, box one in the table stated 'C – no difference to the outcome for the baby'. This should be been graded as B if there was no impact (C – 'would have made some difference to the outcome'). This would be corrected. Grace Quantock (NED) referred to page 95 of the report and that emotional recovery and workload strain is a negative change and asked if the wellbeing arrangements at WVT could be reinforced as felt that it impacts culture longer term. It was confirmed that some work had been done on this recently and that it is often perceived stress rather than personal stress. Had also made sure that staff are off shift on time and have breaks. Work on culture also continues. The CNO flagged a concern over discharges from Gloucester of babies and parents back into our care that we were not notified of and asked if the meeting with Gloucester had occurred. The ADOM confirmed that a round table had identified opportunities to use Badgernet more effectively to improve communications.	
	Resolved – that the Perinatal Safety Report be received and noted.	
QC012/08.24	**DEEP DIVE – EMERGENCY DEPARTMENT POST CQC**	
	The ACMO, Medical Division, together with the Matron ED gave an update on actions taken following the CQC visit to ED in December 2023: • Following an unannounced CQC inspection Dec 2023 overall findings showed requires improvement and inadequate in 'is the service safe'. Four must dos and five should dos were identified and actions taken are summarised in the report. • A key benefit that the inspection has provided is that we are now aware of exactly what was happening in ED and have since developed an improved governance system. • Improvement has been shown in most areas but there are several areas which still need work and the biggest risk remains overcrowding. • The patient triage pathway is still not clear and there is still some work to be completed to be able to give assurance of whether patients are seen relating to triage categorisation.	

	• Management of pain is of concern and some improvement work will take place following the refurbishments. • Good improvements have been made with sepsis with a consultant-level ACP Sepsis Champion in place. Identification of deteriorating patients and referrals to critical care outreach have increased. • There is concern around ability to get staff PILs trained due to lack of courses provided locally. The Chair noted that the progress was a credit to all staff in ED and noted the opportunity for deep dives to identify areas in need of renewed focus. The CNO observed that triage was still not necessarily clear and that when the ICB visited 6 week ago they had thought the same and asked what the plan was to address this. The ED Matron noted that there are differing professional opinions on what should be done and that multi-disciplinary agreement was needed, that some current systems cause duplication and another ED summit is being arranged. The CNO also added that the CQC were concerned around the Symphony system and Maxims and patients falling between the two systems and asked if there had been any changes to address this. The ACMO responded that the CQC had suggested that we should go back to paper charts. We did not agree with this and, at the time of inspection, we did not feel it to be an issue the average time is two hours from referral to being seen and any urgent drugs are given via Symphony. Further mitigations were being completed relating to mental health in majors and the provision of a purpose built room which might result in being able to close this action. The ICB Representative asked if there was anything that could be done to assist with resus training. The ACMO noted that staff sickness and a member of staff from the resus team leaving their role had impacted on ability to provide PILs training. The CNO confirmed that we now have only 0.4 wte Resus Officers and that an options appraisal is under development to address the shortfall. The ICB representative will look and see if there is any system shared resource available to assist. **ACTION** It was noted that out of date SOPs were being prioritised as those clinically most urgent and were looking across the group to see if there was anything which could be used from elsewhere.	**HH**

	The Chair asked what the governance around the CQC plan was. The ACMO confirmed that regular meetings are held around the CQC ED plan and have ED governance and education meetings and the plan is updated at those meetings. Progress will be reviewed in 6 months' time and will report at the meeting in February 2025.	
	<u>Resolved</u> that: **A. The deep dive Emergency Department post CQC report be received and noted** **B. The ICB Representative will see if there is any system shared resource available to support in pills training.**	**HH**
QC013/08.24	**<u>QUALITY AND PATIENT SAFETY PRIORITY UPDATE TISSUE VIABILITY</u>**	
	Sue Moody, Associate Chief AHP, Integrated Care Division provided an update on the tissue viability quality and safety priority: 1. Reduction in the Deterioration of MASD to Category 3/4 or unstageable pressure damage 2. Reduction in cases of grade 2 pressure ulcers • The incidence of pressure ulcers of all categories is reducing • Positive progress in reducing the deterioration of MASD can be seen in the report across all divisions, although the City District Nursing Team has higher numbers this in part will be due to caseload size yet also related to senior DN capacity and oversight in that team • There is good engagement at the weekly pressure ulcer panel where an audit to assess the benefit of staff training is being established. • The data for category 2 pressure damage was included in the report and broken down by division, with numbers also reducing. • The next steps in relation to quality improvement were summarised in the report. The ACAHP asked if Quality Committee would like to see divisional improvement plans. The Chair suggested that divisional improvements should be brought through quarterly divisional report.	
	<u>Resolved</u> – that: the quality and safety priority update for tissue viability be received and noted.	

QC014/08.24	**INFECTION PREVENTION ANNUAL REPORT**	
	The Lead Infection Prevention Nurse presented the IPC annual report • The previous month's infection prevention meeting was stood down due to the CPE outbreak at Ross Community Hospital (RCH). • The lead nurse talked through the key performance indicators which were included in the report. • Work has continued throughout the year to progress the IPC improvement plan and ongoing support is being provided by the ICB and NHSE. We remain on intensive support. • There is some concern over our mortality rates for gram-negative bacteraemia (GNB) and C Diff. We are working with the mortality team to review these cases. • There were a total of 35 outbreaks in the last year, in many cases the areas remained open to enable admissions, discharges and patient flow. Quarterly report • There were 17 cases of C-difficile during April, May and June, which is higher than normal. Of these, six cases were picked out to have had areas for learning related to clinical cleaning, antimicrobial stewardship, and management of documentation. There has also been a rise in cases in region and a summit will be held with representatives from Pharmacy, Quality and Safety, ICS and WAHT to find any additional learning and to look for reasons why there is an increase in cases. • New thresholds have been released for C Difficile and gram negative bacteraemia and future reports will include performance against the thresholds. C Diff cases are at 27 cases at the end of the quarter – this is a cause for concern. High numbers continued throughout July and August. We will review a prescribing practice as part of our improvement plan. There has been a CPE outbreak at Ross Community hospital which started in July. 24 patients were positive for CPE linked to Ross Community Hospital. Working with colleagues at ICS and NHSE looking at all cases and lessons learnt and also undergoing training with staff and reviewing pathways to see if there is any link to transmission. We have requested support from the ICB and NHSE to support with managing this outbreak. • Any patient who is re-admitted following a stay at RCH is screened on admission and isolated.	

