Public Board Meeting

Thu 05 October 2023, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Frances Martin

Jon Barnes, Glen Burley, Andrew Cottom, Russell Hardy and Jo Rouse.

13:00 - 13:00
0 min

2. Declarations of Interest

Frances Martin

13:00 - 13:00
0 min

3. Minutes of the Meeting held on the 7 September 2023

Decision *Frances Martin*

3. PUBLIC BOARD MINS - SEPTEMBER LF. FM.pdf (16 pages)

13:00 - 13:00
0 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

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

13:00 - 13:00
0 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Jane Ives*

5.1 5th October 2023 - WVT CEO Report - BOD - FINAL v2.pdf (8 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 05 August 23.pdf (31 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/David Mowbray*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:00 - 13:00
0 min

6. Items for Approval

6.1. Memorandums of Understanding with One Herefordshire Partners and the Integrated Care Board

Decision *Jane Ives*

- 6.1 MOU- 1H and ICB.pdf (18 pages)

6.2. Patient Safety Incident Response Plan

Decision *Lucy Flanagan*

- 6.2 Covering Report - Board - PSIRP Sept 23.pdf (2 pages)
- 6.2a FINAL DRAFT Patient safety incident response plan WVT v8.pdf (32 pages)

6.3. Board Assurance Self Certification Protecting and expanding elective capacity

Decision *Andrew Parker*

- 6.3 Cover Sheet Trust Board - Board Assurance Self Certification Protecting and expanding elective capacity October 2023.pdf (3 pages)
- 6.3a Board Assurance on OP WL Targets September 2023.pdf (10 pages)
- 6.3b Appendix A - Protecting and expanding elective capacity letter_040823.pdf (6 pages)

6.4. Audit Committee Terms Of Reference

Decision *Erica Hermon*

- 6.4 Board Report for Audit Ctte TOR.pdf (1 pages)
- 6.4a Audit Committee Terms of Reference 2023-24.pdf (6 pages)

6.5. Board and Committee Dates 2024

Decision *Erica Hermon*

- 6.5 Board and Ctte Dates 2024 covering report.pdf (1 pages)
- 6.5a Board & Committee Dates 2024.pdf (1 pages)

13:00 - 13:00
0 min

7. Items for Noting and Information

7.1. Maternity Services Quarterly Report

Discussion *Lucy Flanagan*

- 7.1 October 2023 Board - Maternity Services Q Report.pdf (6 pages)

7.2. Patient Experience Report

Discussion *Lucy Flanagan*

- 7.2 Patient Experience Report September 2023- Board report.pdf (12 pages)

7.3. Infection Prevention Annual Report 2022/23

Discussion *Lucy Flanagan*

- 7.3 Front sheet IPC annual report.pdf (2 pages)
- 7.3a IPC Annual report 2022.23 v.1.pdf (44 pages)

7.4. Maternity CQC Report

Discussion *Lucy Flanagan*

- 7.4 Covering Report - Board - CQC Report.pdf (2 pages)
- 7.4a Maternity CQC Report.pdf (23 pages)

7.5. In-Touch Staff Engagement

Discussion *Geoffrey Etule*

- 7.4 Cover Sheet - InTouch programme.pdf (1 pages)
- 7.4a InTouch programme.pdf (5 pages)

7.6. Committee Summary Reports:

7.6.1. Integrated Care Executive September 2023

Discussion *Frances Martin*

- 7.5.1 ICE Update for WVT Board.pdf (2 pages)

7.6.2. Quality Committee 31 August 2023

Discussion *Ian James*

- 7.5.2 QC Summary Report August 23 Public.pdf (3 pages)

7.7. Committee Minutes

7.7.1. Audit Committee 15 June 2023

Information *NICOLA TWIGG*

- 7.6.1 Audit Committee minutes - June 2023 - FINAL.pdf (17 pages)

7.7.2. Quality Committee 27 July 2023

Information *Ian James*

- 7.6.2 QC minutes - JULY.pdf (19 pages)

13:00 - 13:00
0 min

8. Any Other Business

13:00 - 13:00
0 min

9. Questions from Members of the Public

13:00 - 13:00
0 min

10. Acronyms

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

13:00 - 13:00
0 min

11. Date of Next Meeting

The next meeting will be held on 7 December at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 7 September 2023 at 1.00 pm
Via MS Teams

Present:

Russell Hardy	RH	Chairman
Glen Burley	GB	Chief Executive
Andrew Cottom	AC	Non-Executive Director (NED)
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FMa	Non-Executive Director (NED)
David Mowbray	DM	Chief Medical Officer
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Jon Barnes	JB	Chief Transformation and Delivery Officer
Ellie Bulmer	EB	Associate Non-Executive Director (ANED)
Alan Dawson	AD	Chief Strategy and Planning Officer
Robbie Dedi	RD	Deputy Chief Medical Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Sharon Hill	SH	Associate Non-Executive Director (ANED)
Tim Howson	TH	Branch Chair, Herefordshire Veterans Association – For Item 7.3
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)

The Employee of the Month award for April was presented to Jemma Davis, Community Nursery Nurse and the Employee of the Month award for May was presented to Nichola Ashforth, Respiratory Ward Based Practitioner. The Chair read out the reasons why Jemma and Nichola had been nominated for this award.

The Team of the Month award for April was presented to Cellular Pathology and the Team of the Month award for May was presented to Lynne Stamp and the Referral Management Team, Trauma and Orthopaedics. The Chair read out the reasons why the teams had been nominated for this award

Minute		**Action**
BOD01/09.23	**Apologies for Absence** There were no apologies received.	

BOD02/09.23 **Quorum**

The meeting was quorate.

BOD03/09.23 **Declarations of Interest**

The Chief Executive (CEO) advised that he is now also the CEO for Worcestershire Acute Hospitals.

The Chairman advised that he is now also the Chairman of Worcestershire Acute Hospitals and the owner of Maranatha 1 Property Limited.

Resolved – that the Declarations of Interest be received and noted.

BOD04/09.23 **Minutes of the meeting held 6 July 2023**

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Resolved – that the minutes of the meeting held on 6 July 2023 be confirmed as an accurate record and signed by the Chairman.

BOD05/09.23 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD06/09.23 **Chief Executive's Report**

The CEO presented his report and the following key points were noted:

(a) Conviction of Neonatal Nurse – Lucy Letby – There is a lot of learning from this for the NHS. This trial has shocked everyone, particularly the NHS workforce. We are providing support to our staff in the wake of this. There is learning from not only what could happen in the Neonatal Service, but this could occur in any service. This took place before the Freedom To Speak Up Guardian (FTSUG) posts were in place. We ensure that our FTSUG has the full support of the Board of Directors and that we have the right culture in the organisation for staff to feel able to speak up to the Executives.

(b) Managing Urgent and Emergency Care alongside Elective Recovery – There was a further NHS Recovery Summit held in July, which the CEO attended. This was a follow up from the session held in January. Good progress is being made but this has been impacted by strike action. The Regional position has improved; we have played our part in that and will reflect this in our Annual General Meeting being held later today. Regarding the relationship between managing Elective and Urgent Care, we talked about the need to ensure that we deliver care in the best setting and that patients do not spend longer in the Acute setting than needed. The Acute setting is appropriate for a number of things, but if a patient stays longer than needed, this has a negative impact on their recovery. We are spending time in the Foundation Group on how we educate internally our clinical staff on this and externally to members of the public.

(c) Winter Planning Letter – For the first time, the Winter Planning Guidance was published before winter commenced which we are responding to. Part of this work we are doing is around Emergency Care and sharing good practice with other Trusts. Some of the comments from the "Job Cards" are included within the report. This is around what we do as a System and the accountabilities of the individual providers in this setting.

(d) UEC Performance – Capital Incentive – This comes into play in Quarter 3 and Quarter 4. This may be beyond us to achieve due to our challenged position.

(e) NHS Workforce Plan – The detail around this has been published and is linked to the £2.4bn funding pledge. We are awaiting confirmation of how much of this is true additional funding and how much is assumed productivity. The Report includes a number of pledges aimed at reducing vacancies which includes doubling medical school training places, increasing the number of GP training places and the opportunity to train students locally. The plan anticipates that in 15 years' time we would expect only 9 – 10.5% of the workforce to be recruited from overseas compared to nearly a quarter now.

(f) Fit and Proper Person Test Framework – This was published by NHSE in August 2023 for Board members. The detail around this is included in the report.

(g) More From Our Great Teams – Update from the Integrated Care Division – A lot of work is going on around out of hospital care. This is just as important to improve flow to prevent admission and to keep the flow going.

(h) Mr James (NED) fed back as Chair of the Quality Committee that the Committee considered the implications of the Lucy Letby case. A session was held in the presence of the FTSUG where we reviewed our Freedom To Speak Up (FTSU) arrangements and the point raised by NHSE nationally. Broadly we have a strong FTSU approach and culture in the Trust but we cannot do enough to support staff to speak up to help ensure quality and safety in our services. There are some areas that we can improve upon and this is being led by the Chief Transformation and Delivery Officer and our FTSUG. This will be presented to the Board of Directors for fuller discussion once completed.

(i) The Chairman noted how proud he is of the work the Maternity and Midwifery teams are doing to bring babies into the world. We need to ensure that all processes possible are in place for staff to speak up, but as a Board of Directors, we need to celebrate the fantastic work our teams are doing.

(j) The CEO advised that there are multiple channels for staff to use externally and internally to raise issues. Rumour Mill is one such example where staff can anonymously ask a question, with the response available for all to read. We need to have an internal FTSUG to allow staff to feel able to approach them and their team to tell us of any issues so that we can tackle them early on.

(k) The Managing Director advised that since FTSU has been in place, it has really grown and become better known in the organisation. This is a huge benefit to the Trust and has alerted us to things before they become bigger issues. We will continue to invest in this and we are also looking to recruit more FTSU Champions, ideally having one in every department.

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

BOD07/09.23 **Integrated Performance Report**

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

a) It has been a difficult summer with ongoing urgent and operational pressures along with Emergency Department (ED) demand and industrial action. There is further industrial action planned in September and October with alignment with Consultants and Junior Staff which will make this period even more difficult. We have managed really well so far with a lot of staff involvement in achieving this. We have maintained momentum on the improvement work that we have been doing. Elective productivity was discussed in the Board Workshop held this morning. The Managing Director thanked the Chief Operating Officer (COO) for maintaining this momentum whilst managing difficult pressures.

b) Value Weighted Activity – We have our own measure for our activity diagnostics in our elective pathways. This is weighted depending on the complexity of the case. The proportion of our 2019/20 activity that we have delivered is more than any other Provider in the West Midlands for our latest figures, which is very positive.

c) We continued to maintain focus on staff experience during the summer. The Chief People Officer (CPO) is leading on a big piece of work on staff engagement which will be presented to a future Board of Directors meeting. There are a lot of people involved in this piece of work. Having a great staff experience will filter through to a fantastic patient experience.

d) The Trust are ahead of other Trusts with regarding our Nursing Associates. We are "growing our own" staff from Health Care Support Workers to Registered Nurses – they can progress as far as they are able to go. There is a Business Case on the agenda around this. The Managing Director thanked the Chief Nursing Officer (CNO) and her team for all their hard work around achieving this and implementing this new approach towards recruitment, retention and training the best of our workforce.

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

BOD08/09.23 **Quality (including Mortality)**

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

(a) Included in the report is a summary of our Patient Safety Incident Plan, which is in draft. This will be presented to the September Quality Committee meeting and to the Board of Directors in October to approve.

(b) The draft report from the Maternity Services Care Quality Commission Inspection from the end of June has been received. The aim is to bring the report and associated Action Plan once this is publically available.

(c) Included in the pack is the end of Q1 performance for our CQUIN Programme. We had a strong start to this programme with the identification of frailty in ED and the assessment and treatment of lower leg wounds. Healing time for complex lower leg wounds has reduced from 23 to 14 weeks. The Trust are leading the way in this area.

(d) We marginally missed the CQUIN upper trajectory for NEWS 2. This is for unplanned admission to Critical Care and is a new CQUIN for this year.

(e) We marginally missed the assessment of pressure ulcers and the malnutrition screening. Given that pressure ulcers are applicable to the Acute site and we know where the Community sites started in Quarter 1 last year, this is really strong performance. We used an opportunity when the Care Quality Commission visited us informally a few weeks ago to take our Inspectors to the Frailty Block and to ED to showcase some of the improvements that we are making in relation to prevention of pressure damage for our patients.

(f) There were an increasing number of complaints received during June and July. These mainly related to ED, Head and Neck, Womens and Childrens and access and waiting times to our Community Paediatric Service. Issues around Community Paediatrics and Orthodontics are well known to the Board and actions are being taken. The Annual ED Survey was published about 6 weeks ago, the results from this and the associated action plan along with any themes will be presented to the September Quality Committee meeting.

(g) The CMO advised that it had been a reasonable month for mortality. Our SHMI from NHS Digital was 102.2 in February 2023. Our SHMI from our local data is 103 for April 2023 – this normally drops by 2 or 3 points. The next report should be around 100.

(h) Our outlier groups are all doing well. Fractured neck of femur and heart failure are both showing a satisfying reduction.

(i) Perinatal mortality statistics remain low and are on track to achieve a 50% reduction in mortality rates from 2015 in 2025.

(j) Mrs Martin (NED) noted the positive CQUIN around frailty, noting the implications of staying in hospital too long. Anybody in any service with mal intent or incompetence could carry out similar crimes to Lucy Letby, hence the forensic analysis of data with peers and others is critical. We use multiple ways to review this and triangulate data.

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

BOD09/09.23 **Activity Performance**

The COO presented the Activity Performance Report and the following key points were noted:

(a) Urgent and Emergency Care Plans – We are focusing in particular on changes in the Acute floor with Same Day Emergency Care (SDEC) regarding our winter planning. Over the next week we will be combining our Frailty SDEC with our Virtual Ward under one roof. We continue to perform really well with our ambulance handover and time to be seen, our minors time to be seen and our Paediatric 4 hours, our general 4 hours to be seen remains challenged. The team have been learning from best practice over the summer by visiting colleagues across the Foundation Group as well as a visit this week by the Emergency Care Intensive Support Team (ECIST) who undertook a peer review of our plans. This was in general really well received and they gave us some very good recommendations. We await their formal feedback but this support was well received by the teams. ECIST will continue to work with us, in particular on our demand and capacity model and workforce challenges across medicine with our medical workforce and nursing. With the implementation of an expanded SDEC next week, we know that we have missed opportunities regarding this with patients remaining in ED and being admitted to wards. We should see an improvement in our flow regarding this over the coming months.

(b) Despite the 3 strikes in July by Consultants, Junior Doctors and Radiographers, we continue to see good performance against our activity plans in Day Case and Outpatients and our elective activity which were all above plan. Our Diagnostics was 28% above plan which was excellent news despite all the pressures that we have had.

(c) Our main concern continues to be Endoscopy. This is particularly due to our decreased workforce but there are robust plans in place with additional non-medical Endoscopists increasing their sessions in September and new Consultants starting in October which will increase the core for Endoscopy. We are confident that we can get back on track and reduce the length of time our cancer patients are waiting as we move into the autumn.

(d) At the Board Workshop this morning, we discussed our involvement with the Getting It Right First Time Faster Further Programme within the Foundation Group. We are involved with this along with 25 other Trusts. This is across all specialities, but we are particularly focusing on our 7 specialties which have the greatest 65WW and 52WW challenge before the end of the financial year. We have put some additional support in to help our operational teams and we are looking at improving our validation and communication with patients who are waiting a significant amount of time on our waiting lists. We are also looking at how we improve our advice and guidance to Primary Care, reducing our Did Not Attend rates across Outpatients and Theatres and reducing our follow ups and increasing our new appointments, particularly through increasing the use of patient initiated follow ups.

We have seen across the board during the summer, despite the challenges, an increase in our patient initiated follow ups that go onto this pathway, an increase in our Outpatient utilisation and a reduction in our Did Not Attends. We are aware that there is much more to do and the teams are working through the handbooks that have been given to us by the Getting It Right First Time team and working with other Trusts across the Foundation Group sharing best practice and implementing new ways of working.

(e) On 4 August, NHSE sent a letter referring protecting and expanding our elective capacity, and our team are working hard to ensure that we have a detailed response to this. This requires Board sign off at the end of September.

(f) We had a lot of work going on through the summer including the Theatre Improvement Week, which we discussed at the Board Workshop held this morning. There are a lot more opportunities around this and the team are well engaged alongside a comprehensive action plan. We also held a Cancer Improvement week which had a significant impact on the education and understanding of our operational and clinical teams on Cancer KPIs. It also highlighted improvements to pathways that we can make with our performance standards. Hereford Healthwatch supported this work with patient interviews, with their findings feeding into our action plans. We intend to hold this every 6 months. Through this event we saw a significant reduction in our 62 day waits for cancer, which reduced to its lowest levels since Covid. The report includes some of the highlights to the changes to the cancer performance targets from October. We also used that session to brief colleagues on some of these changes.

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

BOD10/09.23 **Workforce**

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

(a) We are seeing a strong performance for most of our HR KPIs. We have the lowest levels of vacancies and staff turnover seen over the last 12 months. The next few months will be more challenging, hence the HR Team will continue working with Line Managers to ensure that we maintain this good level of performance.

(b) The Trust have just received the NHS Pastoral Award in recognition of our national and staff wellbeing programme. The Health and Wellbeing Programme that we are running with Halo Leisure has also been short listed for a national award.

(c) This week we are promoting the “know your numbers” campaign regarding blood pressure.

(d) Students from the Royal National College for the Blind are supporting our Health and Wellbeing month over the next few weeks.

(e) We continue to work in partnership with Job Centre Plus who will be using our services to conduct recruitment and training programmes for local people.

(f) The In Touch Staff Survey Campaign has now ended. Key actions and feedback received from staff will be presented to the next Board meeting in October.

(g) Mr James (NED) thanked the CPO and his team for all their hard work over the last few months. It is a credit to the team on the performance that we are seeing now. These are the most challenging times for the NHS and yet we are increasing our recruitment and retention and reducing our sickness rates.

(h) Mr James (NED) noted that staff will speak up when they feel valued and supported. The CPO advised that it is FTSU Month next month which will run alongside our Wellbeing Programme. The NHS Annual Staff Survey starts this month and we are hoping to see positive results from this.

Resolved – that the Workforce Report be received and noted.

BOD11/09.23 **Finance Performance**

The Chief Finance Officer (CFO) presented the Finance Performance Report as at Month 4 and the following key points were noted:

(a) There are no capital or cash exceptions to report.

(b) At the end of July, we have a £10.1m deficit which is broadly on plan although there are significant financial risks to mitigate this to achieve outturn.

(c) Herefordshire and Worcestershire Systems are overall behind plan to date due to financial pressures. This is due to inflation, industrial action impact and additional activity.

(d) Expenditure – Nurse and Medical agency spend reduced slightly in month. This is now just 8% of our pay bill. We are sustaining this so far but with the continuation of the industrial action and winter pressures, this will be more challenging to achieve. We need to reduce this further to achieve our CPIP. Our recurrent CPIP is seeing cost pressures due to inflation.

(e) Our efficiency delivery against our £15.7m target is behind plan at this point in the year. The financial impact is being mitigated non-recurrently in line with plan but this is not sustainable and remains at risk for the remainder of the year.

(f) There is a gap of around £6.4m that we still need to identify and deliver before the end of the financial year.

(g) There is significant progress on CPIP operationally and it is the biggest area of concern currently. The impact of the industrial action and demand on services has hampered our operational ability to focus on CPIP as we would normally do. We are scoping a number of technical possibilities.

(h) Income – There is a lot of complexity with the new payment model. Up to and including Month 4, we have been required to report elective income in line with plan, but are due to report in line with actuals from Month 5. This is likely to result in swings in organisations positions. Year to date to Month 4, we have an estimated risk of around £0.5m but through strong elective performance over the summer, this will support mitigation against this.

(i) The CEO noted the agency spend improvement is a significant move for us. The chart in the reports shows for the first time since this was produced, that we are below the ceiling and have therefore been able to take over £5m in costs out compared to last year. This links in with actions from the CPO but are very material.

(j) Mrs Twigg (NED) noted that at Month 4 we have a long way to go, but with a lot of work, we are where we were expecting to be.