	• The CNO had attended a CPE outbreak meeting with the Regional Head of Infection Prevention and has asked for UKHSA specific support with environmental screening.	
	Resolved: that the infection prevention annual report should be submitted to Trust Board and the quarterly report be received and noted.	
QC015/08.24	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The Associate Chief Medical Officer (DCMO) presented the Patient Safety Committee Summary report for July. • There had been low attendance at the last meeting which was not quorate due to annual leave and paper deadlines and it had not been possible to approve the minutes. Attendance from divisions at future meetings to be encouraged. • There has been concern relating to a number areas: o VTE compliance is starting to see marginal gains. A lot of work to be done in autumn to improve. o There had been a small increase in missed doses of medication but remains in the accepted tolerance range. • There have been some discussions around the TOR for NatSSIPS.2 and another meeting has taken place. • For escalation it was noted that the Resuscitation Committee has not met for several months due to reduced resilience in the service. A meeting has now been held and a plan is in place.	
	Resolved – that the Patient Safety Committee Summary Report be received and noted.	
QC016/08.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The QSM presented the Patient Experience Committee summary report: • The new Terms of Reference has been finalised. • Divisions have been really engaged and excellent reports have been received around patient experience. • The new Volunteer Team Lead is now in post. • There are plans to take up an offer of a free trial of Word 360, a new interpreting service, which should be helpful as face to face interpreters are currently used, which are booked in advance. It can also be difficult for some rarer languages.	

	• In patient survey results have now been released and will be brought back following discussion in September.	
	<u>Resolved</u> – that the Patient Experience Committee Summary Report was received and noted	
	<u>CONFIDENTIAL SECTION</u>	
QC017/08.24	**<u>PATIENT SAFETY INCIDENTS SUMMARY REPORT</u>**	
QC018/08.24	**<u>ANY OTHER BUSINESS</u>**	
	There was no further business to discuss.	
QC019/08.24	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 26 September at 1.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**05/12/2024**
Title of Report:	Quality Committee September 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 September 2024

1. Purpose of the report

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

To consider the summary report and minutes and to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

N/A

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

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners***

☒ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays***

☒ ***Work with partners to deliver the improvement plan for Children's services***

Digital

☐ ***Implement an electronic record into our Emergency Department that integrates with other systems***

☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication***

☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record***

Productivity

☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times***

☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population***

☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***

Sustainability

☐ ***Work with Group partners to identify fragile services and develop plans to make them more sustainable utilising the scale of the group and existing networks***

☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity***

☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions***

Workforce

☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants***

☐ ***Increasing the number and quality of green spaces for staff and improve the catering offer at the County Hospital in order to improve the working environment for staff***

☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff***

Research

☐ ***Increase both the number of staff that are research active and opportunities for patients to participate in research through our academic programme in order to improve patient care and be known as a research active Trust***

☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Matters for Noting

1. **ITU Peer Review** – Committee received an update on the findings and subsequent actions following the peer review visit to ITU in June. The findings were consistent with challenges the Trust is already aware of, including lack of AHPs trained in critical care, lack of outreach capacity and risks to detection of deteriorating patients. In these areas, Committee was assured that: 1) 24 hour outreach has been agreed; 2) this will support also the deteriorating patient issues alongside alignment with work of the deteriorating patient committee; 3) AHP capacity is subject to a business case. Areas of good practice were also highlighted by the visit including the use of patient diaries and the ACCP role.

2. **Mortality Report** – Committee welcomed the continued SHMI death rate remaining below 100. Of concern was 2 still births in both July and August which will show as a significant spike in the rolling 12 month average. These have raised some concerns around the preterm pathway referral and monitoring process and these are being assessed for follow-up.

3. **Boarding Report** – We continue to see high numbers of boarded patients and the focus on improved flow of patients through the hospital continues, alongside the work to balance this pressure with ensuring we maintain sufficient specialist beds including for Fractured Neck of Femur and for Stroke patients

4. **Perinatal Safety Report** – A recent safety walkabout had discussed the Fresh Eyes audit which was a feature in the CQC report and is a national requirement. There is no standardised audit tool used and our suggestion is to standardise the audit tool across our local maternity and neonatal system. We have tasked LMNS to come up with a standardised audit tool.

5. **Deep Dive Maternity CQC Action Plan Update** – Quality Committee received assurance on progress in a number of areas:

    a. Mitigation of risks associated with the birthing pool and plans to instal a new fixed pool;
    b. Work to ensure robustness of the Obstetric Support Worker role alongside work reviewing wider support roles in service.
    c. Work to address concerns around management of arterial lines for women who need level 1 care.
    d. Changes to the plan to locate a 2nd obstetric theatre in the new theatre block. An alternative plan to locate this 2nd theatre in maternity is currently being costed

6. **Patient Experience Quarterly Report** – Committee considered ongoing work to address issues around food quality and service, communications around medications on discharge and complaint response times. Committee noted in particular the increase in Health Service Ombudsman referrals, most of which resulted in no further action and the numbers may be a reflection in part of clearance of the caseload backlog from Covid.

7. **Divisional Report – Integrated Care** – The report helpfully allowed the Committee to focus on the 'local' progress and challenges associated with a number of quality issues and priorities including:

    a. Patient feedback – challenges interpreting family and friends responses;
    b. Tissue viability- good progress reducing category 2; category 3, 4 and unstageable still within challenges
    c. Assurance that the falls project is going well in Community Hospitals
    d. Reducing waiting times in children's therapy services.

8. **Paediatric Audiology Update** – Committee was assured by good progress in responding to the Audit and informed that we anticipate the incident response will be handed back to WVT as business-as-usual. Alongside this, CQC has written to all Trusts suggesting they should consider IQIPS accreditation for audiology services. The Trust plans to follow this up with a gap analysis and resource needs assessment.

9. **Regulation 28 Response – Bed Rails and Call Bells** – Committee received the comprehensive response which had been sent to the Coroner following a Regulation 28 notice received regarding concerns about use of bed rails and the process for checking call bells. The Trust was already reviewing practice concerning bed rail usage as in some cases these are being used without completion of an individual assessment.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 26 September 2024 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director (MD)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director (NED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Nicola Twigg	NT	Non-Executive Director (NED)
In attendance:		
Chris Beaumont	CB	Mortality Project Manager (MPM) - For item 8
Tracy Hamer	TH	Sister, Intensive Care Unit - for item 6
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Richard Hodgson	RH	Consultant Anaesthetist - For item 6
Sarah Holliehead	SH	Associate Chief Nursing Officer, Medical Division (ACNO)
Sue Moody	SM	Associate Chief AHP, Integrated Care Division (ACAHP)
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer (DCMO)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division (ACNO)
Carl Stevenson	CS	Consultant Critical Care/Anaesthesia - for item 6
Emma Wales	EW	Associate Chief Medical Officer (ACMO), Medical Division
Hannah Wood	HW	Research Manager, Worcestershire Acute Hospitals NHS Trust – for item 7

QC001/09.24	**APOLOGIES FOR ABSENCE**	
	Chizo Agwu (Chief Medical Officer), Dan Harding (Associate Director Diagnostic Programmes), Rachael Hebbert (Associate Director of Nursing) and Amie Symes (Associate Director Midwifery)	
QC002/09.24	**QUORUM**	
	The meeting was quorate.	
QC003/09.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC004/09.24	**MINUTES OF THE MEETING HELD ON 29 August 2024**	
	Resolved – that the minutes of the meeting held on 29 August 2024 be received and approved.	
QC005/09.24	**ACTION LOG AND MATTERS ARISING**	
	The actions were reviewed and updated:	

	QC009/08.24 – Responses have been received from across the group. There is established practice across a number of sites but noted that it is more difficult to get audit information. Happy with the position but information from more audits would be useful. Action Complete CQ012/08.24 – No shared resource is available through ICS Academy. ICB has received further assurance regarding mitigations regarding Resuscitation Officer resource. WVT now in a slightly stronger position as part time Resuscitation Officer has increased to full time to lead the service and one of the new Practice Educator Matrix workers is dedicated to the Resus service and is undertaking training to become a Resuscitation Officer, therefore have 2 WTE and back out to advert. Action Complete QC006.3/07.24 – Dental access in HW remains challenged not just for CLA. The designated nurse for CLA has met with the ICB representative who is responsible for quality oversight of dental services. CLA are being seen for their dental treatment. Any challenges relating to this can be re-escalated through the ICB quality route which the CLA team has the contact detail for. Bec Haywood-Tibbets is assured that dental need for CLA is being met. Check-up issues will continue to come through quarterly reports. Action complete There were no further matters arsing.	
	Resolved – that: the Action Log be received and updated.	
	BUSINESS SECTION	
QC006/09.24	**ITU PEER REVIEW**	
	Emma Smith, Associate Chief Nursing Officer (ACNO) had fed back in the divisional paper in August in relation to a peer review undertaken in ITU and immediate actions needed to be taken. Richard Hodgson, Consultant Anaesthetist, presented further detail of the review and commenced with an outline of the Critical Care service. • Intensive care is an essential part of any hospital. It is a service that goes out into the hospital and engages across all areas from both an outreach and medical point of view providing the following: Outreach • Provide help for ward based care, direct nursing and medical support and due to lack of enhanced care beds, providing post-operative follow-up for patients and a strong education role within the trust. • It is planned to introduce Martha's rule at the trust within the next year.	

Medical

- Performing clinical reviews, pain management support issues in combination with anaesthetic colleagues. Consultant on call is also on call out of hours for anaesthetics and obstetrics.
- As a remote hospital are involved heavily with patient transfers.
- As outreach is not currently 24 hours post op follow ups are also undertaken overnight.
- Are on all emergency teams and also have a nurse led ITU follow up clinic.
- The unit has 8 beds and delivers any combination of Level 2 and Level 3 patients. Also provide emergency support for Paediatrics, generally supporting children aged 12 and upwards. However, increasingly involved with children of all ages.

In 2020 CQC identified issues around Allied Health Professionals availability and absence of a Matron.

Acuity assessment in 2020 suggested that 10 beds were required. Proposal for additional 4 bedded HDU, later changed to 2 beds.

Aim to encourage development of a long-term strategy for critically ill patients.

Following a GIRFT review in November 2022 the following actions were recommended:

- To prioritise patient flow from critical care
- To increase outreach to 24/7
- increase AHP input in line with GPICS standards
- Improve tracheostomy care within the unit and throughout the trust
- To increase the number of ACCPs

A peer review took place in June 2024 and the themes were consistent with those previously seen. As part of the process some immediate concerns were identified and a response to those concerns to be provided within 10 working days.

- It was felt there was an immediate risk about detection of the deteriorating patient on wards primarily and it was felt that trust policy was not fit for purpose.

	• There were serious concerns around provision of AHPs trained in critical care for rehabilitation purposes. There is a national drive for improvement of rehabilitation services for critically ill patients. .
	
	• There were 40 unmet or partially met standards. 25 were related to lack of AHPs to provide OT, dieticians, Physio, speech and language and psychology support. Three around the deteriorating patient, primarily escalation policies were not felt to be adequate, and six were related to consultant staff.
	