(k) Mrs Twigg (NED) questioned how the ICS deficit challenges affect the Trust. If the ICS is not performing overall, we feel the impact and will we be asked to do more? The CEO advised that part of the challenge that the System faces is within the Worcestershire Hospitals Acute Trust. It is reassuring that they are actively focusing on their CPIP. The National picture is that they need to be clear that they are holding individual organisations to account and have a clear plan to improve. Our CFO has made it clear that we have signed up to our plans and we need to deliver them. We need to focus on our position, and if able, to help the System out if we can. There is increasing pressure if we do not meet our target as an ICS. Some things we are able to do together which will help financially and our patients.

(l) Mrs Twigg (NED) noted that inflation is outstripping what provision we made for this. It would be interesting to know what the difference is and if significant, understanding the effects of this. **KO**

(m) Mr Lappin (ANED) highlighted the huge achievement of 97% of invoices being paid within 30 days. Given the plan to achieve a £22m deficit, do we remain confident that we will obtain the cash support required to continue with this high level of payment. The CFO advised that she is confident, as there is a mechanism in place nationally regarding this. We activated this in Quarter 1 but did not need to make use of this in Quarter 2. We are expecting to have to do so in either Quarter 3 or Quarter 4 depending on timings.

Resolved – that:

(A) The Finance Performance Report be received and noted.

(B) The Chief Finance Officer will review the difference in planned provision for inflation and actual due to recent increases, and the effects of this on the Trust. **KO**

ITEMS FOR APPROVAL

BOD12/09.23 **Nursing Workforce Skill Mix Business Case**

The CNO presented the Nursing Workforce Skill Mix Business Case and the following key points were noted:

(a) The Business Case proposal was presented at a previous Board Workshop, where it was supported. The CNO, CFO and Chief Planning and Strategy Officer have recently met with some of the NEDs to brief them about this Business Case.

(b) This will provide a sustainable workforce in the future, offering more opportunities for our workforce. This builds on the success on the Band 2 to Band 3 progression work previously. Our vacancy factor and turnover for Band 2 staff reduced significantly as a consequence of this work.

(c) This would provide more Band 6 senior nurse cover on our wards, 24/7 alongside providing more Nursing Associate roles and a reduction in Band 5 staff where we are most challenged. It is more cost effective if we undertake all elements of the case at the same time, although each element could be taken forward independently.

(d) If the preferred option is supported the plan is to have achieved the desired skill mix changes by 2026. We will train a larger number of staff to be Nursing Associates in the spring of next year to achieve our target by 2026.

(e) The Summary Table in the Business Case shows the savings we would achieve in the first year. The plan is to recruit 50% of Band 6 staff outside of the organisation, which is a challenging target, ie 18 new Band 6 staff to offset agency costs. Some alternatives have been worked through to show what would happen to the finances if we do not achieve this ambition.

(f) Since the Board Workshop presentation, we have received a funding offer from Health Education England of £4k per student per year to support Nursing Associate training, we are just seeking clarity on some elements of the offer and hope to be able to take advantage of this.

(g) The CFO confirmed that the Business Case has her support. We have modelled in some alternatives if we are not able to achieve at the pace planed.

(h) The CEO noted that ideally we want a fluid response to the development of individuals within the organisation. If budgets are not a constraint and if we are able to provide these roles, he would encourage the CNO to keep this flexibility. If not, the alternative is that we will have to fill the gaps with agency staff and not continue with these improvements.

(i) Mr James (NED) supported the Business Case. This meets a lot of our challenges and is a good measure regarding career progression. We have to move fairly quickly in terms of securing additional staff for the Nursing Associates next year and we are carrying quite high vacancy rates. Do we have an issue here or do we have a cohort of Health Care Support Workers who are wanting to fill these roles. The CNO advised that this is one of the risks with this Business Case, that we might not be able to recruit to the 25 positions. However, in anticipation of this proposal and the Business Case being approved, we have undertaken some surveying of our current Health Care Support Workers workforce to ask if they have considered being a Nursing Associate and would they be interested in undertaking this training next year. If they are not ready to undertake this training next year, we have reviewed what we need to do to support them to enable them to undertake this in the future. Given the feedback from this survey, we are confident that we should get a significant cohort for next year and we also know what we need to do to help others prepare for future cohorts.

Resolved – that the Nursing Workforce Skill Mix Business Case be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD13/09.23 **Digital Programme Update**

The CFO presented the Digital Programme Update and the following key points were noted:

(a) This report provides an update on both the core Digital Programme within the Trust and some of the wider digital priorities locally and across the ICS.

(b) There are a range of programmes underway or due to commence. The majority of these align to the national direction of digital in terms of frontline digitisation, which is where we anticipate the majority of our funding for these programmes to come from, and some of the national standards that we are expected to be implementing. There is a level of detail on each of these within the report.

(c) The main risk in terms of deliverability is the availability of the funding streams and the capacity within the organisation to support multiple programmes at the same time alongside the usual operational challenges.

(d) We have launched the work to refresh the Digital Strategy which is due for a further refresh. We had a really helpful Workshop session on this as part of the Digital Programme Board last month. An update from this is planned to be presented to the next Board Workshop.

Resolved – that Digital Programme Update be received and noted.

BOD14/09.23 **Board Assurance Framework and Divisional Operational Risk Register**

The Associate Director of Corporate Governance (ADCG) presented the Board Assurance Framework and Divisional Operational Risk Register, which was taken as read, and the following key points were noted:

(a) A previous request was to see the direction of travel for our risks. It is pleasing to see that some of these risks are reducing due to the improved controls and further mitigations being put in place.

(b) We are getting to grips with our new management system. This is allowing us improved functionality and to link risks and to triangulate with incidents.

(c) In the Action Log, the ADCG was asked to consider the Industrial Action risk and why this had not been to the Board of Directors. The reason for this was that it had not reached that threshold. This risk was reviewed yesterday and we have now heightened this score. Therefore, the Board of Directors will have visibility of this in the future.

Resolved – that the Board Assurance Framework and Divisional Operational Risk Register be received and noted.

BOD15/09.23 **Armed Forces Covenant/Veterans Hospital Update**

The ADCG and the Air Commodore Tim Howson, Branch Chair, Herefordshire Veterans Association (Branch Chair) gave a presentation on the Armed Forces Covenant/Veterans Hospital Update and the following key points were noted:

(a) The ADCG thanked the Branch Chair for attending, noting that he is also a retired Commodore, Deputy Lieutenant for Herefordshire, Chair of Hereford SSAFA and Vice Chair of the Armed Forces Partnership. It is therefore really important to have his involvement in the Trust.

(b) Wye Valley Trust are proud to be a Veterans Aware Hospital (focusing on the patient) and we have a Silver Award under the Armed Forces Covenant (focuses on the Trust as employers).

(c) We strive to be the exemplar for best care for veterans and their families. We encourage all staff and patients to let us know if they have served in the UK Armed Forces so that we can support them.

(d) The presentation today is covering the Armed Forces Covenant and the principles of no disadvantage and priority treatment to Veterans and Armed Forces families in the NHS. The national and the local context will be covered, including the local services that they can be referred to and staff aspects, and further improvements that are being made.

(e) **What is the Armed Forces Covenant** – This is a legal obligation on certain public bodies. This was reinforced through the Armed Forces Act 2021. We have to pay due regard to the Covenant and principles when exercising certain functions. This covers the whole of the Armed Forces community in the UK including those in the Armed Forces whether regular or reserves, those who have served in the past and their families.

(f) **2 Key Principles of the Armed Forces Covenant Duty** – These are “The Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services”. “Special consideration is appropriate in some cases, especially to those that have given most such as the injured and the bereaved”. This is around parity not priority – eg if a member of the Armed Forces is posted and at a certain point on a waiting list, they remain at the same point on the waiting list in the new area they have moved to. Clinical need will always take primacy.

(g) **National Context** – A Veteran is someone who has served in the Armed Forces for at least one day. It is projected that in 2028 there will be approximately 1.6m UK Armed Forces veterans residing in Great Britain. For every 80 Veterans residing in the UK in 2028, it is projected that 35 Veterans will be of working age and 10 Veterans will be female.

(h) **Local Context** – At 2019 there were 2500 serving personnel, 1600 family members (of which 1144 are of school age (2021 data) and a number are serving as reservists. The slide includes a heat map from the 2021 Census which shows where Veterans are living. Herefordshire stands out proportionately for this along with a few other counties. The majority of the Veterans living in Herefordshire are at retirement age, which affects those who provide care. The total percentage of Veterans living in Herefordshire is estimated at 15% but could be as high as 25%. Herefordshire is always in the top 4 areas for donations for the Annual Poppy Appeal.

(i) **Veterans Health Needs** - Overall health needs for Veterans are similar to other members of the public. However, there are some significant differences as they may have significant mental health issues due to their time in service. This should be identified and flagged on our computer system for staff to be aware. There is a government initiative highlighting the need for Veterans to highlight themselves to GPs, who in turn can advise other health care providers. We also need to ensure that our own staff highlight any Veterans they come across to enable them to receive the right care.

(j) **Herefordshire Armed Forces Covenant Partnership** - This covers the key areas which have signed up to this Partnership: Military Charities, Business Community, Herefordshire Council, Armed Forces Community, other Health & Well Being Providers, Related Organisations and the NHS.

(k) **Veterans Health Needs** - Veterans are at their most vulnerable when they leave service. The transition back to civilian life can be difficult for some, which is where this Partnership comes in and is where we can offer help and support.

(l) **Defence Medical Welfare Service** – The Trust works closely with this Service with Workforce Officers embedded in the Trust. The Service works closely with our Integrated Care Division to ensure appropriate care and support is provided to our Veterans.

(m) **Tailored Service** – This is a confidential person-centred service supporting families, children and individuals in their time of need.

(n) **The first call for help takes courage** - The ADCG read out a letter from a Veteran who had taken this first step asking for support.

(o) **Veterans and Armed Forces Families** – A lot of information is provided on our website along with links to what resources we can support them with.

(p) **Are you a Veteran, in an Armed Forces Family or a Reservist? - Our Staff** - We try hard to ascertain who has been a Veteran. Our appraisal process asks this question. If an Armed Forces family member of staff is identified, we have a Special Leave Policy and Flexible Working Policy in place to enable bespoke training and support.

(q) **NHS Healthcare for the Armed Forces (VTH)** - This provides on line training for staff.

(r) The Chairman advised that families of those working in the Regiment are encouraged not to disclose this. Is there a "soft" process where we can get around this being recorded. The ADCG advised that this is not just related to families but often elderly Veterans who also feel that they are not able to give background to their past. This is a challenge. The Branch Chair advised that Taurus and GPs are aware of this and are very sensitive to it, this is a very difficult area. **EH**

(s) The CEO thanked the Branch Chair for the work he is doing and the ADCG for supporting. He asked that the Branch Chair to advise the Board of Directors if there is anything more we can do to help.

Resolved – that:

(A) The Armed Forces Covenant/Veterans Hospital Update be received and noted.

(B) The Associate Director of Corporate Governance will review whether the Maxims system allows for a "soft" process for recording those patients/families who do not wish to have recorded that they work/have worked in the forces. **EH**

COMMITTEE SUMMARY REPORTS

BOD16/09.23 **Integrated Care Executive 10 July 2023 and 14 August 2023**

Resolved – that the Integrated Care Executive Summary Report 10 July 2023 and 14 August 2023 be received and noted.

BOD17/09.23 **Quality Committee Summary Report 29 June 2023 and 27 July 2023**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report 29 June 2023 and 27 July 2023 and the following key points were noted:

(a) Mr James (Chair of the Quality Committee and NED) advised of the work that the Patient Experience Committee is doing ensuring the quality and safety of our services. This has been strengthened but there is more to do. The Quality Committee are overseeing this.

Resolved – that the Quality Committee Summary Report 29 June 2023 and 27 July 2023 be received and noted.

COMMITTEE MINUTES

BOD18/09.23 **Audit Committee Internal Audit Report Review 26 May 2023**

Mrs Twigg (Audit Committee Chair and NED) presented the Audit Committee Internal Audit Report Review minutes 26 May 2023 advising that each item on the agenda was an Internal Audit Report. This was an additional meeting held to discuss these reports rather than delaying review. There are crucial triangulated pieces of data to review.

Resolved – that the Audit Committee Internal Report Review minutes 26 May 2023 be received and noted.

BOD19/09.23	**Foundation Group Board and Action Log 2 August 2023** **Resolved – that the Foundation Group Board minutes and Action Log 2 August 2023 be received and noted.**	
BOD20/09.23	**Quality Committee 25 May 2023 and 29 June 2023** **Resolved – that the Quality Committee minutes 25 May 2023 and 29 June 2023 be received and noted.**	
BOD21/09.23	**Any Other Business** The Chairman advised that this is the last Board of Directors meeting for Mr Cottom (NED). He has served as a NED for the Trust for a number of years, had an important role with Hoople and been Chair of the Audit Committee. He has also been the Vice Chair for the last year. The Chairman thanked Mr Cottom (NED), on behalf of the Board of Directors, for all his hard work over the years. **Resolved – that the Any Other Business be received and noted.**	
BOD22/09.23	**Questions from Members of the Public** **Q1.** Physical capacity at Hereford Hospital is restricted due to the complex nature of the site. On page 33 of the papers it states: "Increased SDEC physical capacity to ensure that patients can be managed via a SDEC pathway can be streamed away from ED and are not admitted to inpatient wards." What is the present capacity of SDEC? What is it anticipated that this will rise to? Will this increase in physical capacity be at the expense of any other hospital department? If so, what are the implications? **A1.** The COO advised that SDEC is being expanded on our current Acute floor footprint. The design was undertaken by our Clinicians and Operational team. It was their plan to repurpose their department. This does not function well currently following changes made during Covid. We are repurposing our current estate. The current SDEC has 5 Consultation rooms and a waiting area – the new SDEC will have 12 Consulting rooms and 2 waiting areas. Six of these rooms will be for Frailty SDEC, but will be flexible usage. The same patients will be streamed from the Front Door but to a better facility, staffed appropriately. **Q2.** The Public Board meeting papers are long and complex. As a very important area, I was looking for details of bed occupancy, discharge information including details of the number of delayed discharges, length of stay etc for the different Local Authority areas. Also, were the monthly figures going up or down or are they stable? Did I miss this information? If they are not included in this month's papers, will they be included in next month's report? This is extremely important information as to how the hospital is coping before winter pressures arrive. **A2.** The COO advised that the Integrated Performance Report KPIs bed occupancy are included in the papers along with the medically fit for discharge. More detail around this area will be included in next month's report.	**AP**

	<u>Resolved</u> – that: **(A) The Questions from Members of the Public be received and noted.** **(B) The Chief Operating Officer will include more information in his next report on bed occupancy and patients medically fit for discharge.**	**AP**
BOD23/09.23	**<u>Date of next meeting</u>** The next meeting was due to be held on 5 October 2023 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 5 OCTOBER 2023

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD15/04.23 Staff Survey Results 6 April 2023	(D) The Chief People Officer will provide an update at a Board Workshop, prior to the next Staff Survey, on some of the cultural improvements that are being made within the Trust.	GE	Completed - A paper outlining the actions and cultural improvements being made following the Intouch staff engagement campaign is on the agenda.
BOD11/09.23 Finance Report 7 September 2023	(B) The Chief Finance Officer will review the difference in planned provision for inflation and actual due to recent increases, and the effects of this on the Trust.	KO	Working across System to ensure consistent methodology for excess inflation. To be included within reporting pack from month 6.
BOD22/09.23 Questions from Members of the Public 7 September 2023	(B) The Chief Operating Officer will include more information in his next report on bed occupancy and patients medically fit for discharge.	AP	Completed – Within report.
ACTIONS IN PROGRESS			
BOD15/09.23 Armed Forces Covenant/Veterans Hospital Update 7 September 2023	(B) The Associate Director of Corporate Governance will review whether the Maxims system allows for a “soft” process for recording those patients/families who do not wish to have recorded that they work/have worked in the forces.	EH	Verbal Update.

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

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

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

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

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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1) Outpatient Transformation

The challenge of the Elective Recovery Plan nationally has accelerated thinking on the transformation of outpatient activity. I thought that it might be helpful to share some of that thinking in the context of ongoing local work on outpatient transformation.

Around 80% of activity on the NHS waiting list actually takes place in a non-admitted pathway i.e. not in operating theatres. Our outpatient activity falls into two main groups, first outpatient attendances (new patients) and follow up outpatient attendances. The ratios of new to follow up activity vary greatly between specialties and between clinicians. Some of the higher follow up ratios can be explained clinically, such as those associated with complex long term conditions or where prescribing cannot be managed by primary care. But in many cases the variation appears unwarranted. The national Getting it Right First Time (GIRFT) programme has been very successful in developing best practice data by specialty and then comparing this to local, clinician level data. Last year the Foundation Group was invited to join the GIRFT-enabled 'Further Faster' programme. This programme works with 28 pilot trusts to improve outpatient productivity in collaboration with clinicians across all sites.

The Further Faster programme will hopefully soon be rolled out to include a further cohort of trusts including Worcestershire Acute Hospitals NHS Trust (WAHT). I have been impressed with the programme, particularly by way that it is grounded on clinical evidence. One of the bigger areas of focus has been the drive to reduce unwarranted follow up appointments, in many cases replacing these with arrangements which are more flexible for patients. Patient Initiated Follow-Up (PIFU) is one solution. Here the patient is not given a fixed date for a follow up but instead given the opportunity to book one if needed over a time limited period. This therefore leads to a greater level of patient awareness of their condition and allows them to take control. What we have found through the programme is that the level of reactivation (i.e. request for a further appointment) is really quite low. Those who do wish to be seen again are able to be seen more rapidly than the previously fixed re-appointment slot. My only concern relating to this approach is that it could lead to more patients being 'held' on a PIFU pathway where in some cases it may be better and potentially more motivational for them to be discharged. In such cases they can return to their normal life content that our excellent Primary Care teams are there to support them. As a consequence, I have introduced the alternative mantra of TOFU (Take Off Follow Up!) as a challenge to ensure that both options are fully considered.

We are also using technology to make services more accessible and responsive. Telephone and video clinics provide a very convenient way of following up patients where a hands on clinical examination is not required. Wearable devices and other assistive technologies can also support such an approach. Such clinics can then also triage patients so that they can go 'straight to test' into outer diagnostic services where required. App based technologies can also support triage to test.

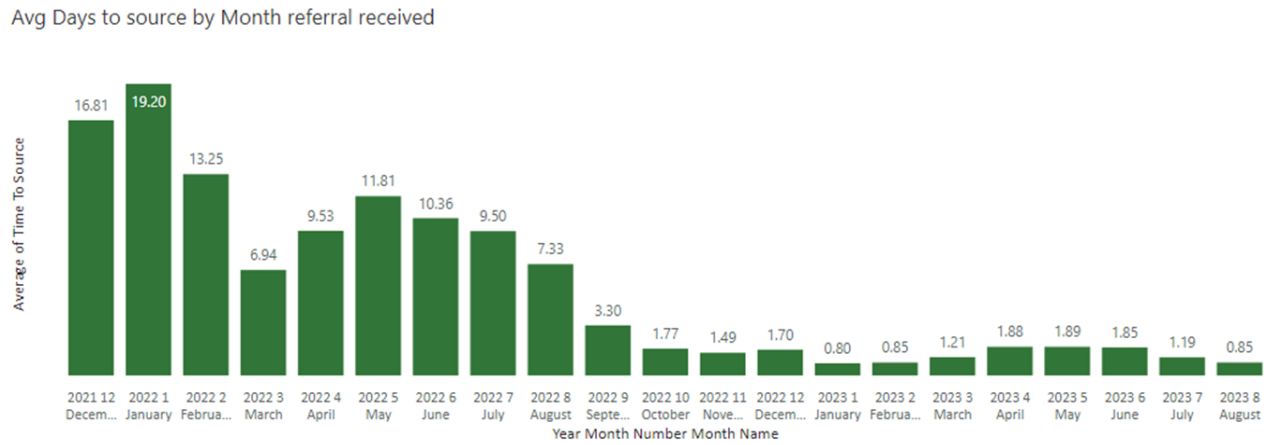
Increasingly, General Practitioners (GPs) are contacting our specialists for Advice and Guidance (A&G) prior to referral. This also can be assisted by technology to route calls or emails directly to the right team and then on to 'straight to test' pathways if required. There has been a suggestion nationally that these 'A&G' pathways could become the only elective referral route for GPs in the future. Whilst this may be advantageous, it also runs the risk of encouraging inappropriate use of Accident and Emergency (A&E).