	• It is not possible to meet GPICS standards currently as we do not have 24 hour dedicated Intensive Care Consultant cover as they cover other areas too.
	
	There has been a worsening situation of flow of patients out of the unit which is due to low bed availability on wards and as we do not have AHP support cannot provide ongoing rehabilitation for these patients. There is significant risk of patients deteriorating and has been of growing concern as a service.
	
	• Good practice seen:
	  ○ A dedicated team but working way beyond their roles.
	  ○ Use of patient diaries
	  ○ The ACCP role
	  ○ The flat hierarchy and education outside the unit is very good.
	
	• Moving forward approval has been given for 24 hour outreach and hope to commence 14 October.
	
	• A business case for establishment of AHPs was put forward to TMB and advised a full review and prioritisation of therapy support prior to any additional investment.
	
	• Pharmacy have developed an action plan to support pharmacy provision in ICU as the previous dedicated pharmacist has moved to another role. This is a priority for AHP support
	
	• All risks are on the trust risk register. A long term strategy and goal for workforce planning is needed.
	
	• In the current unit we have there is one doctor covering out of hours which is the maximum one individual is allowed to cover according to national standards.
	
	The MD questioned whether dispensation had been given to intensivist cover, given our scale and asked if this was still stands.	

	It was noted that national standard is to have a dedicated Intensive Care Consultant 24/7 who has no other clinical responsibility. This is not met at WVT as cover is provided in other areas. Increased workload over time has put pressure on consultants who do not feel completely comfortable covering ITU and find it difficult and has led to people coming off the on call rota. If having shared cover there should be an agreement with another hospital who could provide cover. This however, does not work practically as would only be verbal support. Peer review do not like our system as it is not an officially recognised way of working. The MD wanted to point out that sometimes standards often made by large tertiary centres are difficult to apply at general hospitals and noted a balance is needed between what can practically be done and what is affordable. That priorities are really important and have done that in terms of the outreach team, which was a huge gap. The MD also noted that there is now a group to pull together proposals for plans around broader acute critical care and need to see those proposals for the longer term and what resources will be needed Frances Martin (NED) was concerned about a single consultant covering ITU/maternity and theatres. Emergency obstetric cover is also a concern and would like to be clear on the mitigation and how much of a risk this is in reality and would discuss this offline. The MD asked if this was discussed at any organisational forum. It was confirmed that some elements are picked up at The Deteriorating Patient Committee. There is also a leadership forum within critical care which escalates up into the division The ICB Representative asked about governance going forward and was there a formal action plan and what the timeline is for review. The ACNO added that there is a clear action plan from the report and have commenced a working group and is discussed at Deteriorating Patient Committee. Work is ongoing and will continue to feedback to Quality Committee through divisional reports. The Chair noted the need for an audit trail and that it was acceptable for this to through the divisional report.	
	<u>Resolved</u> – that the ITU Peer Review updated be received and noted.	
QC007/09.24	**<u>RESEARCH REPORT</u>**	
	Hannah Wood, Research Manager, Worcestershire Acute Hospitals NHS Trust presented the Research and Development report. It was noted that this is the report from quarter one.	

	• There were 95 participants into 17 studies across 12 Specialties, including one commercial trial. • During Quarter 1 opened a further non-commercial trail • Ranked 14th in Midlands for recruitment. • Highest recruiting trials were PQIP, INFORM and Result-Hip. • The strategy action plan was presented to TMB earlier this year which focusses across all 4 objectives. Once a full complement of staff are in place are keen to get engagement and assign responsibilities for implementation of the plan. • The objectives will be brought to the next Quality Committee meeting and the new research nurse will also attend. • It is hoped that the full suite of SOPs will be signed and approved in the near future. • No adverse events or serious breaches were reported in quarter one. • There has been a good response rate to the patient experience survey and are pushing for this to be completed electronically rather than by paper. The experience survey is sent once across each trial, and provides useful feedback including whether patients would wish to take part in research again. The current rate of 97% of patients would consider participating again. • A full time lead Research Nurse will be in post from beginning of October who is an internal hire, which is a good step forward for the trust. • An advert is also out for a full-time Research Manager will enable the trust to implement the academic programme • Most staff are now full time and once all vacancies are filled will review training needs and finances and decide how to move forward • The department is self-funding and is in a stable position. • Work continues as a consortium working closely with and meeting with ICS ICB colleagues regularly. The Chair noted the importance of this work at the trust to be a place of excellence in terms of Research and Development.	

	It was confirmed that Clinical Research and the Clinical Research Network are moving across to become the Regional Research Delivery Network and there are a number of trials we are not able to take part in due to low numbers. This has been highlighted and each one is escalated within CRN. The Chair also noted the Interesting Executive comment at top of the report talking of the unique position in Herefordshire and wanted to highlight this as it opens up a useful area of endeavour.	
	Resolved – that the Research Report be received and noted.	
QC008/09.24	**MORTALITY REPORT**	
	The MPM presented the mortality report. The paper was taken as read and the following points were highlighted: • The latest SHIM is at 98.3 and there were 25 less deaths than expected. • Crude mortality maintained a low rate during August of 60 deaths. The following are outlier groups: • Sepis will be picked up by another forum and will obtain feedback from divisions who are doing a compliance audit specifically around the sepsis care bundle and will use this as a basis for our action plan. • COPD and pneumonia both are blow 100 which is a reflection of integrating mortality into divisional meetings. Regular mortality/morbidity meetings are taking place and learning is shared amongst teams. • Heart failure and stroke continue to reduce. A meeting is planned with Public Health to look further into the data in the community, particularly around stroke, as Nationally we reporting an outliner group for female under 75 stroke mortality rate • Fractured Neck of Femur (NOF) received an outlier alert in August. Workshops are due to take place on 7th and 21st October and will map out the pathway, add metrics and to try and address some of those changes. • Perinatal mortality for July and August saw 2 still births in each of those months, which was a significant spike in the overall 12 month rolling rate and is above national ambition. The Learning From Deaths Committee audited the last 12 months of deaths and each one was provided with some learning and action points to go with that case. This also outlined some review processes and how that	