The expansion of Same Day Emergency Care (SDEC) services has also changed the profile of outpatient referrals. Ideally SDEC should be a better alternative to admission for patients who present as emergencies. I do have a concern that this could become a means of fast-tracking outpatient referrals, particularly where routine waiting times are stretched. To avoid this, we should ensure that there are a suitable number of 'hot clinic' slots in appropriate specialties which can offer an appointment within a few days of assessment by our acute medical teams or on the advice of our specialist teams.

This impact of all these initiatives should be that we require fewer follow up outpatient slots and less physical outpatient capacity. The manpower that this frees up can initially be directed to tackling the non-admitted care backlog. But in the long run we should consider whether a switch to supporting Urgent and Emergency Care (UEC) pathways may deliver even more value. We will therefore need to carefully model our demand assumptions.

2) Integration Frontrunner

This Warwickshire-wide project is being led by South Warwickshire University NHS Foundation Trust (SWFT) in collaboration with Integrated Care System (ICS) partners. The objective is to increase the capacity and responsiveness of the Domiciliary Care sector to ensure that we can effectively deliver the levels of Discharge to Assess (D2A) Pathway 0 (rehabilitation and assessment at home) to meet need. The approach includes making commitments to suppliers in advance of need (pre-booking) and adding enhanced therapy support delivered by NHS staff. The approach has significantly reduced the time between the identification of need and the delivery of the care package. The chart below shows the average time to source packages in days, charting the period from December 2021 through to August of 2023. These are very encouraging results which we will be seeking to maintain over the coming winter.



3) NHS Finances

Additional NHS funding which the Prime Minister announced in September 2023 for 'winter' will be used to cover trusts' additional costs linked to strike action, and hence will not be available to support new initiatives. It comes amid growing concerns over national finances this year after the positions reported by ICS in the four months to August 2023 were around £800m worse than planned. The overspending against the plan is significantly worse than any comparable figure reported by the sector at this point in the year during the last decade. The impact of strikes, inflation and other pressures including prescribing and continuing healthcare costs mean that most areas have struggled to keep to their spending plans. There is further concern that many other systems, including Coventry and Warwickshire and Herefordshire and Worcestershire are currently off plan but are not yet reporting that they will miss their targets. NHS England (NHSE) plan to hold the additional funding back and use it later in 2023-24 to cover costs expected to be caused by industrial action.

NHSE is still considering how to distribute the money, but it was due to be allocated locally later in the year, rather than used for central costs. At this stage it is unclear how this will be allocated. It is clear that strike action has affected different trusts in different ways. It is also clear that some trusts have been more aggressive in-patient cancellation ahead of strike action. Rates of reimbursement to other clinicians providing enhanced cover during strikes has also been quite variable, including application of the British Medical Association (BMA) 'rate card'. In my view it would be wrong to simply reimburse trusts based on their stated costs as this could inadvertently penalise organisations which have worked harder to minimise the impact of strikes on patient care. It may therefore be more sensible to use a formulaic approach to allocating appropriate shares of the *Retain* - A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options including pensions.

4) MORE FROM OUT GREAT TEAMS – Update from the Surgical Division – October 2023

Theatre Improvement Event

The Theatre improvement event was held in July for 2 weeks, aiming to address, challenge and improve productivity, utilisation and efficiency of the emergency and elective surgical pathways:
During this period there was a total of 169 theatre session of which 103 of these session were shadowed

Theatre Sessions shadowed also included elective theatre session as well as Trauma, CEPOD, Obstetrics – with a mixture AM, PM and Eve sessions shadowed
Staff also shadowed Day Case/ SAU and Recovery area
Matron and Ward Manager form Frailty / Dinmore shadowed recovery
Approx. 40 staff were involved across the whole 2 weeks either shadowing a theatre session, Day case, SAU, Recovery or supporting in the co-ordination hub - this included Exec and NEDs

During this period over 400 patient had surgery / theatre procedure (Inc. Trauma, CEPOD, Obstetric)
Over 700 comments/ suggestions/ observation notes were collated. These have been themed

- Equipment
- IT
- Scheduling
- Capacity
- Timings
- Recovery
- Radiology
- Pathology
- Staff Resourcing
- List order Change
- Pharmacy Drugs
- Communication
- Porter needs
- Other

Next steps following the event:
The comments / themes were reviewed

- Actions for each theme have been developed (based on the comments received)
- An action plan developed, proposing responsibilities for taking forward and timescales
- Action plan shared/ discussed at divisional meeting
- Monitoring/ Tracking process to be confirmed
- Feedback session to Theatre etc. completed

An endoscopy services improvement event has been planned for October 2024.

Surgical Robot Update

The implementation of robotic assisted surgery continues to progress at pace. The team attended the Intuitive Event in London in July 2023 to hear stories from other Trusts who have implemented Robotic Surgery across the Country, learning from and Networking with key colleagues in Robotic Surgery

Both Gynaecology and Urology are signed off and operating regularly, Colorectal have 2 Surgeons operating at Proctor stage and are on track for sign off in August. Gynaecology have identified a 3rd Consultant who would like to commence in training.

The first Governance meeting was held on 11th July, an opportunity to discuss all surgical cases, any complications or readmissions and share any learning. This meeting will run monthly and be open to all clinicians involved in Robotic surgery, the invite will now be extended to SWFT to attend.

Elective Surgical Hub (ESH) Update

A project plan identifying key milestones, measures, risks and a Quality Impact Assessment are in process of being completed. Please see brief update on each area of plan below:

Activity

- Theatre templates for May 2024 have been drafted and populated.
- Further revision of this initial draft will require further adjustments following completion of a review of referral trends and specialty-by-specialty need for increased capacity.
- In process of reviewing evening lists (these are not very productive (GiRFT) – SWIFT do not have evening lists) versus weekend or 6 day working.

Workforce

Initial workforce plan under review with some changes to the initial requirement including:

- Confirmation of theatre staffing requirements for both day case and cataract theatres
- Development of staffing plan for admission and second stage recovery for cataract surgery complete and other day case work in progress
- Review of pharmacy staffing under review
- Review of therapy staffing complete
- Medical staffing will be complete once activity profile finalised

Pathways

GiRFT and British Association of Daycase (BAD) pathways being reviewed and will form part of a review with each specialty to confirm adoption in Hereford.
A review of BAD's procedures list against our elective profile to identify opportunities to focus on any elective pathways that have the potential to convert to day cases (day case rates in Hereford are already very good but there are some areas that we could focus on for further improvement)

Peri-operative groups

The project group are in the process of identifying the need for sub-groups to focus on systems, processes and practices associated with Day Case procedures and the functions of the new hub.

Pre-operative assessment

The project group need to agree pre-operative assessment and preparation approach for day surgery patients, group to be set up and benchmarking to be undertaken. Need to work through pharmacy workforce in association with pre-operative preparation.

Equipment/SSD

Equipment has been identified and listed for ordering, just agreeing lead and order times. Further clinical kit will be identified once activity templates complete. Estates and project team are working with Sodexo/SSD to ensure services can accommodate the additional theatres.

Operational Overview – Key Highlights

- Focused work to reduce the Did Not Attend rate in Pre-Op is delivering some early successes: DNA rate in August saw a reduction in DNA to 7.6%, down from 10.2% in July). August's figure is also a notable improvement on the 6 month rolling average of 9.36%
- The Division continues to focus on ensuring effective theatre scheduling. The mean number of cases per list improved during August, increasing to 3.1 cases per session against a 6 month rolling average of 2.4
- Pre-Op Mini-Screening in Outpatient setting, based on SWFT model, is working well. An audit is being kept of the number of complex patients who have been identified earlier in the pathway through triage and can therefore be optimised for surgery
- Virtual reviews of Gynae patients waiting in excess of 52 weeks for a first OPA has seen some early positive results. Circa 40% of patients reviewed did not need to be seen in a conventional face to face clinic with patients instead being triaged onto more appropriate pathways including straight to test, virtual appointment or Patient Initiated Follow Up for example
- The General Surgery team have focused resource on reducing the new outpatient waiting list size, reducing this backlog from 1,106 in June to 361. The 18 weeks backlog has also reduced from in excess of 600 patients to 141. New speciality doctor appointees will allow the Directorate to reduce wait times further with a focus on sustaining this improvement
- Through work to improve productivity, the number of patients on Ophthalmology IVT lists will increase through the design of new templates from 10 to 14 patients per session

5) Going the Extra Mile Awards – June and July 2023

Team of the Month June 2023 – Emma Cooke and Robyn Evans

Emma and Robyn have supported the Recruitment Team by managing two divisions within WVT because of staff shortages. Robyn first started her role with KPI's of 20%, however has worked so hard with determination and dedication that she has reached KPI's within the 80's. Her HRBP's are impressed with Robyn and her strive for excellence within her role. Emma has also recently received feedback from Senior Managers in the Trust, thanking her for her patience, support and advice during their recruitment process. Emma is doing a brilliant job and shows her dedication and amazing work ethic. Emma and Robyn have and continue to do a brilliant job, and should be extremely proud of themselves and how they have come in their roles.

Employee of the Month June 2023 - Lauren Austin

Lauren cared for me on and off whilst I had my stay on Wye Ward. Yet again for me, this was another stressful stay. I have no idea what is going on and kind of have to just go with the flow. Lauren was always calm, reassuring, and a friendly face when I came back round. Lauren went above and beyond just so I could have a little privacy and dignity, when being observed due to my other symptoms and needs. She is very calm in some very trying situations. She is friendly, helpful, and empathetic and really needs to be acknowledged. She has my total admiration. Please don't stop at HCA, you will go far!

Employee of the Month July 2023 – Sophie Wheadon

Due to the Clinical Lead resigning, there was a major gap in the authorisation of results. Sophie worked tirelessly with Dr Rees to refine a procedure for authorising results which was based on a clinical algorithm. Sophie led on a procedure to audit this new system to ensure it was clinically safe, carried out the audit and discussed issued with Dr Rees to refine the new system. She wrote her own training records which were signed off by Dr Rees and has now started cascade training to other staff.

Sophie has demonstrated a brilliant grasp of what is required to maintain a high quality service, shown she gain apply her knowledge in a logical manner and an understanding of what is within and what is outside her current scope of practice.

Team of the Month July 2023 – Acute Medical Unit, Ashgrove MDT, Samantha Bemand & James Bartlett

I want to acknowledge the dedication, compassion and excellent care provided to a young lady who I will refer to as R by the whole teams on AMU and Ashgrove and with continuity of care provided by Dr James Bartlett.

They were all able to deal with a challenging patient, who threatened staff, to harm herself and to damage hospital property, due to being distressed and discharge her to a care new home, which R is now loving.

Both teams on AMU and Ashgrove and Dr James Bartlett to be acknowledged for their dedication, commitment and compassion in keeping R and others safe in hospital and the exemplary example of personalised care planning.

Glen Burley
Chief Executive Officer

Integrated Performance Report

August 2023

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

I suggested at the beginning of summer that we needed to make hay whilst the sun shone. Despite the summer of discontent which has intensified as we move in autumn, we have made a lot of progress and improvement right across the Trust, down to hard work and tenacity of our teams. Unfortunately we have become more adept at managing strike action to continue to deliver as much care as possible.

Industrial action has become more frequent and intensified. At the time of the Board meeting we will have just completed 3 days of joint junior doctor and consultant strikes. For the first time this has impacted patients waiting for operations for cancer with only 4 of the 10 planned cancer lists running. In addition to this other than some minor operations that don't require anaesthesia we have been able to deliver only emergency surgery for the last 3 days.

This is unacceptable for patients and both sides need to agree a solution so that further physical and psychological patient harm is prevented.

In the quality section of the report three national patient survey reports demonstrate national average performance and some solid improvement over last year. That said our aspirations is for all of our patients to have a really good experience in our care and whilst the patient experience committee is leading the improvement work it is the responsibility of all of our staff and teams to deliver improvements.

It is very notable that our mortality statistics are at their lowest ever level at 101.8 SHMI and the thanks of the whole organisation go to David Mowbray our CMO. This is his last Board meeting before retirement (and return to the group). His exemplary leadership of mortality reduction along with the rest of his portfolio has made an impact for patients and colleagues alike. Thank you David.

The changes to our urgent care flows at the front door have started and the new frailty SDEC service located next to ED has made a really positive start. The next steps to relocate medical and surgical SDEC with more space and integrate with the virtual ward are being planned. Improvement to discharge processes and capacity are underway through the internal professional standards sign off and D2A board with the council. The delegation of the BCF to One Herefordshire partners will enable the D2A improvement work to speed up.

Elective productivity work has continued apace and WVT has been the top performing Trust in the region in July and August for delivering more than the 19/20 benchmark and is currently at 115%. There is still a lot more productivity improvement to be made especially in theatres and pre-operative processes.

Our people metrics on vacancies, turnover and sickness continue to be very good, building on the good work of our teams over the course of the year. The HR team had a busy summer running a very large staff engagement exercise involving 100's of staff. Their feedback on 4 key questions has now been assimilated into a Trust wide action plan, displayed on posters around the organisation along with local action plans. The national staff survey is now live and we are targeting an over 50% response rate this year to gather further staff feedback.

Our financial position has deteriorated and we are reporting a £1m adverse variance to plan. £0.7m is elective activity and in part due to the industrial action. Our £0.3m cost overrun is mainly due to our CPIP under delivery and focus continues to improve efficiency and reduce costs.

Our Quality & Safety – Executive Narrative

David Mowbray

Chief Medical Officer

Lucy Flanagan

Chief Nursing Officer

Patient Experience

The Trust has received results for three National patient surveys and are summarised as follows;

National Inpatient Survey

Overall the Trust received improved scores for 50% of questions, 26% scored the same and 24% worsened. However in all except one question the Trust scored 'about the same' as all other Trusts. In recent years there have been thematic areas of concern emerging from the results of the survey; discharge, communication (doctors and nurses) and food quality. This year the Trust has seen an overall improved score in all these areas. There was one new emerging area of concern related to communication before and after an operation or procedure. Further analysis of the quantitative data will be undertaken to understand the issues and develop actions to improve this.

Urgent and Emergency Care Survey

In all areas of this report, the Trust scored about the same as other Trusts. A detailed breakdown of the results was presented at Quality Committee and the overarching themes identified for improvement were; leadership, communication and capacity vs. demand. A detailed action plan has been developed to address the specific issues identified for the five areas where the Trust scored poorly (bottom five scores); patients having time to discuss their condition and treatment with staff, being given information about symptoms of the condition and any side effects of medications and finally were patients given enough privacy when being examined.

Cancer Patient Experience survey

The survey encompasses all aspects of patient care and treatment from diagnosis to discharge. The survey identified two areas of above expected scores and an upward trend over a three year period; patient was told about their diagnosis in an appropriate place and patient has had a review of cancer care by their GP.

There were five areas where scores were below the expected and show a downward trend over a three year period. These areas have action plans developed for improvement;

- Patient had a main point of contact in the care team
- Care team reviewed patient care plan with them and kept up to date
- Patient had enough understandable information before commencing radiotherapy
- Patient was offered practical advice on dealing with treatment side effects
- Cancer research opportunities were discussed.

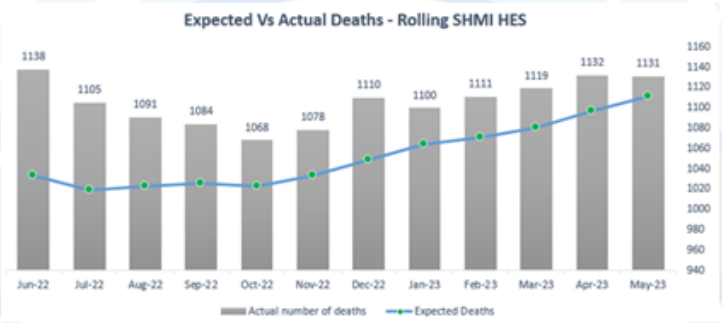
Quality and Safety – Mortality

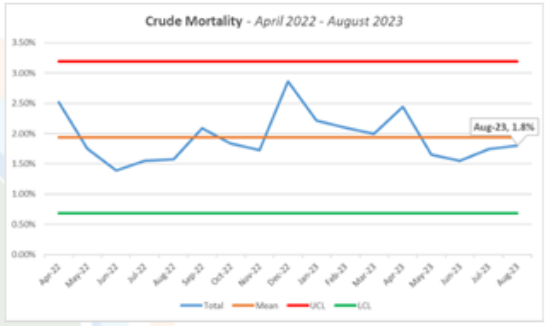
We are driving this measure because:

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

Data

Indicator	Description/Notes	Data month	Month Actual
SHMI (NHS Digital)	*Monthly 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Mar-23**	103.1
SHMI (in hospital)			95.1
SHMI (out of hospital)			123.0
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**May-23**	101.8
SHMI (in hospital)			96.5
SHMI (out-of-hospital SHMI)			114.4





What the chart tells us:

- The latest **SHMI** (*HES Based*) from June 2022 to May 2023 shows Wye Valley NHS Trust at 101.8, with a further reduction of 1.2 this month, and continuing the overall downward trend towards the national mean of 100.
- Latest **crude mortality** rate for August 2023 is 1.8% for all admissions.
- The bar chart on the previous page shows a relatively stable number of observed deaths, with an upward trend for the number of expected deaths. This closing gap between the blue line and the grey bar, equates to a lower SHMI.
- Based on the latest SHMI data (*June 2022 – May* 2023), the majority of our mortality outlier groups now sit within 'as expected ranges'. The current exception is our heart failure mortality, which has reported another small rise in the latest 12 month rolling period. Latest **stillbirth rate** (*September 2022 to August 2023*) **2.44** deaths per 1000 live births. In addition, the **extended perinatal rate** for the same 12 month period, shows a reduction to **3.05** deaths per 1000 live births.

Key Actions:

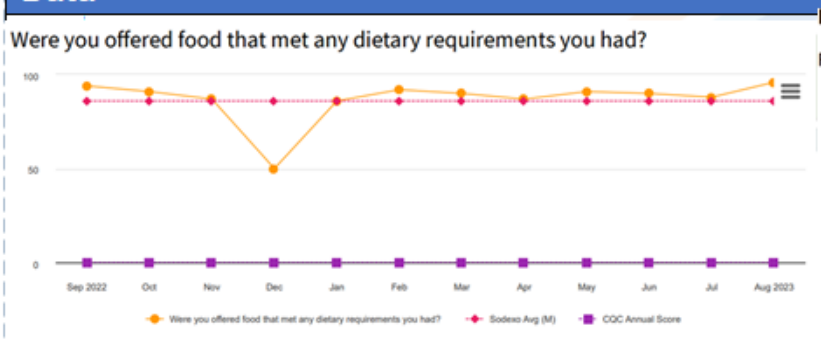
- Commencing in October, all Coroner referrals for deaths occurring in WVT will be logged on In-Phase as a Moderate Harm incident. The aim is to ensure that the Trust and Divisions have oversight of these cases, and where appropriate, instigate a review process to ensure any learning is identified and acted on. As an initial pilot, the Medical Examiner service will record the details of the referral on the system, and the Medical Division will review these incidents on a weekly basis.
- Clinical Coding have recently embedded a process to ensure a review of these cases are undertaken, and clinical teams are involved to ensure the diagnosis is can accurate reflection and subsequently updated. This month has reported a significant reduction in the number of cases where a primary diagnosis was recorded as a '*Sign or Symptom*'. This will directly impact mortality through the higher weighting of a known condition, such as Heart Failure, as opposed to a symptom like a 'chest pain'.
- An audit has been conducted, which focussed on our heart failure mortality, whereby 12 of the deaths were subject to an in-depth case review. The final report, which includes the learning and actions, has been completed, and will be shared in the October monthly mortality report.

Quality and Safety – Nutrition

We are driving this measure because:

Improving nutritional standards is a quality priority for 2023-24.

Data



What do the charts tell us

The charts show patient feedback month on month in relation to food quality, choice and ability to meet dietary requirements on the acute site. The overall positive responses are mirrored in the community hospital data and reflected with an improvement in our National Inpatient survey scores.

Key Actions:

- PLACE audits are due to be undertaken over the course of the next 2 months and provide a further opportunity for feedback on nutritional quality.
- The monthly audits will continue and be monitored by the Nutritional Steering Group.

A gap analysis against the NHS National Standards for healthcare food and drink has been undertaken. Key actions have been developed to continue to improve nutritional standards for patients;

1. A working group will be set up to produce a WVT strategy based on best practice and exemplar models. This strategy would encapsulate action plans and work streams identified in the gap analysis.
2. Explore options to develop a Food Safety Specialist role.
3. The Lead Dietician is exploring the option of introducing an ICS wide catering dietician role to support this agenda

Quality and Safety – Staffing

Fill Rate and CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	93%	86%	89%	87%	9.3
Maternity Ward	85%	78%	89%	87%	5.3
Children's Ward	112%	102%	100%	92%	21.8
Lugg Ward	104%	98%	101%	123%	6.0
Wye Ward	118%	80%	117%	91%	7.1
Cardiac Care Unit	100%	91%	100%	95%	12.5
Leominster Community Hospital	154%	108%	140%	172%	7.8
Bromyard Community Hospital	118%	162%	103%	218%	9.2
Ross Community Hospital	101%	107%	103%	113%	5.9
Teme Ward	102%	45%	76%	51%	10.7
Redbrook Ward	95%	97%	101%	98%	6.5
Special Baby Care Unit	91%	-	94%	-	11.8
Intensive Care Unit	125%	-	103%	-	60.4
Gilwern Ward	148%	122%	100%	108%	6.6
Acute Medical Unit	116%	95%	89%	138%	8.3
Ashgrove Ward	111%	80%	101%	137%	7.6
Dinmore Ward	128%	80%	101%	116%	7.0
Garway Ward	104%	105%	104%	134%	7.3
Frome Ward	110%	101%	99%	114%	7.1
Arrow Ward	132%	84%	138%	91%	7.9
Women's Health	100%	94%	100%	-	8.6

There are ward areas that due to the increases in acuity and dependency of our patients and due to significant increases in boarding patients have required additional staff over the establishment levels. Therefore as can be seen in the table above, there are a several ward areas that are above the fill rate level:-

Community Hospital – Due to high dependency patients and patients needing 1:1 care, and additional beds at Bromyard and Leominster.

Frailty Wards – Due to high patient dependency and additional boarding patients during the day and night.

Wye Ward and AMU - Due to high patient acuity and dependency.

Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV).

Gilwern Ward – Establishment baseline is incorrect and staffing is provided at a higher level to

In August 2023 agency usage increased, with an increase of 20.5 WTE from the previous month to 133.88 WTE.

Bank usage increased during this period, using 117.70 WTE.

The increases have occurred due to:-

- Additional care requirements for high patient acuity and dependency
- Additional staff for escalation areas in ED and Day case
- Additional nurses required for boarding patients
- Nurses for additional escalation beds in the community hospitals.

What the chart tells us:

The chart with percentages measures the nurses and HCA's a ward/clinical area planned to have on duty when the rota was set and then compares this to what actually happened when the shift was worked, once sickness, unexpected leave, unfilled agency shifts and / or additional staff allocated. The data is aggregated for a whole month, in addition it calculates how many care hours each patient receives (CHPPD) in a 24 hour period given the actual staffing. CHPPD can be benchmarked against other trusts, as all trusts are required to collect data in this way.

Our Performance – Executive Narrative

Andy Parker

Chief Operating Officer

The pressure of maintaining our Urgent and Emergency Care [UEC] and Elective activity during periods of intense Industrial Action [IA] continues.

I cannot underestimate the level of effort required by all our teams to maintain our services before, in the pre-planning, during and after, to ensure urgent and long waiting patients are treated as soon as operationally / clinically possible.

As a write this update we have just completed a week of four days of IA where we have had consultants and junior doctors undertaking IA separately and jointly, a first for the NHS. Over this week we had to postpone almost 200 outpatients, 150 procedures and 50 diagnostics procedures.

The first week in October will see three further days of IA with consultants and junior doctors undertaking action together, for the entire period, along with radiographers for 24 hours on one of the days. Our currently planning assumptions for this period of IA is an even greater impact on our elective patients.

Even with IA during August, our Value Weight Activity [VWA] comparison against 2019/20 based on, not just activity number, but complexity and treatment received shows our Trust as over 115% above 2019/20 levels for the first two weeks of August and the leading Trust in the Region for last reporting period.

Despite the impact of planning and co-ordinating our operational response to IA we continue with our UEC Quality Improvement Plans ahead of the winter. At the start of September we started our reconfiguration of the acute floor by dedicating part of our current escalation area into a Frailty Same Day Emergency Care [FSDEC] facility which is staffed by our care of the elderly consultants, Frailty Advanced Care Practitioners [ACPs] and dedicated frailty nursing team. This facility will care for our older patients 24/7 and ensure those patients that require input from this speciality team are moved out our ED as quickly as possible to start treatment. Patients need to fulfil certain criteria to be accepted into FSDEC to ensure clinical safety. FSDEC works closely with our ED, the ambulance service, our Virtual Ward, our Integrated Discharge Team and the inpatient frailty wards.

As part of this redesign our Virtual Ward [VW] team are also now based with our FSDEC and we have already seen an increase in reduced admissions for this cohort of patients and an increase in the number of patients being cared for on our VW.

The next steps over October is to increase our ability to stream additional medical and surgical patients away from ED that require Same Day Emergency Care [SDEC], and although our percentage of patients treated via a SDEC pathway within our Trust is one of the most favourable, Nationally, we know we have “missed opportunities” due to physical capacity constraints that need to be addressed.

In my update this month I have included a summary of our Bed Occupancy and Delayed Discharges. In summary, when comparing the first 5 months of 22/23 to 23/24, there have been a slight increase in the number of patients delayed for Discharge to Access [D2A] discharge pathways, however, the overall bed days have reduced. Particularly for Pathway 1 patients where we have seen reduction in bed days lost across all Local Authorities who admit patients to our Trust.

There are various actions ahead of winter to reduce these delays even further including:

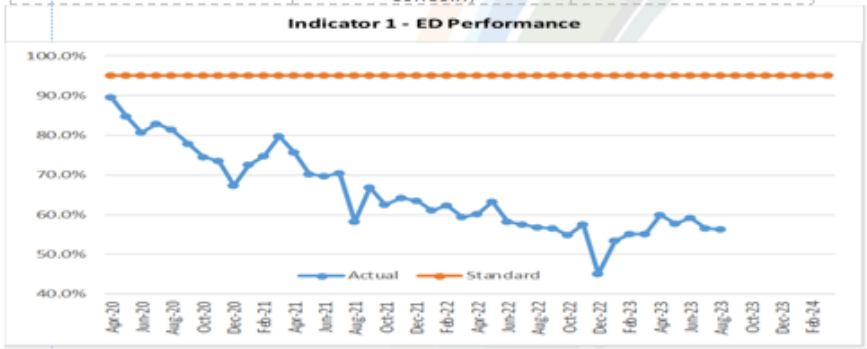
- Continuing with Health led ‘Bridging team’ created to support HomeFirst with around 12-15 patients at any one time. This has been successful and there is learning to be had across the system how this team operates that can help improve capacity in other HoemFrist provision.
- Discharge to Assess Board launched and has drafted a new D2A process, commissioning model and data dashboard to support the design and delivery of Herefordshire’s D2A plan.
- Additional commissioning of HomeFirst providers launched recently which has reduced the numbers of people at home awaiting care and those in HomeFirst over-staying from circa 30 to 15.

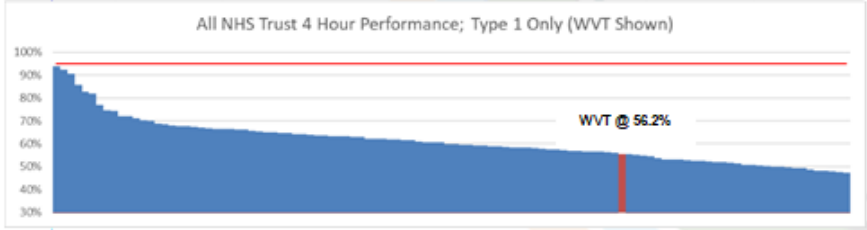
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

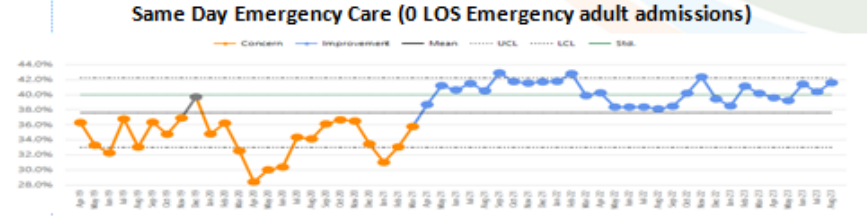
We are driving this measure because:

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

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







Performance and Actions

- 5,886 patients attended ED in August which was fewer than the previous three months, but the busiest August the Trust has seen. The range of attendances varied from 159 to 2230 with 190 being the average daily attendances
- 1,791 ambulances conveyed to the Trust in month which was the second highest month this year. The range in month was 42 to 72. This includes 5.5% from Worcestershire [98], 4.8% from Shropshire [87] and 9.4% from Powys [169]
- Ambulance handover delays over 1hr were 4% [60] of all conveyances 89% [1,341]of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 814 of all admissions [42% of all admissions] via a Same Day pathway within no overnight admissions.

Actions to Address:

Trust wide UEC Quality Improvement Plan [QIP] in place ahead of winter with oversight via Valuing Patients Time Programme Board [VPTB]:

- Expand Medical and Surgical SDEC ahead of winter
- Refresh and Review all Internal Professional Standards across all Divisions. Surgical Division signed off and implemented. Remaining Divisions to be signed off in October.
- Virtual Ward. Resolve issues with remote monitoring equipment and establishment overnight support to increase utilisation.
- Standardisation of Discharge processes across all wards and Community Hospital sites.
- Improved Discharge to Access [D2A] pathways across Herefordshire system. Oversight via D2A Board.
- Follow-up on ECIST visit and support work streams as part of UEC QIP.

Risks:

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

What the chart tells us:

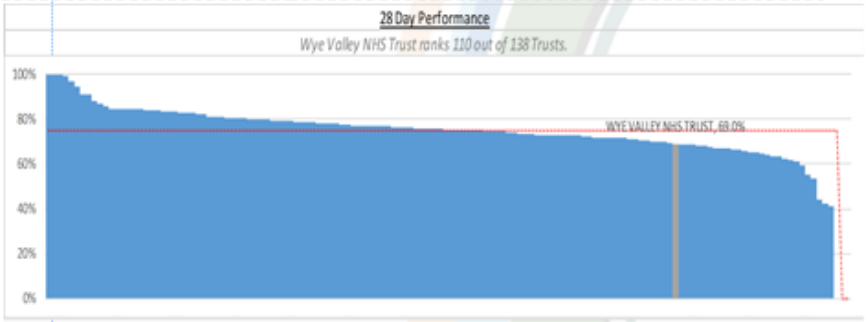
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.

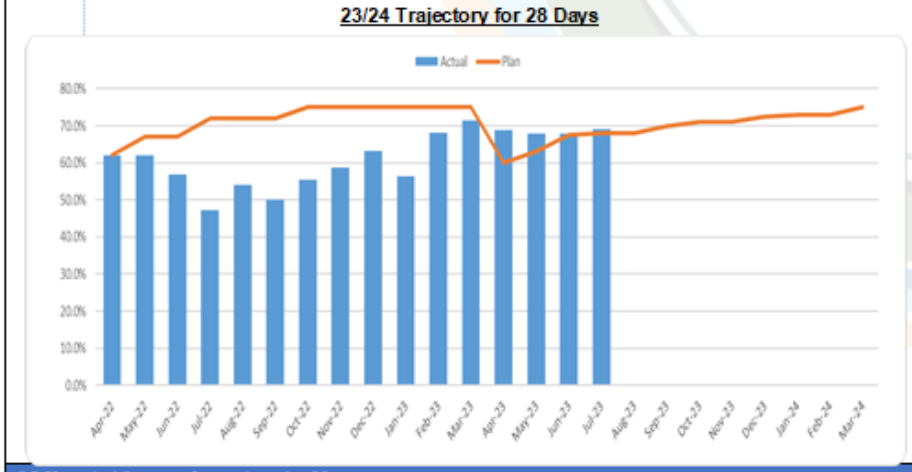
Operational Performance – Cancer Performance—28 Days Fast Diagnosis Standard [July 23]

We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. Research suggests that someone in the UK is diagnosed with the disease every two minutes and half of the population born after 1960 will be diagnosed with cancer during their lifetime. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two key measures are monitored below. 75% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer and 85% start first treatment within 62 days.

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





Performance and Actions

Referrals

- Cancer referrals remaining high with a 39% increase compared with 3 years ago, an additional 3168 patients, also 9% above our planning assumptions for 2023/24.
- Gynaecology referrals have remained high, an increase of 20% compared to last year (215 additional referrals) and 78% increase compared to three years ago (585 additional referrals). Audit is being undertaken to understand what type of referrals are increasing the demand.
- Colorectal referrals have remain high at a 70% increase compared to three years ago. The implementation of the FIT pathway in October should show a decrease in these referrals, as shown at Worcester.

Main Issues impacting on performance and actions:

- Radiology reporting still is a concern and is impacting FDS but has shown improvements since sending all cancer scans out to a outsourcing company. Formal meeting is being arranged to discuss CT Colonoscopy [CTC] referrals due to demand increasing.
- Histology still have vacancies across the consultant team therefore work is being sent to Worcester and South Warwickshire NHS Foundation Trust [SWFT] for breast. insourcing company and bank locums for other, reports can take 2-3 weeks to be sent back. Work is still being undertaken in relation to digital and how the region/other Histopathologists' will support. Histology now have a cancer navigator in post to support with all these pathways.
- First outpatient shortfalls have impacted on performance, as a trust it have been agreed locally to book first outpatient appointments at day 10 across all specialties, although within the new cancer waiting times there is no longer a first outpatient appointment target.
- To look at text messaging for patients to receive non cancerous results to improve communication to patients and support FDS.

Risks:

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

What the charts tell us:

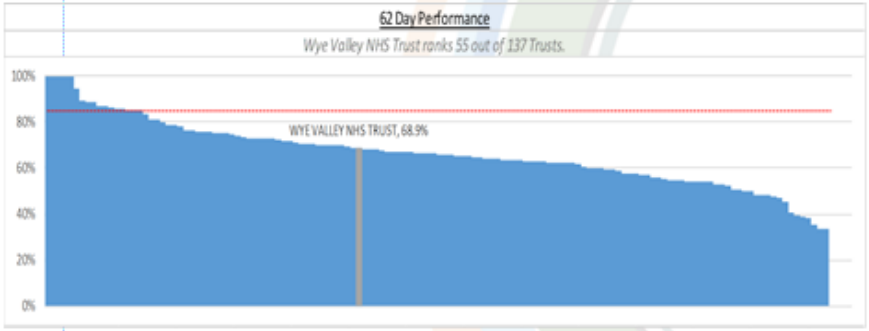
- 28 Day faster diagnosis = Performance against this target was 69% and remained below the target of 75%.

Operational Performance – Cancer Performance 62 days Start of Treatment Standard [July 23]

We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. Research suggests that someone in the UK is diagnosed with the disease every two minutes and half of the population born after 1960 will be diagnosed with cancer during their lifetime. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two key measures are monitored below. 75% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer and 85% start first treatment within 62 days

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



Performance and Actions

62 Days:

- The trust position for 62 days in July was 69% with 21 patient breaches, The pressures have been the same related to the Faster Diagnosis Standard [FDS] performance, also consultant and junior strikes which has led to cancellations and admin delays.
- During August our over 62 day positon increased to 100 patients due to the challenges in FDS and 62 days, but the end of month position was 87. September remains a challenge with the ongoing impact of Industrial Action.
- Endoscopy booking times have improved, lower endoscopy's are being booked at 12 days and upper endoscopy's are being booked at 7 days.

Key Actions:

- Non specific symptom pathway provisional go live date 1st November 2023 due to a change in clinical leadership
- All specialties to be booking first OPA within 10 days
- FIT pathway going live on 2nd October
- Our electronic patient system to be updated with cancer performance targets, to support with booking in breach order.
- Majority of cancer navigators will now sit under cancer services to ensure robust cross cover, close working with multi disciplinary team (MDT) and same processes being followed.

Risks:

- Histopathology / Radiology vacancies—further workforce challenges ongoing
- Impact of further Industrial Action

What the charts tell us:

- 62 day Treatment standard = The Trust performance was 69.1 % against a target of 85%.
- Number of patients waiting over 63 days did reduce to 72 at the end of July and 87 at the end of August

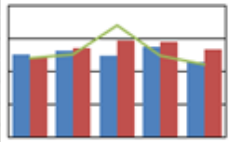
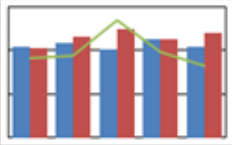
Operational Performance – Referral to Treatment Performance / Activity / Productivity

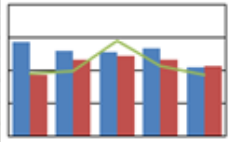
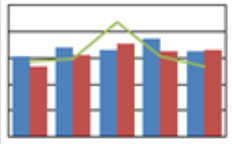
We are driving this measure because:

Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks for English patients and 26 weeks for Welsh patients from when the referral is received by the Trust either booked through the NHS e-Referral Service, or when a referral letter received.

Activity plans are measured against the Trusts agreed plans as part of the annual Business Planning process with commissioners

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

Outpatient Activity		Year To Date	Charts	Apr	May	Jun	Jul	Aug
New	2019/20	25309		5026	5283	4970	5476	4554
	Plan This Year	26041		4822	5044	6819	4948	4407
	This Year	27346		4859	5436	5870	5808	5373
	Diff vs 19/20	2037		-167	153	900	332	819
	Variance	8%		-3%	3%	18%	6%	18%
	Diff vs Plan	1305		37	392	-949	860	966
	Variance	5%		1%	8%	-14%	17%	22%
	Face To Face	23318		4170	4665	4975	4917	4591
	Telephone/Virtua	4028		689	771	895	891	782
	Total New	27346		4859	5436	5870	5808	5373
Follow Up	2019/20	53153		10402	10891	10213	11275	10372
	Plan This Year	49994		9126	9401	13426	9819	8223
	This Year	57764		10328	11570	12530	11276	12060
	Diff vs 19/20	4611		-74	679	2317	1	1688
	Variance	9%		-1%	6%	23%	0%	16%
	Diff vs Plan	7770		1202	2169	-896	1457	3837
	Variance	16%		13%	23%	-7%	15%	47%

Admissions		Year To Date	Charts	Apr	May	Jun	Jul	Aug
Elective Inpatient	2019/20	1285		289	259	256	269	212
	Plan This Year	1082		191	198	292	214	187
	This Year	1113		186	234	246	234	213
	Diff vs 19/20	-172		-103	-25	-10	-35	1
	Variance	-13%		-36%	-10%	-4%	-13%	0%
	Diff vs Plan	31		-5	36	-46	20	26
	Variance	3%		-3%	18%	-16%	9%	14%
Elective Daycase	2019/20	8386		1537	1691	1652	1877	1629
	Plan This Year	7951		1437	1485	2175	1522	1332
	This Year	7935		1330	1564	1761	1628	1652
	Diff vs 19/20	-451		-207	-127	109	-249	23
	Variance	-5%		-13%	-8%	7%	-13%	1%
	Diff vs Plan	-16		-107	79	-414	106	320
	Variance	0%		-7%	5%	-19%	7%	24%

Performance and Actions

Activity Summary:

- New Outpatients [OP] activity was 22% above plan in August
- Elective inpatient was 14% above plan in August
- Elective Day Cases was 24% above plan in August

Productivity:

Theatres increased in month due to 75.9% Capped Model Hospital utilisation despite ongoing challenges with Industrial Action. However, the mean number of patients per session did increase to 3.1. up on 2.4 in July and the 6 month rolling mean of 2.4

With our Pre-Operative [Pre-Op] Assessment unit we are using mini screening/use of questionnaire, based of Foundation Group colleagues model where a streamline Pre-Op that was introduced over the summer is working well in streaming appropriate patients to telephone pre op consultations or where no actual appointment is required. All new patients now being asked to completed the questionnaire.

Theatre Scheduling and a review of the "surgeon mean operating times" remains a key area of focus to improve our planning of Theatre sessions.

Outpatients clinic utilisation continues to improve to 85% utilisation [90% target utilisation] with the both the percentage of patients who Did Not Attend [DNAs] clinic increasing slightly to 5.8% [5% target]. There is much more to do around much more to do, particularly around reviewing past lists and learning from previous weeks productivity.

Patient Initiated Follow-up continue to increase steadily with 3.8% of outpatient attendances moving to a PIFU pathway.