	learning is shared with division. The team continue to do further work. • The Medical Examiner Service was implemented on 9th September and has gone very well with good engagement from GPs. It has had a big impact on patients across the county, giving them an opportunity to raise any concerns or questions. The CNO raised a point regarding the perinatal mortality spike and noted that there are concerns around preterm pathway in terms of referrals onto the pathway and are monitoring those women who are placed on the pathway. A highlight from the CMO from Learning from Deaths Committee was that sepsis is a focus for maternity moving forward. The MD noted that the CMO was concerned that the coding change around SDEC in April would affect SHIMI and asked for a view on this. The MPM thought that there will be an affect but that it would be balanced out once enforced across all trusts. Has shown in May's data but thought that this would reduce. Jo Rouse (ANED) asked about NOF mortality and added that it was great to see it reducing that an 8 points difference is bordering on significant and asked what the reason was for that down trend. The MPM noted it was a month with a significant drop in deaths and with a total 38 deaths over the year that a small drop will have big impact**.** Frances Martin (NED) recalled that there had been a plan to ring fence beds for NOF and asked if that had that been done. The ACMO responded that this had been done looking at the patient journey from ED and looking at where the delays occur and there was a need to look at and improve processes in ED before implementing this and that this would be reviewed at the meetings in October.	
	Resolved – that the Mortality Report be received and noted.	
QC009/09.24	**BOARDING REPORT**	
	The ACMO presented the Boarding Report. The presentation was taken as read and the Committee was asked to note the following: • The position had been slightly improved during August but had deteriorated again this week which was likely due to the refurbishment of the Emergency Department. • Continue to work on improved availability of ring fenced beds, particularly Fractured Neck of Femur and have improved admission to the Stroke Unit within 4 hours making gains despite occupancy of the hospital.	

	• Guidelines have been published around providing safe/good quality care in temporary escalation areas, which includes corridor care and non-bed spaces. We are reviewing guidance and addressing what we can. • New Patient Flow Facilitator has been appointed and will be in charge of Discharge Lounge enabling beds to be freed up and people to move up more quickly. Plans are in place to move the lounge and increase capacity. The Chair asked about the progress of the admissions avoidance work. The ACMO replied that an audit had been done of criteria to admit and found that 17 of 51 patients audited could have been in a different place, either at home, treated via virtual ward or looked after via an SDEC pathway. An action plan from that is in development. Grace Quantock (NED) asked if there is a time estimate for opening of the new discharge lounge. The ACMO confirmed that this will going to CPEC within the next week and the MD added that the aim is to have this in place before end of December. The Chair reflected on those patients who are held up in Intensive Care and asked if this forms part of the discussion around flow. The ACMO confirmed that it does, however part of this lies with having nurses who have the right competencies looking after patients coming out of ITU, for example, those with tracheostomy. The first pan-divisional meeting around patients with tracheostomy has taken place to make a way forward for this group of patients. The ACNO agreed that this had been a really positive meeting and a working group has now been set up to move it forward and comes into line with 24 hour critical outreach which would be able to support in those competencies overnight. In relation to patient flow the ACNO confirmed there are some issues re capacity and these patients always discussed at bed meetings and is around balance of risk and decisions around capacity at the front door. The DCMO agreed that it is that balance of risk and is an issue that affects many ITUs with delayed transfers of care. It is not just about competencies and need to be mindful of that balance or risk but not frustrating teams enough that they are not generating flow because of fear of not having a bed.	
	<u>Resolved</u> – that: the Boarding Report be received and noted.	
QC010/09.24	**<u>PERINATAL SAFETY REPORT</u>**	
	The CNO presented the Perinatal Safety Report. • There were low numbers of cases with reported red flag incidents, those in the report were responded to appropriately.	

	• There are no concerns around staffing in relation to obstetric, midwifery and anaesthetic rotas. • Neonatal staffing has remained the same and is a known risk. • There are two cases in the minimum data set that have not been through full PMRT process and learning from those will be presented in a future report. • A recent safety walkabout had discussed the Fresh Eyes audit which was a feature in the CQC report and is a national requirement. There is no standardised audit tool used, despite being a national requirement to undertake Fresh Eyes audits. Our suggestion was to standardise the audit tool across our local maternity and neonatal system, so when comparing our performance data we know that comparison is like for like. We have tasked LMNS to come up with a standardised audit tool. Grace Quantock (NED) asked for an update on the saving babies' lives element for foetal monitoring in labour which was highlighted red. The CNO noted that this is an element which has been given a longer timescale to deliver. LMNS have been asked to provide a view as to whether sufficient progress has been made to declare compliance to that standard within CNST and will provide a more detailed update next time.	
	<u>Resolved</u> – that the Perinatal Safety Report be received and noted.	
QC011/09.24	**<u>DEEP DIVE CQC UPDATE</u>**	
	The CNO explained that although we had received a positive CQC inspection and report into our maternity service, during inspection a number concerns were raised which were rectified immediately so did not feature as a regulatory concern within the report. This report intends to cover those elements and included: Policies, emergency drug boxes and the way that midwives and Obstetricians were taught to respond to emergency situations did not align (teaching and grab box were correct, policy required updating). This was addressed immediately during the inspection and this report covers how we are addressing policy development moving forward and the checking mechanism for emergency drug boxes. • A fixed water birthing pool which was in a bathroom in one of the labour rooms, although subject to skills drills the CQC felt that there was not enough room for evacuation during an emergency. The pool was decommissioned following the inspection leaving only an inflatable pool which has raised concerns around water management, there is a risk assessment and this has been appropriately mitigated. A plan is in place to install a fixed pool that meets both the services and water requirements and enables	