Risks

- Impact of UEC pathways on elective bed base
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff and risks around Industrial action.
- Continued high levels of referrals

What the chart tells us:

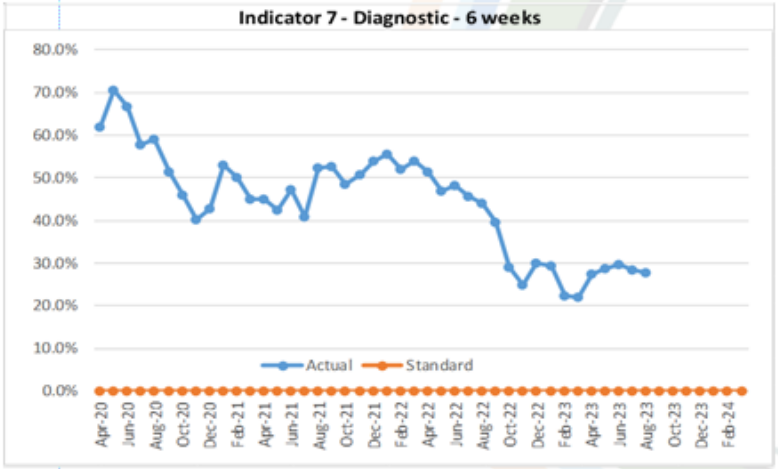
- Performance against English RTT standards in April was 57.7% - 0.5% increase since last month.
- Performance against the Welsh RTT standards in April was 65.5% - 2.5% decrease since last month
- Referral to Treatment Number of Patients over 104 weeks = 1 / over 78 weeks = 30 English on Incomplete Pathways Waiting List

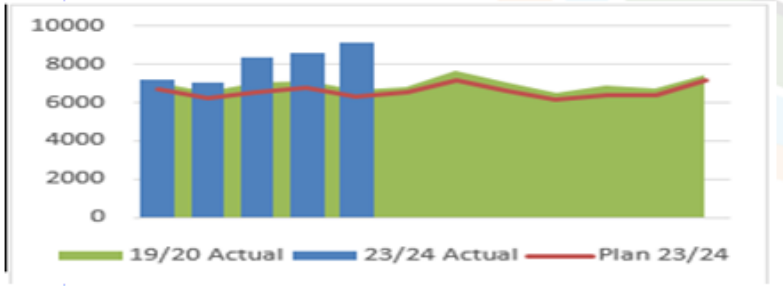
Operational Performance – Diagnostic Performance

We are driving this measure because:

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

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





Performance and Actions

Imaging:

- Magnetic Resonance Imaging [MRI] achieved 180% of 2019/20 activity last month, supported by additional staffed capacity plan via MRI van 12 days per month, as well as insourced radiographers supporting in-house scanners in both MRI and CT at weekends.
- Computerized Tomography [CT] achieved 145% of 2019/20 activity last month.
- Non-Obstetric Ultrasound [NOUS] achieved 138% of 2019/20 activity last month.
- MRI, CT and NOUS are all delivering more than the planned activity for 2023-24 at 204%, 144% and 155% respectively.
- Insourced radiographers supporting in-house scanners in both MRI and CT at weekends to deliver additional capacity
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] on average were 4 and 10 days respectively compared with 3 and 19 days last month.

Echocardiography [Echos]:

- Delivered 141% activity above 2019/20 levels in August with the waiting times of around 120/12 weeks for routine Echos. However, there are many additional clinics booked for October with our Insourcing team to address this and bring wait times down to more sustainable levels. Urgent patients remain priority and are usually seen within 2/4 weeks maximum.

Endoscopy

- Delivered 106% of 2019/20 activity in August and 127% above plan
- Spotlight on Endoscopy perfect weeks to run 16-27th October. Key objectives include identifying and embedding good practice, improved throughput, reduction in patients who Do Not Attend [DNA] rate, reduction in backlog
- Clinical validation of waiting list over 6 weeks underway and has seen a reduction in the number of patients waiting 13+ weeks. Trajectory to clear 13+ weeks by mid-October

Risks:

- Increased referrals both internal and external. Various work streams on going to reduced referrals
- Workforce challenges to deliver activity plans

What the charts tells us:

- Diagnostic 6 weeks waits, overall, continue to recover from the impact Covid had on the overall waiting lists. Fluctuations in the recovery mirrors operational pressures with Covid through the various surges over the last two years.
- Reduction in the number of patients waiting over 6 weeks for a diagnostic test. 27% now waiting greater than 6 weeks.

Operational Performance – Bed Occupancy and Delayed Discharges

We are driving this measure because:

As part of the National NHS Objectives for 2023/24 each Trust should reduce adult general and acute (G&A) bed occupancy to 92% or below .

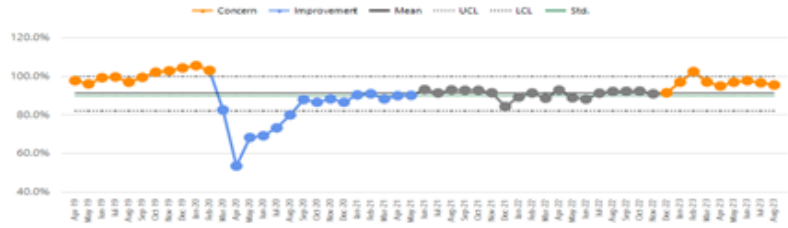
As part of the NHS Winter Plan for 2023/24 two of the high impact interventions are:

-**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care and length of stay for key pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

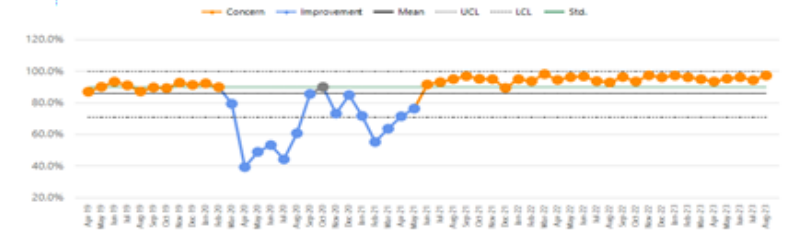
- **Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.

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

Bed Occupancy—Acute



Bed Occupancy—Community Hospitals



Total Number of Patients Delayed

Performance and Actions

Bed Occupancy:

Acute Bed Occupancy since the end of 2022 and start of 2023 has returned to pre-covid levels and averaged 96% for 2023/24. The reduction in bed occupancy over 2020 reflected the reduced emergency and elective attendances due to the Covid pandemic.

Community Hospital Bed Occupancy has followed the same pattern as Acute beds with current levels of 95% year to date bed occupancy, returning to pre-Covid levels. Again the reduction in occupancy seen across 2020 reflected the lower attendances and across 2021 due to various Covid outbreaks reducing bed occupancy across the year.

Current Challenges with Discharge Delays:

The bottom left chart shows the total number of patients delays on Discharge Pathways 1– 3, [patients requiring support to recover at home to patients rehabilitation at a bedded setting] has increased when you compare the April/May/June 2022 to 2023 but static when comparing July/August 2022 to 2023.

A closer look at the various pathway delays over the first five months of 2022/23 vs 2023/24, looking at bed days lost, shows the following:

- Pathway 1: Bed days lost have reduced across all of the major counties that admit patients to the Trust
- Pathway 2: Bed days have slightly increased across all of the major counties bar Worcestershire where we have seen a decrease and Powys which have remained static.
- Pathway 3: Has seen a decrease in bed days lost across Herefordshire and Worcestershire.

		Pathway1 (Days)								Pathway2 (Days)								Pathway3 (Days)							
Month	Patients	Total	Acute	Community	County_Herefordshire	County_Powys	County_Shropshire	County_Worcestershire	County_Other	Total	Acute	Community	County_Herefordshire	County_Powys	County_Shropshire	County_Worcestershire	County_Other	Total	Acute	Community	County_Herefordshire	County_Powys	County_Shropshire	County_Worcestershire	County_Other
22/23	204	545	157	388	337	120	42	39	6	195	66	129	115	41	10	9	6	264	86	178	204	33	15	7	0
23/24	215	488	150	338	328	108	19	30	2	179	33	145	117	41	14	1	3	209	85	124	159	13	23	11	3
+/-	12	-58	-7	-51	-9	-12	-23	-9	-4	-16	-32	16	3	1	4	-7	-3	-56	-1	-54	-45	-21	8	3	3

The actions related to improving these delays is covered in the Executive Narrative

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

Industrial action continues across the NHS and we are working closely with our divisional leads and professional union representatives to ensure we have appropriate service plans in place to provide a safe service to our patients. The BMA have announced further strike dates from 2nd to 5th October and Radiographers will also be striking on 3rd & 4th October. Planning for strike action continues through the WVT industrial action group. In planning for industrial action we are maintaining good relationships with our union representatives and senior clinical colleagues.

Our comprehensive *intouch* WVT wide staff engagement programme which focused on 4 key questions (*being a more flexible employer, creating a more compassionate & respectful culture, improving the quality of care, improving health & wellbeing)* aligned to the NHS Staff Survey is now over and a paper is attached for the board.

In line with the national position we have seen a slight increase in absence largely due to short term sickness. HR teams will continue to sensitively support the management of sickness absence and the close monitoring and management of sickness absence will remain a key priority area for the HR team over the autumn / winter months. Our enhanced wellbeing provisions for staff with a dedicated staff physiotherapist and a mental health & wellbeing nurse located within the occupational health team will remain in place to offer support to staff. The flu and covid vaccination programme has also commenced for staff.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 10.9% in the past 4 years. Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 10.98% (Aug 23). We have also seen a significant reduction in staff turnover for band 2 hcsw staff from 28.3% (Jul 22) to 14.02% (Aug 23).

Active work continues to fill our vacancies and since July 2022, we have reduced our vacancies from 11.21% (400 fte) to 5.4% (197 fte). We now have 37 WVT ambassadors who are supporting recruitment events for different staff groups and we continue to work closely with DWP on several joint recruitment events throughout the coming months. The WVT recruitment hub at the Franklin Barnes building is now open and we are working with line managers and the DWP in using this facility to promote WVT careers and job opportunities to the local community. To-date, 8 local individuals have been appointed to roles at the Trust through our partnership work with the DWP.

We remain committed to our equality, diversity, inclusion agenda and we promoted the NHS Inclusive week in September. We will be promoting Black History month in October. We are working with Group and ICS colleagues on implementing the 6 high impact actions in the NHS EDI Improvement Plan.

With October being the Freedom To Speak Up month, we will be running events to raise awareness and to promote the importance of staff speaking up with the FTSU Guardian. We are adopting the NHS Sexual Safety at Work Charter and we will be raising staff awareness on this from October. We are in discussions with Group and ICS colleagues to roll out active bystander awareness training to members of staff over the next year to ensure employees have the confidence and support to call out any bad behaviour or conduct in the workplace.

Our annual health and wellbeing week will take place in early October with a series of wellbeing events supported by external partners including students from the Royal College For The Blind. The next HR roadshow will also be held in early October across all sites to raise awareness of key policies (Dignity at Work, Freedom to Speak Up, Code of Conduct, Sickness Absence) and to promote the range of benefits available for members of staff.

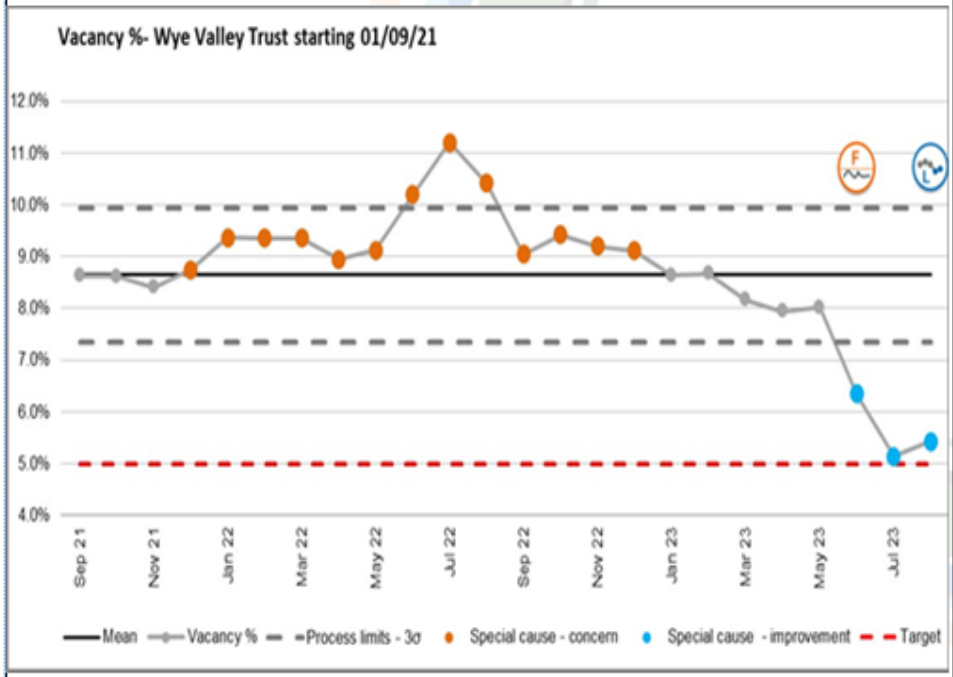
Our Workforce – Vacancy

We are driving this measure because:

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

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
10.4%	9.0%	9.4%	9.2%	9.1%	8.6%	8.7%	8.7%	7.9%	8.0%	6.3%	5.1%	5.4%

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



Performance and Actions

Over the past year, we have seen a significant reduction in vacancies from 10.4% to 5.4% through concerted efforts by HR and divisional managers.

HCSW – the WVT pay and career progression framework for band 2 /3 staff continues to have a positive impact and we now have the lowest vacancies (10fte) at the Trust.

N&M - we currently have 59fte vacancies which is the lowest level over the past 4 years. This year, over 60 new international nurses have joined WVT and we are on track with our international recruitment plan. Retention rates of international nurses remains excellent at 95% of those recruited since 2018 with some progressing into senior roles.

M&D - with national shortages of drs in certain specialties, we continue to work with recruitment agencies in sourcing suitably qualified candidates from overseas. Regular meetings are in place with the CMO, Medical Staffing Manager & Strategic Medical HR Lead to review progress with vacancies and cases of concern .Overseas recruitment of medics to continue throughout 2023/24. We currently have 46fte vacancies.

Pharmacy - considerable national recruitment challenges remain in filling vacancies and an international recruitment plan for junior pharmacists is being developed with the Head of Pharmacy.

Community Diagnostic Centres - programme for recruiting international radiographers is well under way, interviews have taken place in August and so far we have offered 9 positions.

Surgical Elective Hub - international recruitment has started to ensure we have the clinical workforce required for the hub as planned.

We are extending our recruitment events with ICS colleagues and we continue to promote our vacancies Herefordshire wide with a series of events over the coming year. We are also extending WVT presence at regional and national fairs to promote our job opportunities. Our WVT Ambassadors are supporting engagement events with local schools and colleges.

Risks: Clinical vacancies

What the chart tells us:

The rolling 12 month position has been improving over the past year with a large improvement over the last 2 months.

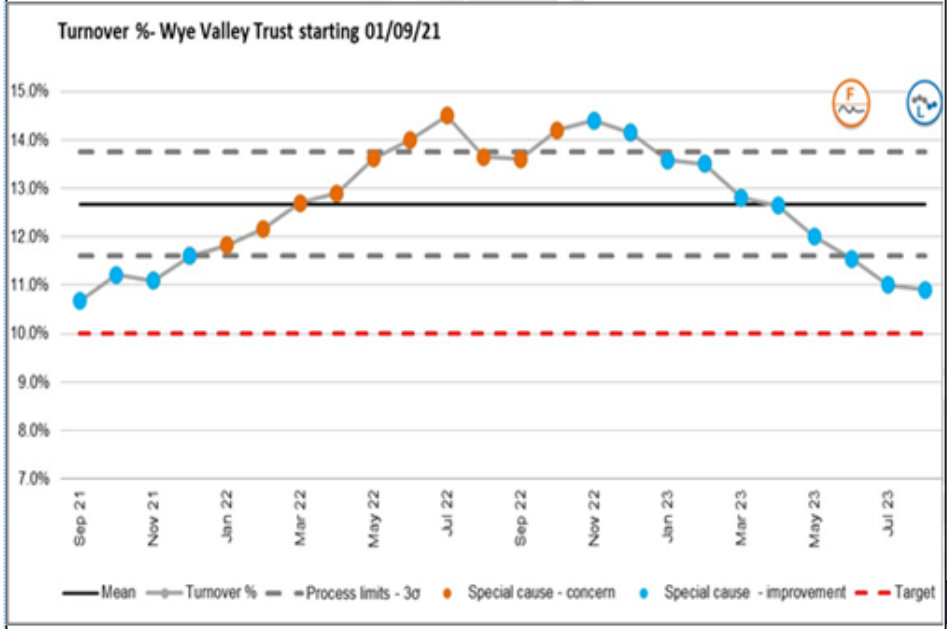
Our Workforce – Turnover

We are driving this measure because:

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

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
13.7%	13.6%	14.2%	14.4%	14.2%	13.6%	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%	10.9%

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



Performance and Actions

The overall rolling 12 month turnover at Trust level is now at 10.9% for August 2022 to July 2023, with an average for the previous 12 month's turnover being 13.1%

The WVT pay & career progression framework is having a very positive impact on the recruitment & retention of clinical support workers. Turnover has reduced from a high of 24.70% to 14.02%.

Turnover rates for qualified nurses & midwives has reduced from a high of 15.24% to 10.98% through international recruitment and intensive efforts being taken to retain staff.

The new band 4 trainee nurse associate programme with the University of Worcester will commence in March 2024 and the band 6 retention programme for nursing is being finalised. These initiatives are a key part of our grow your own staff strategy and will enhance recruitment & retention of nursing staff at the trust over the coming years.

All divisions are continuing with their local recruitment & retention working groups in order to analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group will continue 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: turnover for some staff groups

What the chart tells us:

The rolling 12 month position shows a decreasing trend over the last 6 months.

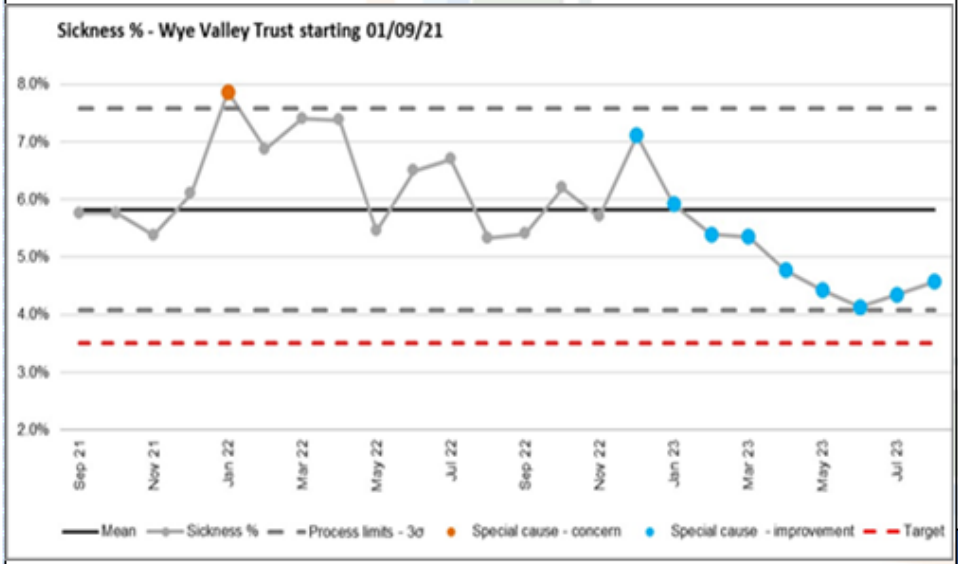
Our Workforce – Sickness

We are driving this measure because:

To ensure wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staffing namely agency.

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
5.3%	5.4%	6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%	4.6%

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



Performance and Actions

During this month, overall sickness at Trust level has increased to 4.6%, but this is lower compared to a rolling 12 month average sickness of 5.3%. In line with the national position, the trust is experiencing an increase in short term absence largely due to winter ailments.

We will continue to provide occupational health and wellbeing support to staff whilst ensuring that appropriate management actions are being taken to manage sickness absence effectively. At F&PE meetings, divisions will continue to present comprehensive data on sickness absence including heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

HR teams will continue to sensitively support the management of long and short term sickness absence and we will continue to enhance the wellbeing staff support offers. As appropriate, fast track referrals will be implemented and the mental health & wellbeing nurse is providing wellbeing training and offering more psychological and team based interventions. The wide range of health & wellbeing initiatives (schwartz rounds, employee assistance programme, NHS apps and support lines, face to face counselling, clinical psychology) are still in place for staff.

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

Risks: clinical staff absence

Clinical staff absence

What the chart tells us:

The rolling 12 month position shows a slight increase in sickness absence over the last two months.

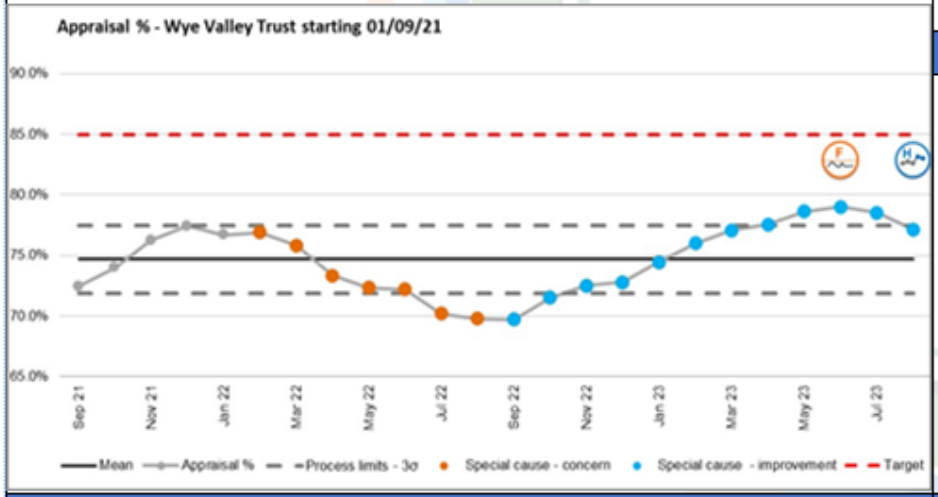
Our Workforce – Appraisal

We are driving this measure because:

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

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
69.8%	69.7%	71.5%	72.5%	72.8%	74.5%	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%	77.1%

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



Performance and Actions

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

Risks:

What the chart tells us:

The rolling 12 month position shows a fluctuating low picture across the period between May 2021 and September 2022. This is primarily due to the challenge of maintaining standards across the Covid Pandemic, however it is steadily increasing over the last 9 months, with only a slight decrease in the last two months probably due to leave.

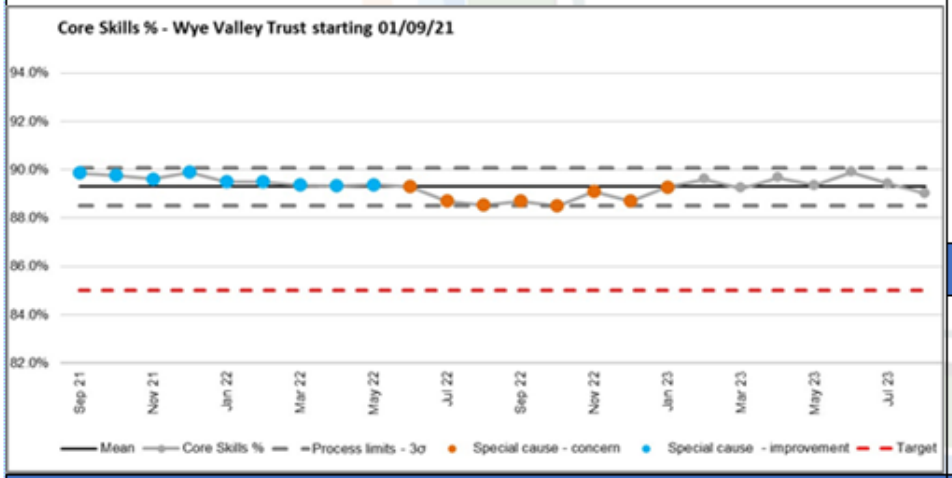
Our Workforce – Core Skills

We are driving this measure because:

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

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
88.5%	88.7%	88.5%	89.1%	88.7%	89.3%	89.6%	89.2%	89.7%	89.3%	89.9%	89.4%	89.0%

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



Performance and Actions

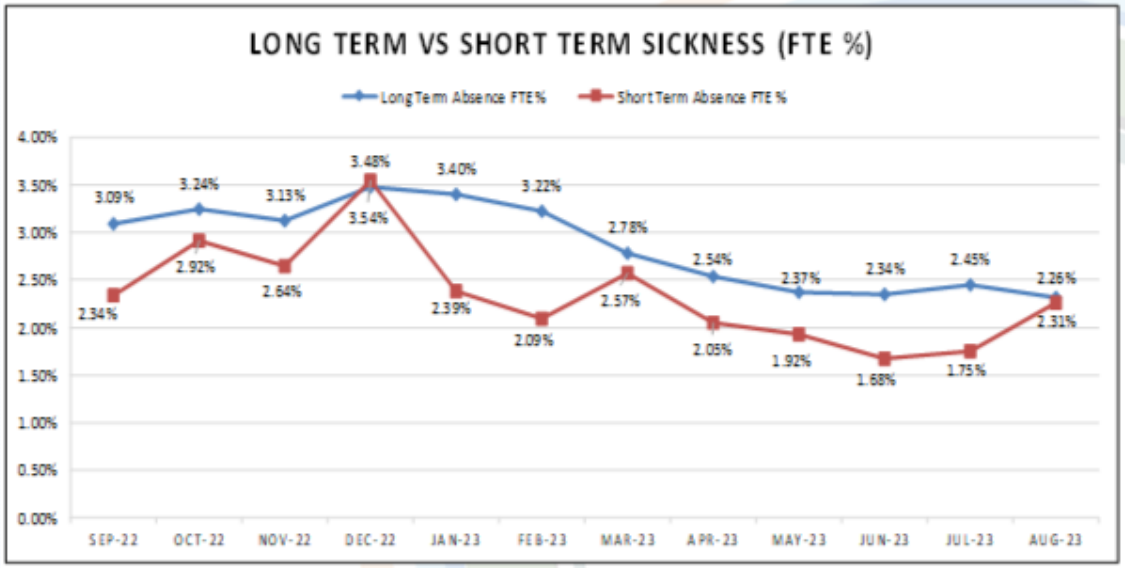
The Trust continues to make good progress in this area. This will continue to be reviewed at F&PE meetings

Risks:

What the chart tells us:

The rolling 12 month position remains fairly consistent across the period between September 2021 and August 2023. This is primarily due to the challenge of maintaining standards across the Covid Pandemic.

We are experiencing an increase in short term absence in line with the national position. We will continue to support staff and manage sickness absence appropriately over the winter months



Main reason form absence - Top 5	
Cold, Cough, Flu - Influenza	
Gastrointestinal problems	
Anxiety/stress/depression/other psychiatric illnesses	
Other musculoskeletal problems	
Pregnancy related disorders	

Chart below shows a reduction in turnover for healthcare support workers

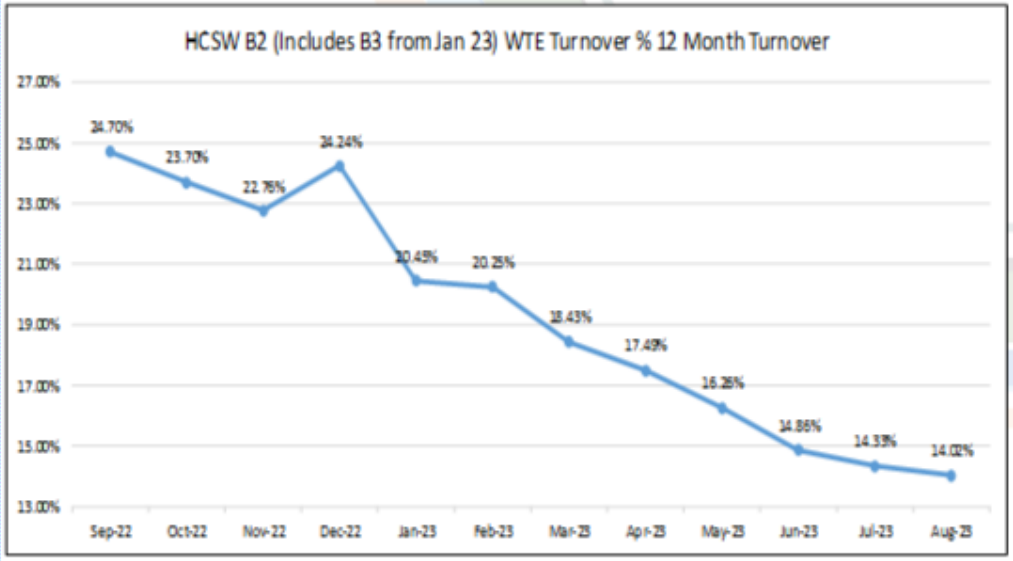
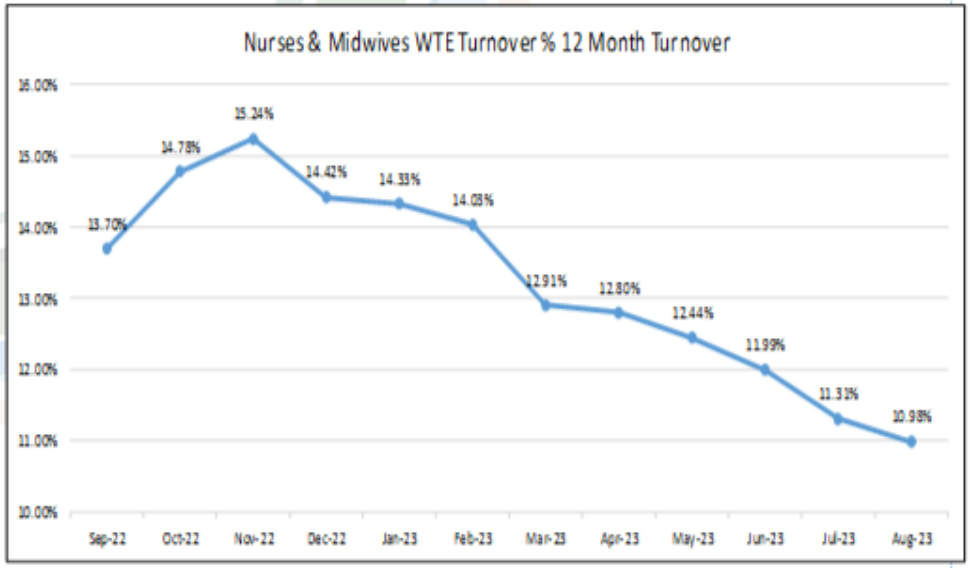


Chart below shows a reduction in turnover for nurses & midwives



Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Financial Plan 2023/24

Our planned in year Income and Expenditure deficit is £22.3m though it is important to note that the recurrent underlying position of the Trust continues to run at a greater level of deficit, once non-recurrent items are removed. The financial position across the system remains challenging.

Income & Expenditure Performance

The financial position at the end of month 5 (August) was a deficit of £13.3m which is £1m adverse to the planned deficit at this point in the year. Known financial risks are starting to put greater pressure on delivery of our planned financial position. A mid year review is planned for October.

In August, in line with national guidance we have calculated and reported the year to date position on variable elective income which accounts for £0.7m of the adverse variance to date, though is projected to improve over coming months through sustaining the strong elective performance we have seen over recent months. Focused activity to reduce reliance on premium cost agency workforce has resulted in significant reductions compared to the prior year though we have seen an upward trend in month linked to acuity and impact of ongoing industrial action. We continue to see the impact of inflationary pressure on our non pay spend, above the levels we had assumed within the plan. Delivery of our efficiency requirements and productivity improvement are key assumptions within the financial plan. Efficiency delivery is behind plan at this point in the year; significant operational focus and cross divisional working continues to mitigate the shortfall.

The wider Herefordshire and Worcestershire Integrated Care System (ICS) has a planned deficit for 2023/24. The system position to the end of month 5, is adverse to plan, reflective of the level of challenge within the plans, premium capacity utilisation and inflationary pressures such as on medicines.

Capital

The capital programme for 2023/24 includes high value projects to deliver the new Elective Surgical Hub (ESH), a Community Diagnostics Centre (CDC) and the Integrated Energy scheme phase 2 (IES). Local capital funding has been identified to meet equipment, digital and backlog maintenance requirements and schemes are now progressing to delivery. Spend in the first five months of the year totals £9.7m.

Cash

The cash balance at the end of August decreased further than planned to £13.7m. BPPC performance remained strong. The overall cash position is subject to weekly management given our deficit plan and the need to access national revenue support during the year. Practical measures have been implemented to ensure requests for revenue cash support are only made where necessary, which is anticipated to be in Q3 and Q4.

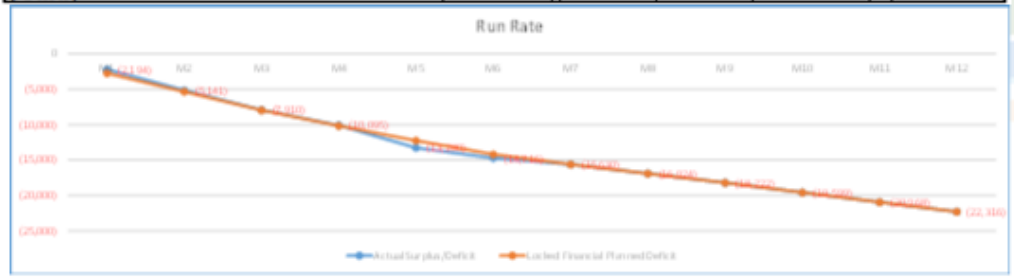
Our Finance – Year to Date Income and Expenditure

We are driving this measure because:

The Income and Expenditure plan reflects the Trust's operational plan, and the resources available to the Trust to achieve its objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

STATEMENT OF COMPREHENSIVE INCOME - To Month 5 - 31st August 2023 - 2023/24

	2023-24 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Contract Income	284,789	116,910	116,379	(531)	(483)
Excluded Drugs	11,954	4,981	5,511	530	50
Non Contracted Activity (NCA's)	1,635	681	681	0	0
Other Income for Patient Care	10,250	4,302	4,259	(43)	(63)
Donations For Non Current Assets	20,500	5,793	6,253	460	(1,139)
Other Non Patient Income	7,375	3,121	3,022	(99)	(85)
COVID Funding	332	118	42	(77)	(3)
NHSE - central (22/23 pay award)			0	0	0
Total Operating Income	**336,834**	**135,907**	**136,147**	**240**	**(1,722)**
Pay Expenditure	206,103	86,489	86,538	(49)	(486)
Non Pay Expenditure	87,693	37,419	38,003	(584)	(91)
Excluded Drugs	22,394	9,322	9,501	(179)	46
Total Operating Expenditure	**316,190**	**133,231**	**134,043**	**(812)**	**(531)**
EBITDA	**20,644**	**2,676**	**2,104**	**(572)**	**(2,253)**
Depreciation	13,685	5,706	5,760	(53)	(8)
Gain or loss on asset disposal	0	0	0	0	0
Interest Receivable	867	575	575	0	0
Interest Payable on Loans	265	111	86	24	5
Interest Payable on PFI	6,377	2,657	2,638	19	19
Dividends on PDC	3,868	1,612	1,612	0	0
Operating Surplus/ (Deficit)	**(2,682)**	**(6,834)**	**(7,416)**	**(581)**	**(2,237)**
Technical Adjustments					
Donated Assets - Additions	20,500	5,793	6,253	460	(1,139)
Donated Asset Depreciation	(864)	(360)	(389)	28	6
Donated Assets Adjustment	**19,636**	**5,433**	**5,864**	**431**	**(1,145)**
Adj. financial performance retained Surplus/ (Deficit)	(22,316)	(12,267)	(13,280)	(1,012)	(1,093)



Performance and Actions

The position at the end of month 5 (August) was a deficit of £13.3m. This was behind the current plan with an overall adverse variance of £1.0m year to date.

- Pay is marginally overspending overall with high use of temporary staffing offset by some slippage on recruitment linked to capacity and unfilled vacancies. This net position includes agency — 7.54% of total pay costs in August which remains static. Medical bank use at premium rates further increases this to 12.0% of overall pay. This is driven by volume and price.
- The plan includes a significant level of additional capacity provided to achieve the operational plan, particularly recovering elective activity.
- We continue to experience significant cost pressures in staffing and non pay cost linked to the urgent care pathways, increased volumes and acuity of patients and ongoing inflationary impacts.
- The Trust has set an annual cost improvement (efficiency) target of £15.7m (of which £2.5m is a further stretch target). Delivery is currently behind plan and mitigations are being identified.

Risks:

Key Financial risks

- Stretch target (£2.5m not delivered).
- Income including potential for funding misalignment with commissioners
- CPIP Cost Efficiency delivery recurrently
- Level of Agency (as % of pay)
- Impact of inflation on non pay expenditure run rates

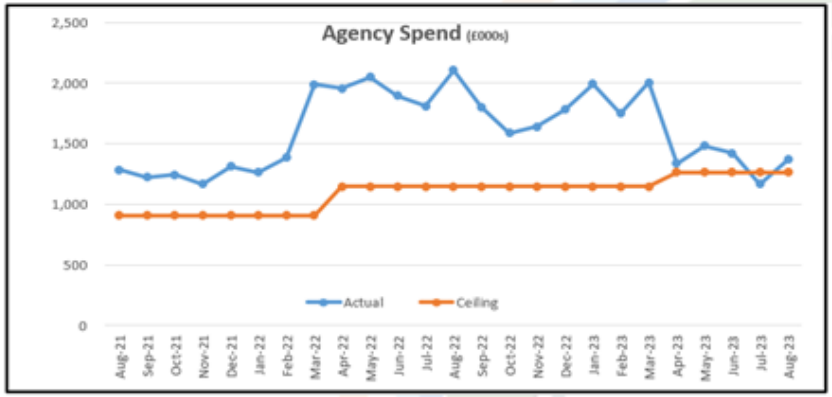
What the chart tells us:

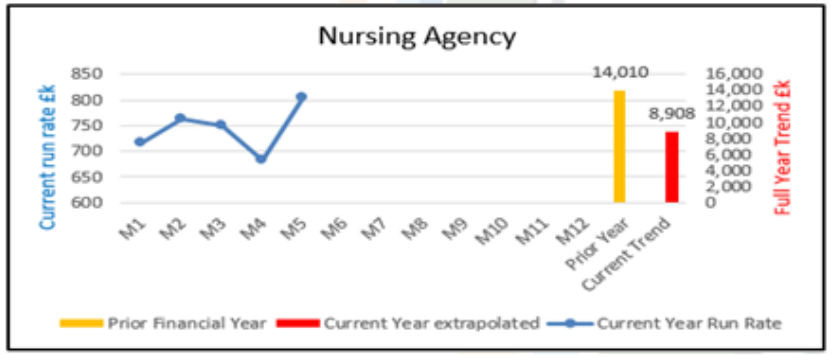
Known financial risks are starting to put greater pressure on delivery of our planned financial position. A mid year review is planned for October.

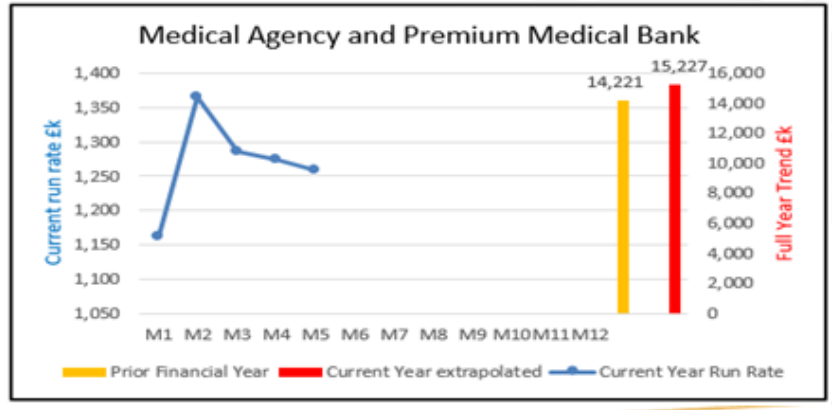
Our Finance – Agency Spend

We are driving this measure because:

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







Performance and Actions

Agency represents 7.54% of total pay costs year to date. This benchmarks poorly, and is above the NHS Agency Cap Ceiling. There is still a considerable way to get back to an acceptable baseline trend, although the marked reduction in month 1 particularly on Nurse Agency usage has broadly been maintained to date. All agency spend year to date (and excluding premium cost medical bank) has been £6.8m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** Increased control actions through NARP, together with the new Master Vend contract rate changes have shown improvement since the prior year. The Trust spent £14.0m on nurse agency in the prior year (22-23) and the extrapolated current year position would be £8.9m which is more in line with 21-22.
- **Medical staffing agency and premium cost bank:** Commercial agency and Internal Medical Bank often have a correlation depending upon availability and route into the Trust. Medical bank typically still involves high premium rates, even if marginally lower than agency on average. In month 1 we saw a small decrease in the run rate for medical agency and bank, this has increased in month 2, with further reductions in month 3 to 5. The Trust spent £14.2m in the prior year (22-23) and the extrapolated run rate (£15.2m) would not deliver the target spend for the year. Targeted MARP schemes including enhanced controls are delivering financial improvement, though new workforce gaps, the impact of industrial action and demand / acuity pressures are eroding the benefit of this.