	emergency evacuation. Once this in place we will decommission the temporary pool. • The role of Obstetric Support Workers who support in Caesarean Sections was challenged by CQC who thought they were Surgical Assistants which does require a nursing or ODP registration. We were able to resolve that issue subject to a risk assessment. Since the inspection some further work is ongoing into blending some support roles in the maternity service to add resilience to the wider workforce. That work is yet to conclude. • The second area of concerns related to women who need Level 1 care who ideally would be cared for in a Critical Care Unit. There was some concern around management of arterial lines. The approach to training and competency assessment has been revised and a risk assessment is in place. • The use of the treatment room as a second obstetric theatre in an emergency. The report documents changes in plan. The original plan was to move elective C-section in to the main theatre complex and only perform C-Sections in the delivery suite in emergency situations. However, there was a view that this would cause other concerns in terms of workforce, therefore an alternative proposal is to provide a second obstetric theatre within the maternity footprint. The plan for this needs to be fully costed and would need capital funds to proceed. This did not feature in the CQC report as they were satisfied that there was a plan to move activity to the main theatre complex. There are a very small number of instances when we need to use the treatment room and we do have a mechanism for capturing this. To note, no patients have come to harm and there have been no adverse outcomes. The Chair asked about the support worker role and the reason for the proposed new registered role. The CNO confirmed that there had been some fragility of support worker roles in another part of maternity so took an opportunity to define the support worker role in obstetrics and whether that provides an opportunity to have a different skill mix, also a grow our own opportunity for staff and to go on to achieve equivalent of Nursing Associate. Is also a different way to have a more resilient workforce to be used in different parts of the service and provides an opportunity for better recruitment and retention. The DCMO was pleased that we are looking at a potential second theatre and was concerned that the C-section rate is rising which puts additional pressure on those facilities and that a category 1 section required in 30 minutes is a big undertaking and that a possible solution would be very welcome.	

	Frances Martin (NED) noted that the rising C-Section rate is not just a WVT issue but put different safety and capacity pressures on all of those teams tied up on a planned procedure. The Chair endorsed this. The CNO added that region have asked all maternity units to respond on how many obstetric theatres they have and what is their emergency backup plan. Also to be noted Worcester have more births but have only 1 theatre to do both elective and emergency work and could take some possible learning from this.	
	Resolved – that the deep dive CQC update be received and noted.	
QC012/09.24	**PATIENT EXPERIENCE QUARTERLY REPORT**	
	The ADQG presented the Patient Experience quarterly report. There has been a delay in the national inpatient survey results and it is hoped to bring these to the next Committee with more detail. Some issues flagged in the draft report we were already aware of and improvement work has already commenced. • Food quality and safety. Some intelligence received from staff that there were some issues with quality of food and service provision. A summit was held with Sodexo, who already knew of some concerns. There was collective agreement from both organisations to get this right and will take forward a working group to improve the food service. • Communication around medications on discharge which is a theme that has arisen in previous services and incidents and concerns. There are some clear issues in inpatient areas communicating around medicines and improvement work lead by the Medicines Safety Officer is ongoing. • Complaint numbers are still very high, especially compared to foundation group colleagues. Responsiveness, how often we meet the 30 day target and how often we meet the agreed target for response outside the policy are improving. Also reflected in reducing number of overdue complaints. Seeing improvement overall. • There has been an increase in contact from the Public Health Services Ombudsman which was looked into due to the number of cases. Whilst having a high number of contacts most cases have not resulted in further action. One was partially upheld and one where the Ombudsman suggested mediation with the complainant and a further one where it was suggested we should offer financial compensation for one element of the complaint. There was a backlog in PHSO during the pandemic which could account for this.	

	• The high number of vacancies in the PALS team is a cause for concern however has provided an opportunity to review the structure. From next week there will be only one part time member of staff to manage the service and this will be entered on the risk register. It is a fragile service and we are worried we will not be able to respond quickly and may result in more complaints. There is a mitigation plan yet does require divisional teams to work differently in responding to PALS concerns. • The end of the report summarises progress against the patient experience quality priority against measures with a RAG status to show progress. • Patient Experience Committee has had good engagement and the reports are included as an appendix to the report. Sharon Hill (NED) asked about re-opening of complaint cases noting that good numbers are answered in 30 days and asked if there are any concerns about the quality of responses. The ADQG replied that further analysis is needed to see if there is a correlation where responding has been timely or have been late responding and patient is already upset. The MD provided reassurance regarding the quality of responses and is confident that they are not being turned around too quickly. Noted that more complaints are being dealt with via phone call and meeting followed by letter which has been effective. The Chair noted that focus should be on number of complaints and speed of response and noted the work under PSIRF in gynaecology and Women's Health is already having some benefits and wondered if there is more can be done in other areas using that approach to get to some of the thematic issues. The ADQG noted that the divisional reports in the appendix show what is underlying and how that improvement can be generated. The ACNO added that the gynaecology work seems to be having impact and had seen only three complaints in the last three months compared to 7-8 per month leading up to that. Will feedback through Transformation Tuesday next week and will continue to bring through Quality Committee. There has been a recent increase in urology complaints and some themes within those so another PSIRF project has commenced.	
	<u>Resolved</u> that: The Patient Experience Quarterly Report be received and noted.	
QC013/09.24	**<u>DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE</u>**	
	The AHP Integrated Care presented the quarterly report for division. The report was taken as read and the following points noted:	