Risks:

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

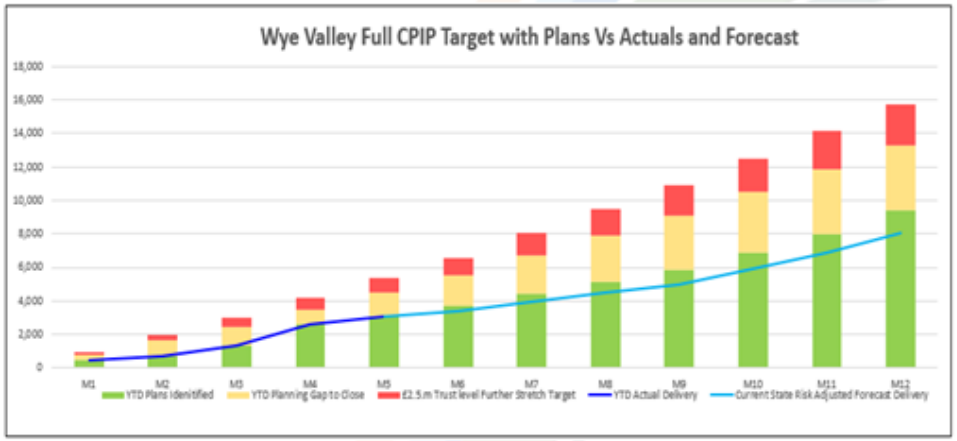
What the chart tells us:

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

Our Finance – Cost Improvement Programme

We are driving this measure because:

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



Performance and Actions

The £15.7m target breaks down into two areas: £13.2m cost out efficiency (of which we are targeting a £7.6m agency reduction); and a further £2.5m stretch target accepted by the Trust as part of concluding the financial plan. Progress is being made against the cost out efficiency requirement though the stretch remains unmitigated.

Operational challenges over quarter 4 hampered the pace of full identification of recurrent plans to meet the cost out efficiency requirement meaning there is still a large shortfall in identified recurrent schemes. Inflationary impacts, increased demand and the impact of industrial action mean that some of the financial improvement has inevitably been cost avoidance to stabilise the run rate rather than delivery of recurrent efficiency to improve the bottom line. Increased scrutiny and oversight is in place including weekly progress tracking and escalation through TMB and F&PE meetings.

At month 5, there are no longer sufficient non recurrent mitigations to fully address the shortfall as known financial risks put greater pressure on delivery of our planned financial position.

A mid year review is planned for October, and focus continues through the F&PE meetings, and a refreshed monthly CPIP meeting to maximise delivery in year, and development of recurrent schemes. Work across the system to identify and deliver financial improvement opportunities is progressing.

Risks:

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

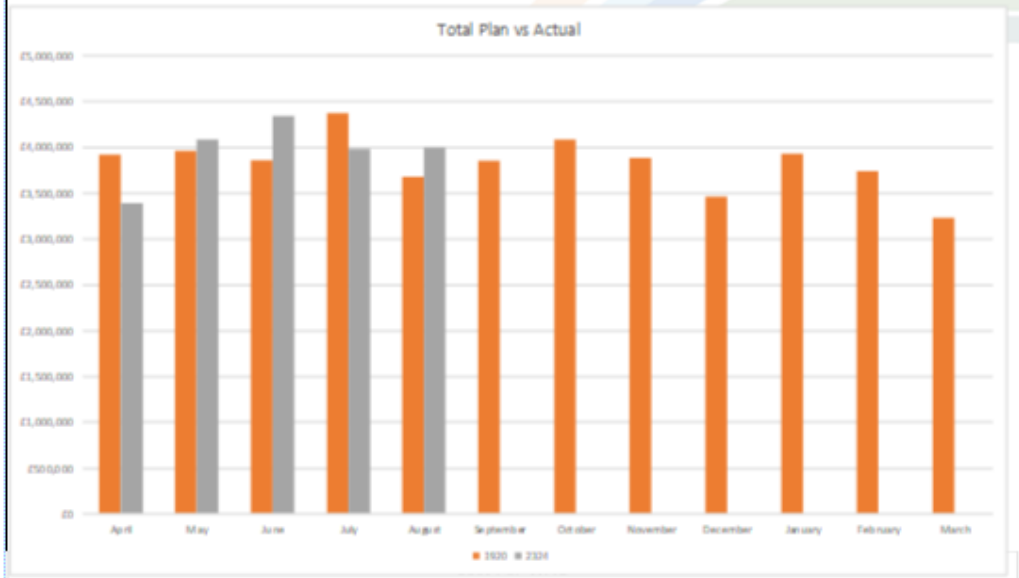
What the chart tells us:

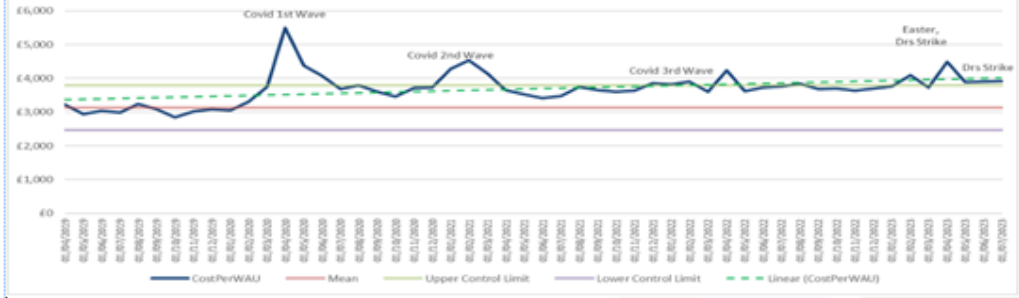
There remains a shortfall in plans to deliver the planned level of CPIP, and delivery has been impacted by a range of factors. Focus is on converting opportunities into deliverable schemes, particularly recurrent schemes to mitigate the financial risk of underachievement against this programme and into 2024/25.

Our Finance – Productivity Improvement

We are driving this measure because:

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





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

Performance and Actions

Our revised operational target requires us to deliver 104% of 19/20 activity (OP New, Inpatient/daycase & endoscopy. OPFU's are capped at 75% of 19/20 activity.)

We also required to have no 65 week waits by the end of March 24. Delivery of our planned levels of activity not only drives recovery of the elective backlog, but also supports our ability to retain Elective Recovery Funding (ERF).

The monthly monitoring shows that for August elective activity in terms of volume was 119% of 19/20 and in financial terms (see chart) 109%. It is mainly driven by over performance in outpatients with inpatients at 99%. Overall we are behind YTD (100% of 19/20) At month 5 we have reflected the YTD risk associated with the achievement of elective income in our financial position.

Nationally we understand that there may be further revisions to recognise the impact of further industrial action but this has yet to be confirmed and there also remains a risk of clawback where we do not achieve the planned levels.

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

Risks:

- Non delivery of 104% of case mix weighted activity resulting in clawback of system elective activity . Mitigation - Additional capacity funding provided to the Divisions, close monitoring of activity performance and productivity.

What the chart tells us:

Given the significant operational challenges activity levels have not fully recovered to the planned levels, particularly for elective inpatient and day cases. The increased cost base driven by high agency use, coupled with lower than planned activity levels drive a high cost per WAU. Whilst some productivity initiatives have started to deliver, we are not yet seeing the overall level of productivity required.

Our Finance – Capital and Cash

We are driving this measure because:

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

Scheme Type	Interim Annual Plan £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Digital Total	1,250	357	141	216
Equipment Total	1,593	452	226	226
Estates Total	1,630	464	194	270
Total Core Operating (ICS) Capital	**4,473**	**1,273**	**560**	**713**
ESH	12,602	3,570	2,562	1,008
CDC	10,296	1,760	117	1,643
Frontline Digitalisation PDC Total	3,300	933	209	724
Total National Programme Funding Bids	**26,198**	**6,263**	**2,889**	**3,374**
Donated Assets/Grant IES	20,600	5,836	6,253	(417)
Grand Total	**51,271**	**13,372**	**9,701**	**3,671**

Cash Balance

Month	Performance	Target	Direction	Rating
June	24.8	21.2		
July	20.6	21.2	↓	
August	13.7	19.9		

The cash balance at the end of August decreased further planned. This reflects an increase in accounts receivable, a reduction in accounts payable and current capital expenditure. While accounts payable increased slightly, BPPC performance was largely maintained and is above target (see below). Revenue PDC funding for the second quarter has been reviewed phasing of contract payments from the ICB has been agreed to assist with payment of the quarterly PFI unitary charge.

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
June	98.2%	95.0%		
July	97.8%	95.0%	↑	
August	98.8%	95.0%		

August's results indicate that on a volume basis, the Trust paid 98.8% of invoices within 30 days exceeding the target for the fifth month in succession. The performance measured by invoice value was 100%, also above the target.

Performance and Actions

Capital: The overall capital expenditure at Month 5 is £9.7m which represents 19% of total budget spent. The YTD position indicates an underspend of £3.67m. This underspend mainly relates to National Programme Funding bids. These are now expected to incur costs later in the year, especially around ESH and Frontline Digitalisation. Set against this costs are running ahead of plan for the IES. The current expectation is that National Programme expenditure will be in line with the full year plan.

Cash: The cash balance at the end of August decreased further than planned. This reflects an increase in accounts receivable, a reduction in accounts payable and current capital expenditure. While accounts payable increased slightly, BPPC performance was largely maintained and is above target (see below). Revenue PDC funding for the second quarter has been reviewed and phasing of contract payments from the ICB has been agreed to assist with payment of the quarterly PFI unitary charge.

Risks:

- General risk regarding the delivery of the capital programme although funding approval for ESH and the CDC has now been received
- Insufficient capital to deliver critical / high risk infrastructure replacements. Mitigation: work with system and regional partners.
- Cash availability and prompt payments worsen due to deficit plan. Mitigation: focus on delivery of financial plan, and rolling cash flow forecasts.

What the chart tells us:

Capital expenditure is broadly in line with plan, and cash balances whilst sufficient, do require more careful management over the next few months.

Our Finance – Statement of Financial Positon

We are driving this measure because:

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

August 2023	2022/23	2023/24			
	Accounts £000s	M5 Plan £000s	M5 YTD £000s	Variance £000s	YTD Change £000s
NON-CURRENT ASSETS:					
Property, Plant and Equipment	130,133	127,446	133,033	(5,587)	2,900
Intangible Assets	13,834	15,743	16,086	(343)	2,252
Trade and Other Receivables	573	817	573	244	0
TOTAL Non Current Assets	**144,540**	**144,006**	**149,692**	**(5,686)**	**5,152**
CURRENT ASSETS:					
Inventories	5,316	4,780	5,328	(548)	12
Trade and Other Receivables	21,085	13,709	17,941	(4,232)	(3,144)
Cash and Cash Equivalents	34,969	21,220	13,656	7,564	(21,313)
TOTAL Current Assets	**61,370**	**39,709**	**36,925**	**2,784**	**(24,445)**
TOTAL ASSETS	**205,910**	**183,715**	**186,617**	**(2,902)**	**(19,293)**
CURRENT LIABILITIES					
Trade and other payables	(49,794)	(26,489)	(38,947)	12,458	10,847
Borrowings - Loans, PFI and Finance Leases	(5,779)	(5,942)	(6,992)	1,050	(1,213)
Provisions	(55)	(46)	(46)	0	9
Total Current Liabilities	**(55,628)**	**(32,477)**	**(45,985)**	**13,508**	**9,643**
NET CURRENT ASSETS/(LIABILITIES)	**5,742**	**7,232**	**(9,060)**	**16,292**	**(14,802)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**150,282**	**151,238**	**140,632**	**10,606**	**(9,650)**
NON-CURRENT LIABILITIES:					
Borrowings - Loans, PFI and Finance Leases	(31,138)	(30,519)	(27,707)	(2,812)	3,431
Provisions	(1,686)	(1,579)	(1,677)	98	9
Total Non-Current Liabilities	**(32,824)**	**(32,098)**	**(29,384)**	**(2,714)**	**3,440**
ASSETS LESS LIABILITIES	**117,458**	**119,140**	**111,248**	**7,892**	**(6,210)**
TAXPAYERS EQUITY					
Public dividend capital	270,216	273,686	270,216	3,470	0
Revaluation reserve	26,991	30,874	28,199	2,675	1,208
Income and expenditure reserve	(179,749)	(187,682)	(187,167)	(515)	(7,418)
TOTAL	**117,458**	**116,878**	**111,248**	**5,630**	**(6,210)**

Performance and Actions

General

The table identifies the statement of financial position as at 31 August 2023 against the plan.

Non-Current Assets

Non-Current assets increased £0.5m in PPE, compared to last month, due to capital expenditure (net of depreciation). Intangible assets have reduced due to amortisation.

Current Assets

Accounts Receivable reduced by £1m compared to the previous month. This is due to a reduction in sales ledger debtors. There is a £0.6m increase in the VAT debtor, awaiting receipts from HMRC and prepayments and accrued income have increased by £1.2m against previous month. Cash held decreased by £6.9m in the month as a result of increased debtors, reduced creditors and capital expenditure.

Current Liabilities

Current liabilities decreased by £3m compared to last month largely due to the release of deferred income.

Non-Current Liabilities

Non-current liability movements reflect the on-going repayment of PFI liabilities but also include lease liabilities included as part of the IFRS 16 asset recognition exercise.

Taxpayers Equity

The income and expenditure reserve reflects the deficit to date.

Risks:

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

What the chart tells us:

The SOFP has reduced, compared to the year end position, largely due to the year to date deficit.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 75.0%	Variable	Common Cause		71.3%	68.8%	67.9%	67.8%	69.0%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		88.0%	81.9%	84.5%	86.2%	83.5%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		63.6%	50.0%	14.8%	18.2%	47.8%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	91.1%	88.5%	74.5%	83.3%	86.7%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Improvement - High		12	9	13	11	11	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Concern - Low		54.5%	48.1%	50.4%	61.4%	69.1%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		0.0%	0.0%	100.0%			
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause	Yes	71.0%	70.4%	57.1%	75.0%	81.5%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Common Cause		89	117	112	108	72	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High	Yes	100.4%	93.8%	104.3%	102.7%	105.2%	
	Urgent Response > 1st Assessment completed on same day (facilitated discharge &	Primary care and community	80.0%	Pass	Concern - Low	Yes	98.2%	96.7%	100.0%	96.4%	44.2%	37.3%
	Urgent Response > 1st Assessment completed within 2 hours (admission	Primary care and community	70.0%	Variable	Common Cause		83.3%	91.5%	76.5%	85.5%		
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Common Cause		89.2%	90.2%	89.7%	90.8%	89.9%	90.0%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		107.7%	98.9%	100.7%	98.0%	98.4%	101.8%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause		82.9%	75.1%	76.2%	81.7%	81.4%	83.1%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Common Cause	Yes	5.2%	9.0%	9.0%	4.6%	6.4%	3.7%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		117.3%	117.7%	110.2%	108.2%	111.2%	112.9%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		40.2%	39.6%	39.2%	41.4%	40.4%	41.6%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High	Yes	16.2%	9.7%	14.8%	13.8%	14.0%	17.3%
	A&E - Time to treatment	Urgent and emergency care			Common Cause		0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care			Improvement - Low	Yes	3.1%	2.8%	2.5%	2.3%	2.3%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High	Yes	263	107	225	259	178	213
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Concern - Low		8.3%	7.1%				

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>=	92.0%	Fail	Concern - Low		58.3%	56.7%	59.3%	59.4%	57.2%	57.7%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>=	95.0%	Fail	Concern - Low		67.3%	64.7%	65.1%	67.1%	68.0%	65.5%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care				Improvement - High		25957	26503	26797	26710	26882	27963
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Concern - High		1453	1552	1718	1688	1804	1853
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Improvement - Low		6	27	23	18	36	30
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<=	0	Fail	Improvement - Low		0	1	1	1	2	1
	GP Referrals	Elective care				Improvement - High	Yes	168.1%	94.5%	100.8%	119.5%	99.2%	114.5%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care				Improvement - High	Yes	116.2%	96.7%	102.9%	118.1%	106.1%	118.0%
	Outpatient Activity - New attendances (volume v plan)	Elective care				Improvement - High	Yes	94.9%	100.8%	107.8%	86.1%	117.4%	121.9%
	Total Outpatient Activity (% v 2019/20)	Elective care				Improvement - High	Yes	114.3%	98.4%	105.1%	121.2%	102.0%	116.8%
	Total Outpatient Activity (volume v plan)	Elective care				Improvement - High	Yes	100.0%	108.9%	117.7%	90.9%	115.7%	138.0%
	Total Elective Activity (% v 2019/20)	Elective care				Improvement - High	Yes	103.9%	78.6%	97.0%	104.8%	88.4%	106.1%
	Total Elective Activity (volume v plan)	Elective care				Improvement - High	Yes	88.1%	84.4%	97.0%	79.5%	111.1%	127.1%
	BADS Daycase rates	Elective care				Common Cause	Yes	82.7%	76.7%				
	Elective - Theatre utilisation (%) - Capped	Elective care	>=	85.0%	Fail	Common Cause			77.0%	78.7%	78.5%	73.6%	75.9%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care				Common Cause		16	9	22	24	32	40
	Diagnostic Activity - Computerised Tomography	Elective care				Improvement - High		107.6%	137.8%	120.5%	139.9%	144.9%	143.7%
	Diagnostic Activity - Endoscopy	Elective care				Common Cause	Yes	122.7%	50.2%	126.4%	79.4%	76.9%	93.4%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care				Improvement - High		116.5%	165.8%	158.3%	171.3%	161.5%	204.4%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care				Improvement - Low		22.0%	27.6%	28.9%	29.8%	28.4%	27.7%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care		90.0%	Variable	Improvement - High		98.6%	96.7%	94.6%	94.0%	93.1%	93.6%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<=	15.0%	Variable	Concern - High	Yes	16.2%	14.0%	19.3%	21.3%	20.9%	17.1%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<=	34.0%	Fail	Concern - High	Yes	60.0%	58.8%	58.2%	57.0%	55.5%	60.0%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<=	60.0%	Fail	Concern - High		86.6%	87.3%	87.5%	89.6%	91.5%	91.8%
	Maternity Activity (Deliveries)	Elective care				Improvement - High	Yes	117.1%	110.6%	108.8%	98.5%	91.3%	106.6%

Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<=	40.0%	Pass	Common Cause		5.8%	5.8%	6.2%	6.2%	5.9%	5.9%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>=	90.0%	Fail	Common Cause	Yes	78.4%	80.6%	82.5%	86.7%	85.4%	83.9%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation				Improvement - High	Yes	113.6%	99.3%	106.2%	122.7%	100.0%	116.3%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation				Improvement - High	Yes	102.4%	113.2%	123.1%	93.3%	114.8%	146.7%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<=	25.0%	Fail	Improvement - Low		22.6%	24.6%	23.4%	23.4%	23.2%	20.8%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term				Common Cause		7.3%	13.6%	17.4%	10.0%	9.5%	11.6%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		97.1%	95.0%	97.0%	97.8%	96.7%	95.5%
	Bed occupancy - Community Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		95.0%	93.6%	95.4%	96.3%	94.4%	97.4%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<=	0	Variable	Common Cause		150	173	181	110	75	109
	Patient ward moves emergency admissions (acute)	Safe, high quality care				Common Cause		7.3%	9.1%	7.5%	7.4%	7.3%	10.5%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<=	5	Variable	Concern - High		4	4	4	4	4	4
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<=	3	Variable	Common Cause		2	3	3	2	2	2
	Medically fit for discharge - Acute	Safe, high quality care		5.0%	Pass	Common Cause		22.0%	19.5%	22.5%	24.6%	17.9%	22.2%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Concern - Low	Yes	61.1%	60.4%	58.7%	58.9%	57.9%	45.4%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Common Cause	Yes	6.3%	10.2%	11.0%	8.9%		
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Variable	Concern - High		110	110	111			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		102	102				
	Never Events	Safe, high quality care		0	Variable	Common Cause	Yes	1	0	1	0	0	0
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Concern - Low		0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care				Common Cause	Yes	0	1	1	1	2	0
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care		44	Fail	Common Cause		5	5	6	6	1	0
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause		5	3	4	3	2	0
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<=	0	Variable	Common Cause	Yes	3	2	1	3	2	1
	Serious Incidents	Safe, high quality care				Common Cause	Yes	16	6	8	7	8	6
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		90.4%	89.6%	90.8%	90.9%	90.2%	90.1%