	• Friends and family is causing some frustration as it is difficult to get detail from the community and is not broken down by team very easily. • Overdue incidents. No legacy incidents remain on InPhase. • Tissue viability. MASD incidence in city team for deterioration to category 3 or unstagable pressure ulcers is still an issue within district nursing and is under close review working with teams • MASD is of concern at Community Hospitals as well as within district nursing services. • Category 2 pressure ulcers are reducing and will review throughout the year and category 3 and 4 and unstagable pressure ulcers show early signs of improvement • A lot of improvement work is taking place across teams and is a good template for learning. Performing triangulation on training to see if it has made a difference • There is a gap in reporting of medication incidents and work is ongoing to get the detail. Numbers are low and Rachael Wordsworth has been invited to monthly governance meetings to talk through medications. • Falls – The bed rails project at community hospitals is going well and the number of falls over bed rails has reduced. • Community hospital eligibility criteria has been running since August. Teams say that it is working well and community hospitals feel they have control over which patients are being admitted. • No complaints about discharge process or communication were received during this quarter. There were two other complaints received in July and one in June. Concerns are being managing and resolved quickly. • Children's therapy waiting times are reducing. OT speech therapy is down to under 36 weeks. Drop in and open sessions for parents and staff are available to discuss issues rather than waiting for a referral which seems to be making a difference and now need measure the impact. • Ross Community Hospital were pleased to receive a positive compliment letter from a patient relative. The CPE outbreak remains an ongoing issue and there have been further concerns around cleanliness and IPC practices with staff. Many of the staff are agency and a meeting has been scheduled with ID Medical to discuss.	

	The Chair observed that the tissue viability graphs showed numbers in the city team to be very high but was not able to tell how high relative to patient numbers and compared to other areas. It was thought that this is likely to be that the city team is larger than the other teams and also have more patients and a review the data and a relative comparison would be done. **ACTION**	**SM**
	Resolved – that: **A. The Quarterly Report Integrated Care Division be received and noted.** **B. The ACAHP would review tissue viability data from the city team and do a relative comparison to other teams.**	**SM**
QC014/09.24	**PAEDIATRIC AUDIOLOGY UPDATE INCLUDING IQIPS**	
	The CNO updated the Committee on the progress against the Midlands Review of Paediatric Audiology Services. • Concerns in audiology services in Scotland led to NHSE incident response and review process for all paediatric audiology services. The Midlands peer review visit took place earlier this year and following this visit the division presented the findings and associated action plan to Quality Committee. • We await the results of the audit of children and young people on the non-discharged ABR pathway. Providing this audit is satisfactory we anticipate the incident response will cease and ongoing monitoring and review of the service will be handed back to WVT as BAU. • The CQC wrote to trusts in April suggesting that all trusts should consider IQIPS accreditation for audiology services. The agreed Wye Valley Trust response was attached to the report. • Subsequently NHSE have written to all trusts providing the service to request a timescale and action plan to achieve IQIPS accreditation be submitted by 4th October. It will require a substantial infrastructure, project management and available workforce to take forward IQIPS accreditation and there would be some costs associated with buying the platform to document the accreditation. • This has been discussed with the clinical and Executive team and the suggested response to the region is that IQIPS accreditation is part of our plan; our action plan will be to undertake a gap analysis against the standards, determine the resource implications for delivery and assess the likely timescale for delivery. ICB have offered support to work collaboratively with Worcester Acute.	

	The Chair asked for clarification on how ICB are supporting the response. The CNO confirmed that this would be to work with us with on the gap analysis, e.g. gaps in policies which could be shared or developed with Worcester Acute. The ICB Representative noted that Worcester had already had an IQIPS benchmark visit and had a report of gap analysis and noted that IQIPS requires a lot of work and acknowledged that audiology services are fragile regarding workforce. Only 25% of the region are currently nationally accredited and it is expected that if all sites are to be accredited that this will be a gradual process and done at differing paces. The CNO noted that the workforce challenge to deliver the audiology service is partly the reason for being unable to progress IQIPS at this point or do the gap analysis quickly.	
	Resolved: that the paediatric audiology update be received and noted	
QC015/09.24	**STAFFING REPORT**	
	The ACNO, Surgical Division presented the staffing report. • It had been another busy month with pressures at the front door. Boarding had continued through August although this had reduced slightly. Some community beds and the escalation area in endoscopy had also been open throughout the month. • The fill rate month to month is reducing to a level expected at overall 103%. Incidents re staffing have also reduced. • The number of vacancies has increased slightly and are doing some work to understand that data. • Sickness has increased slightly with spikes in particular areas. There has been an increase in colds and Covid. • Agency spend has reduced in August and although bank use has increased, this is in line with the increase in establishments. • Surgical Hub went live in July and saw increase in establishment • The report includes a review of funded establishment compared to gap, how much agency and bank staff we are using and how much time was needed for sickness cover. Each division is in line with expectations. • The highest use of agency staff was in ED, mainly due to vacancies and additional staffing agreed through TMB not yet in establishment, also escalation areas. Community hospitals have second highest use of agency due to vacancies and additional beds open during that period.	

	• A lot of work has been done to reduce Thornbury spend in line with the break glass process, with 3 shifts only in August. • The target is to reduce agency spend by £4M and need to reduce to 225 shifts per week. This has been reducing week by week and at beginning of September were at 280 shifts. This has increased over the last few weeks to over 300, which appears to be in line with work happening in ED and aligns to the increase in sickness in some areas. • The focus is on ED, community and frailty looking at vacancies, recruitment processes and also at the break glass process for HCA shifts. This does appear to be on the right trajectory and hope to reduce once ED are back in their footprint. The Chair asked how HCA recruitment is progressing. The ACNO responded that centralised recruitment is now in place but the issue is with the length of time for people to commence in post (4 months) and are working with HR to improve on this. Also retention of HCAs as a number go to further education and a large co-hort do not fully understand the role when they apply and leave after a short period of time. There is also a high rate of sickness. Looking at this as part of NARP to what can be done to support those staff to retain them, there is a high turnover nationally. Frances Martin (NED) noted that it would be helpful to see how HCAs are benchmarking across group and appreciated that it is lot of work to maintain appropriate levels and thought it really encouraging to see how we were inspiring that and getting the team to work with resources available. The Chair endorsed this and added that it about quality and safe services and that this is much easier to maintain using our own staff rather than agency.	
	Resolved – that the Staffing Report be received and noted	
QC016/09.24	**CLINICAL EFFECTIVENESS AND AUDIT COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Clinical Effectiveness and Audit Committee Summary Reports. The clinical audit programme for the next year had been brought to a previous Committee where it was felt that more work was needed before it was approved. There was further engagement with individual services and the programme was approved at the meeting in August. However, there were three national audits which have not progressed as we would have liked for the following reasons: 1. Delay in submitting data	

	2. Not having complete data set 3. Non-participation The Chair asked what was being done regarding the national audit issues. The ADQG responded that the issues have been dealt with by services and have reported through. Non-participation is managed as a risk and managed through the risk process. Delay in data submission is a process issue and incomplete data set is in relation to the time it takes to complete that audit. There is an effort to get top priority data in rather than a complete set and noted that in the past when we have not had a complete set have received mortality outlier alerts that did not reflect the situation. The Chair asked if it was mandatory for all trusts to complete all national audits. The ADGQ responded that trusts are mandated to participate in approximately 100 audits and have to be transparent about the data gathered if participating. There are no financial implications. The ACMO added that the Medical Division have been trying to liaise with the Specialty Audit Lead and Clinical Lead and will invite them to come to CEAC to give a clear explanation as to why have not progressed as we would have liked. The Chair noted the need to understand the implications of not responding to national audits.	
	<u>Resolved</u> – that the Clinical Effectiveness and Audit Summary report be received and noted.	
QC017/08.24	**<u>INFECTION PREVENTION COMMITTEE SUMMARY REPORT</u>**	
	The CNO presented the Infection Prevention Committee summary report and asked for the following points to be noted: The minutes of the committee are currently in draft and the IPC will be meeting tomorrow for final approval. • The last quarterly information on Clostridioide showed high infection rates. Last year tracked below trajectory, yet we have had a bad start to this year and current performance is off trajectory. A meeting including the ICB Lead infection prevention nurse, doctor and anti-microbial stewardship pharmacist has taken place to review this. The new speciality doctor in infection prevention and control felt that our testing regime is different to that of other trusts and is more sensitive therefore identifying more cases. There is also research showing higher rates in rural communities. • Antimicrobial stewardship is felt to have the biggest impact on Clostridioide rates and the Antimicrobial Stewardship Pharmacist, will work with the Infection Prevention doctor and come to	

	appropriate forums to raise awareness around antimicrobial stewardship, this may lead to a further review of our formulary. • Additional support has been requested in relation to environmental swabbing from UKHSA in relation to the CPE outbreak at Ross community Hospital. <u>Matters for Escalation</u> • M-Pox Clade 1 is a high consequence infection and there is new guidance relating to PPE and training which Trusts must have in place by April 2025. There have been two suspected cases in the Trust last week. This tested our pathways with lots of learning identified. Region will facilitate a learning exercise. • Work is ongoing with the Practice Education Team in relation to blood culture testing given a high number of contaminants were identified on a recent audit. The MD asked if antibiotic prescribing and stewardship had seen much benefit from EPMA. The CNO noted that it is encouraged to use order sets but these are optional as a prescriber and some individuals prescribe outside of order set. We have previously looked at hard stop dates for antibiotic use but was deemed at the time that it would represent more risks than benefits. There is an opportunity to further review this and would welcome views from users of the system. The ACMO thought that EPMA is very good for order sets and to make use of the correct antibiotic for the right severity of infection but noted that not all conditions were listed on the system. The CNO agreed to look into data sets on EPMA and ensure that all conditions are listed all infections have order sets. **ACTION**	**LF**
	<u>Resolved</u> – that: **A. The Infection Prevention Committee summary report be received and noted.** **B. The CNO to look into data sets on EPMA and to ensure that all conditions are listed on the system and all infections have data sets**	**LF**
QC018/09.24	**<u>REGULATION 28 REPORT RESPONSE</u>**	
	The CNO updated the Committee on the response to the Regulation 28 which had been received from the Coroner. • A Regulation 28 had been received by the trust regarding bed rails and processes for checking whether call bells are working.	

	• Our review identified that whilst some centralised testing of call bells, the local checking system is variable. • Use of bed rails was of the most concern. Audit information demonstrated that in most instances we are conducting assessments and rails are in a compliant positon when audited. However, small numbers where not right. • As rails are now integral to the bed it easier for individuals to mistakenly use them when not required especially as the individual undertaking the assessment may not necessarily be the individual providing care on a daily basis and part of the problem is how hand over takes place and is a communication issue. Community hospitals are doing a trial involving bed rails; once a registered nurse has made an assessment the rails are secured in position with a security tag if they are not going to be used. This approach will be evaluated prior to roll out to the acute hospital. • The response to the coroner was submitted in line with the time scales and no further response has been received from the Coroner to date. The Chair asked how quickly Estates are committed to fix a faulty call bell once reported. The CNO did not know but would look into this **ACTION** The ACMO asked if the bed rail audits in community hospitals is of all patients or just a snap shot. It was confirmed that it was for all patients. The ACMO stressed the importance of checking that assessment forms have been correctly completed. The CNO added that the quarterly bed space audit is most robust and one to take most assurance from and covers everything including, whether the assessment was correct and whether bed rails are in the right position. It has been showing positive results over the last two quarters. The CNO noted that we have recently moved Digital Nurse Noting on to the clinical noting platform and two thirds of hospital patients across community hospitals are now on the new system and will transition over time. Working to make electronic assessments much simpler and easier to navigate and feedback supports this. There will be 10 weeks of optimisation and there are some areas subject to further improvements; risk assessment for falls and Bed rails and falls are two of these.	**LF**
	<u>Resolved</u> – that **A. The Regulation 28 Response update be received and noted.** **B. The CNO to look into how quickly Estates are committed to fix a faulty call bells once reported**	**LF**

	CONFIDENTIAL SECTION	
QC019/09.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC020/09.24	**RESPIRATORY ISSUE**	
QC021/09.24	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
	DATE OF NEXT MEETING The next meeting is due to be held on 31 October at 1.00-4.00 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