Safe, high quality care	WHO Checklist	Safe, high quality care	>=	100.0%	Variable	Common Cause	Yes	99.5%			99.8%		
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>=	60.0%	Variable	Common Cause	Yes	48.8%	68.8%	88.6%	87.0%	68.8%	43.8%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>=	90.0%	Variable	Common Cause	Yes	75.0%	57.1%	40.0%	0.0%	100.0%	50.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		88.1%	86.7%	80.4%	88.9%	77.1%	76.9%
	Number of complaints	Safe, high quality care				Common Cause	Yes	25	21	23	43	31	24
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Improvement - Low		0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Variable	Common Cause		71.4%	54.5%	50.0%	34.3%	43.3%	33.3%
	Friends and Family Test - Response Rate (Community)	Safe, high quality care	>=	30.0%	Variable	Concern - Low		0.0%	0.2%	0.1%	0.1%		
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	0.0%	76.3%	76.0%	79.6%	72.9%	73.0%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low		86.4%	90.0%	89.1%	87.4%	86.2%	81.0%
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	100.0%	81.8%	100.0%	100.0%		
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	100.0%	0.0%	100.0%	100.0%	100.0%	94.0%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Common Cause	Yes	0.0%	21.0%	21.0%	20.5%	17.0%	20.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High		21.0%	19.0%	20.4%	19.0%	17.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause	Yes		0.0%	0.0%	1.5%	46.0%	26.0%

People

Sub Domain	KPI	Subject		Target	Target Expectation	Variation	Exception	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>=	6.4%	Variable	Common Cause	Yes	6.9%	8.1%	8.4%	8.4%	6.8%	7.5%
	Appraisals	Looking after our people	>=	85.0%	Fail	Common Cause	Yes	77.1%	77.5%	78.6%	79.0%	78.5%	77.1%
	Mandatory Training	Looking after our people	>=	85.0%	Pass	Concern - Low		89.2%	89.7%	89.3%	89.9%	89.4%	89.0%
	Overall Sickness	Looking after our people	<=	3.5%	Fail	Improvement - Low		5.4%	4.8%	4.4%	4.1%	4.3%	4.6%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<=	10.0%	Fail	Improvement - Low	Yes	12.8%	12.6%	12.0%	11.5%	11.0%	10.9%
	Vacancy Rate	Looking after our people	<=	5.0%	Fail	Improvement - Low	Yes	8.2%	7.9%	8.0%	6.3%	5.1%	5.4%

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Memorandums of understanding with One Herefordshire Partners and the Integrated Care Board
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	TMB
Lead Executive Director:	**Managing Director**
Author:	Jane Ives
Documents covered by this report:	Memorandum of Understanding between One Herefordshire Partners and Memorandum of Understanding between the One Herefordshire Partnership and the Herefordshire and Worcestershire Integrated Care Board

1. Purpose of the report

To seek approval for the Board to sign the two MOU's that cover the collaboration between One Herefordshire Partners and between the 1HP and the Integrated Care Board for the delivery and oversight of specified services;

Better Care Fund Plan
Primary Care Enhanced Services
Enhanced Health in Care Homes
Urgent Community Response
Proactive Care Planning
Virtual Wards

2. Recommendation(s)

The Board previously approved these documents in principle in July, but due to the delay in agreement of the BCF between the ICB and Herefordshire county council, it is only now ready for formal sign off. The Health and wellbeing Board approved the BCF on 25th September 2023.

Recommendation: that the Board give authority to the Managing Director to sign the MOU's noting that approval for partner organisations is being achieved concurrently through their governance routes.

3. Executive Director Opinion[1]

The strength and depth of our relationship with Herefordshire partners continues to deepen and it now requires a formal MOU to underpin how we work together and importantly how the ICB can be assured that the delegation of a series of specified service can be safely achieved.

There are two MOU's for Board consideration

MOU – One Herefordshire Partnership.

The purpose of this MOU is to provide a formal basis for the collaboration and working arrangements between the organisations involved in the 1HP (the participants), specifically to detail the collaborative approach to delivery and oversight of integrated health and care delivery in Herefordshire. This MOU sets out a framework of roles and responsibilities for the participants engaged in Place collaboration.

MOU – between the One Herefordshire Partnership and the ICB for services to be co-ordinated by 1HP.

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

The purpose of this Memorandum of Understanding (MOU) is to provide a formal basis for the collaboration and working arrangements between HWICB and organisations involved in One Herefordshire Partnership specifically to detail the collaborative approach to delivery and oversight of services identified.

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

Quality Improvement	***Sustainability***
☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes***	☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff***
☒ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)***	☒ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process***
☒ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care***	***Workforce***
Digital	☒ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners***
☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy***	☐ ***Develop a 5 year 'grow our own' workforce plan***
☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways***	***Research***
Productivity	☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***
☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations***	
☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	

One Herefordshire Partnership

Memorandum of Understanding

Herefordshire Council

and

Herefordshire General Practice

and

Herefordshire and Worcestershire Health and Care NHS Trust

and

Wye Valley NHS Trust

Regarding the

One Herefordshire Partnership

Background

1.1 The Herefordshire and Worcestershire (H&W) Integrated Care System (ICS) has worked together for some time on ambitious plans to meet a broad transformation agenda, now formalised through legislation. These plans depend on an array of complex partnerships, structural reforms and behavioural changes, with leaders focusing much of their energy and resources on coordinating actions at the local level, using place-based approaches that incorporate the crucial role of the developing primary care networks (PCNs). The H&W ICS breaks down into two 'places'; Herefordshire and Worcestershire.

The 'One Herefordshire' (1H) approach goes back many years and is founded on the recognition that Herefordshire's health and care organisations could only find solutions to the strategic issues they face collectively. The Covid outbreak galvanised this arrangement significantly, heralding a much more agile, permissive approach underpinned by clinician and practitioner leadership. This approach was formalised in the creation of the 1HP and its associated governance structure in June 2021. The following guiding principles were agreed by the partners.

- Partners are equal members and decisions are made transparently in the context of a lead provider contract
- Priorities are jointly identified through an intelligence-led approach focusing on outcomes
- Services are delivered through empowered local network teams, with distributed leadership and clear accountability
- At the heart of strategy development and service improvement are patient, service user and citizen voices and clinician and practitioner leadership
- Resources are allocated in partnership to deliver best value for the Herefordshire £; risk and reward is jointly managed and protects against personal financial risk
- Governance processes are efficient and effective and utilise organisational governance as the cornerstone of system working

Overall though, the strengths of the 1HP are the relationships between the members and their organisations, that underpin a collective approach to problem solving in order to improve the lives of Herefordshire's residents.

2. Purpose of the Memorandum of Understanding

2.1 The purpose of this MOU is to provide a formal basis for the collaboration and working arrangements between the organisations involved in the 1HP (the participants), specifically to detail the collaborative approach to delivery and oversight of integrated health and care delivery in Herefordshire. This MOU sets out a framework of roles and responsibilities for the participants engaged in Place collaboration.

3. Duration

3.1 This MOU will remain in effect unless terminated until the 31st March 2028.

4. Termination of the MOU

4.1 This MOU may be terminated by any Participant upon three months' written notice or immediately by joint consent. This will not affect current work programmes, until the completion of said programmes, unless decided otherwise in writing between the Participants.

4.2 In the event of termination, the commitments regarding the use of confidential information generated under this MOU will continue.

5. Coming into Effect

5.1 This MOU will come into effect upon signature by all Participants.

Signed for and on behalf of	Signed for and on behalf of:
Herefordshire Council	Herefordshire General Practice
Name:	Name:
Sig:	Sig:
Date:	Date:

Signed for and on behalf of	Signed for and on behalf of:
Herefordshire & Worcestershire Health and Care Trust	Wye Valley NHS Trust
Name:	Name:
Sig:	Sig:
Date:	Date:

SCHEDULE 1: One Herefordshire Partnership Governance

1.1. ROLES AND RESPONSIBILITIES

The Health and Care Act (2022) makes provision for greater collaboration between the NHS, local authorities and other organisations. In the Herefordshire and Worcestershire system, the agreed principle of subsidiarity encourages provision to be managed and coordinated at a Place-level to maximise the opportunity for joining up service arrangements for patients, public and communities. This MOU outlines the formal governance arrangements of the 1H Partners put in place in order to deliver integrated services in Herefordshire. This document supports openness and transparency between all parties.

1.1.1. Role of One Herefordshire Partnership (1HP)

The main decision making body is the 1HP itself which sets the strategy, agrees priorities and reviews high-level outcomes. The 1HP assures itself that appropriate engagement has taken place through the three bodies that sit alongside it, the Clinician and Practitioner Forum (CPF), the Integrated Care Executive (ICE) and the Community Partnership.

The four One Herefordshire partners are:

- Herefordshire Council
- Herefordshire General Practice
- Herefordshire and Worcestershire Health and Care NHS Trust
- Wye Valley NHS Trust

The following organisations are invited members of the Partnership.

- Herefordshire HealthWatch
- Herefordshire and Worcestershire ICB

The primary purposes of the 1HP are to:

- Set the strategy for Herefordshire's health and care services, responding to national, regional and local plans and strategies
- Approve priorities, programmes, plans and objectives
- Receive updates on progress against the objectives and performance of integrated services
- Ensure that appropriate engagement with the public, service users and staff has taken place

The 1HP is responsible for:

a) Working with the Health and Wellbeing Board (HWB) – providing oversight of the delivery of the two core priorities of the Health and Wellbeing Strategy
b) Approving priorities – a forum for top level approval with priorities determined by clinicians, practitioners and wider public engagement
c) Providing a forum for forward-focussed strategic discussions and integrated planning approaches
d) Maintaining oversight of the collective financial outlook of the partners

e) Providing a formal basis for delivery of the MOU between the ICB and 1H partners
f) Reviewing and approving objectives related to the priority schemes being delivered as part of the 1HP work programme
g) Ensuring engagement & co-production – confirming that stakeholders including the public, patients and service users are actively engaged with service changes
h) Agreeing an annual work plan to deliver the priorities of the partners
i) Receiving reports from the Integrated Care Executive which oversees performance on behalf of 1HP and constituent partners.

As set out in the approved governance structure for the 1HP, three main bodies sit alongside the 1HP and shall escalate any partnership issues to the 1HP:

- Clinician and Practitioner Forum (CPF)
- Community Partnership
- Integrated Care Executive (ICE)

The CPF reflects the voice of senior clinicians and practitioners, agreeing clinical approaches and pathway changes, leading on transformation and ensuring that plans and priorities are suitably evidence based.

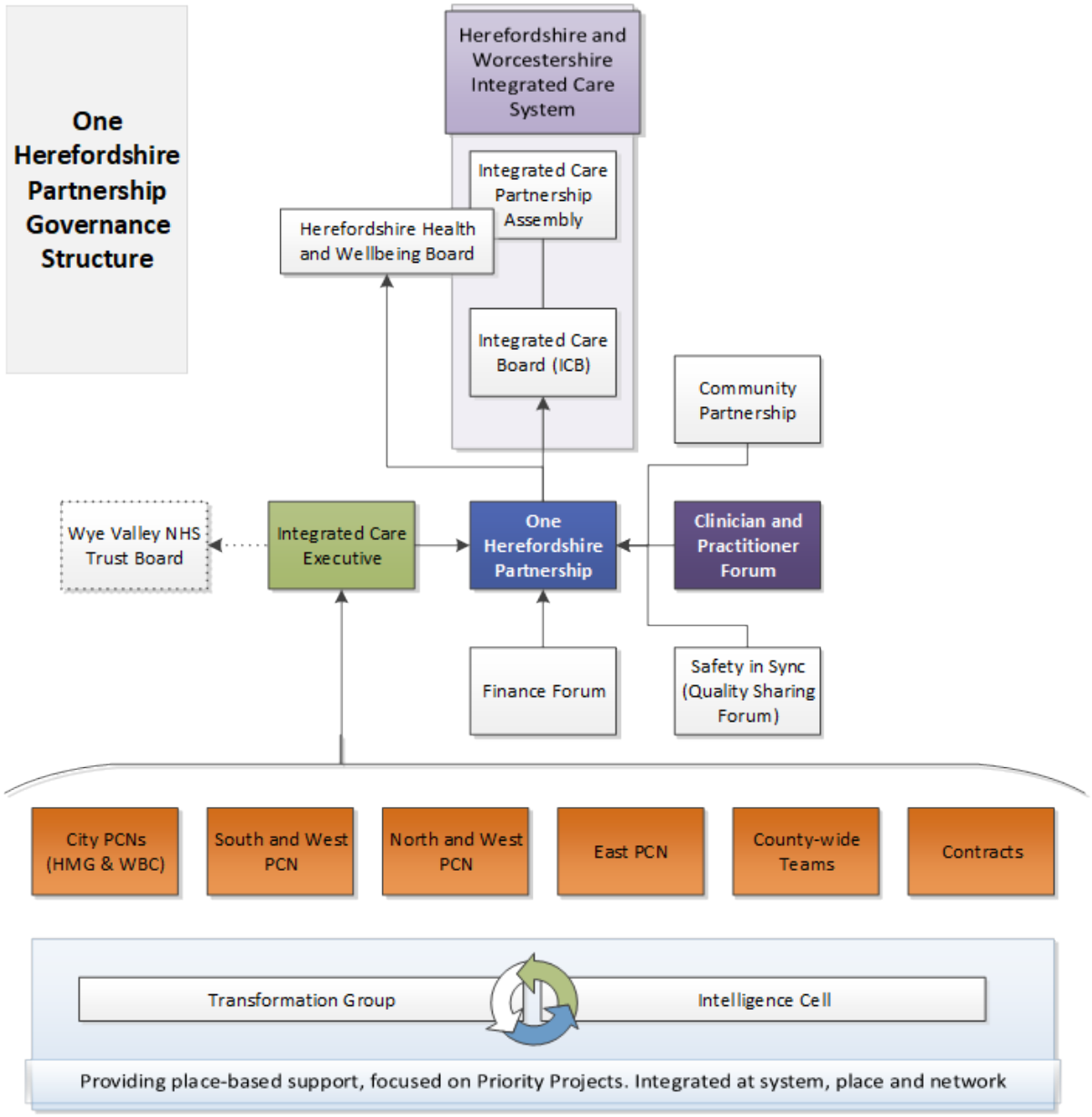
The Community Partnership is led by Healthwatch Herefordshire on behalf of the 1HP and is the main conduit to service users, citizens and the voluntary sector. The approach allows 1HP members to engage CP members collectively, gaining crucial feedback on strategies, plans and pathway changes and providing opportunities for genuine coproduction.

The focus of ICE is on delivery and performance of the 1HP priorities, ensuring that teams are adequately supported to deliver their agreed objectives. This includes performance against the key Better Care Fund metrics. ICE will also oversee the performance against any delegated contracts.

Where the contracts or resources for activities are delegated to the 1HP, the Partnership will appoint a single organisation to receive the funding from the ICB; effectively deciding the most appropriate lead provider by consensus. The organisation chosen will be agreed between members based on a best-fit with the specific contract and that organisation will take formal contractual responsibility for all matters related to it. Oversight of the contract will remain the responsibility of the 1HP.

1HP will provide assurance on delivery at Place to both the ICB and HWB.

1.1.2 One Herefordshire Partnership Governance Structure



1.1.3 Authority

Decisions made at the 1HP are underpinned by the delegated authority of members via their organisations. Any decisions that require approval beyond the delegated authority of members will require formal approval by partner organisations. It will be the responsibility of representatives to seek formal approval from their organisations.

The aim will be to achieve consensus when making decisions, in line with the agreed principles outlined above. In the event that a consensus view cannot be achieved, partners will vote. Each partner organisation shall have one vote (four in total) and there shall be no casting vote for the chair.

The 1HP can seek external advice from any source if necessary, taking into consideration issues of confidentiality and delegated authority of members.

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Memorandum of Understanding

One Herefordshire Partnership

and

Herefordshire and Worcestershire Integrated Care Board

Regarding

Services to be coordinated by One Herefordshire Partnership

1. Background

The Health and Care Act 2022, implemented in July 2022, put Integrated Care Systems (ICS) on a statutory footing. A core part of this legislation and the associated national guidance, makes provision for Integrated Care Boards (ICB) to delegate responsibility for delivering core functions through a range of mechanisms including joint committees and lead provider arrangements.

It is the intention of Herefordshire & Worcestershire ICB to utilise these new powers to delegate certain responsibilities and functions to Place Based Partnerships (such as One Herefordshire Partnership (1HP) or provider collaboratives

2. Purpose of the Memorandum of Understanding

The purpose of this Memorandum of Understanding (MOU) is to provide a formal basis for the collaboration and working arrangements between HWICB and organisations involved in One Herefordshire Partnership (the participants), specifically to detail the collaborative approach to delivery and oversight of services identified in schedule 1.

3. Duration

This MOU will remain in effect unless terminated until the 31st March 2024

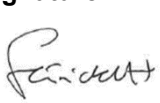
4. Termination of the MOU

This MOU may be terminated by any Participant upon 3 months' written notice or immediately by joint consent. This will not affect current work programmes, until the completion of said programmes, unless decided otherwise in writing between the Participants.

In the event of termination, the commitments regarding the use of confidential information generated under this MOU will continue.

5. Coming into Effect

This MOU will come into effect upon signature by all Participants.

Name:	**Name:** **Simon Trickett**
Signature:	**Signature:** 
Date:	**Date:** **27th September 2023**
Signed for and on behalf of ***One Herefordshire Partnership***	***Signed for and on behalf of:*** ***Herefordshire and Worcestershire Integrated Care Board***

SCHEDULE 1: COLLABORATIVE SERVICE OVERSIGHT AND DELIVERY

1.2. ROLES AND RESPONSIBILITIES

The Health and Care Act (2022) makes provision for greater collaboration between the NHS, Local Authorities and other organisations. In Herefordshire and Worcestershire system, the agreed principle of subsidiarity encourages provision to be managed and coordinated at a Place-level to maximise the opportunity for joining up service arrangements for patients, public and communities. This MOU outlines the roles and responsibilities between the Integrated Care Board and One Herefordshire Partnership to deliver integrated services in Herefordshire. This document supports openness and transparency between all parties.

Agreement to areas of delegation will be initiated using an agreed benefits-based approach. For the delegation to be enacted there needs to be a clear and agreed case between relevant stakeholders that delegation of the function, funding or responsibility will lead to better outcomes, improved performance and better value for money than retaining the status quo.

1.2.1. Role of Integrated Care Board (the ICB)

The Integrated Care Board is accountable for the arrangement of healthcare services. The Board will set the outcomes for the population and the national and local requirements for the areas listed in the MOU.

At the start of each financial year, the ICB will identify, allocate and communicate the resources available for each area outlined in the MOU.

The ICB will remain accountable for ensuring that good outcomes are achieved and that services deliver good value for money to the taxpayer. Some activities, such as contracting and procurement will remain the responsibility of the ICB because of economies of scale or best use of resources. In such events, the ICB and OHP will work collaboratively to inform the execution of these functions. In addition, some enabling work programmes (for example digital) will be managed across the ICS. The same principle about collaborative working will apply.

1.2.2. Role of One Herefordshire Partnership (the Partnership)

The Partnership will have collaborative and shared delivery structures that will progress the achievement of outcomes and the delivery of evidence-based interventions. This will include regular monitoring and oversight of the progress, the risks, issues and successes. Senior Responsible Officers will be assigned to each area in the MOU. The governance by the Partnership will demonstrate fitness to receive the responsibility for the areas delegated in Section 1.2.

Where the contracts or resources for activities are delegated to the Partnership, the Partnership will appoint a single organisation to receive the funding from the ICB.

During the year, the ICB will receive regular updates from One Herefordshire Partnership about delivery of provision through the Quarterly Place Review meeting, chaired by the ICB CEO. The Partnership will instigate programmes of work to actively reduce duplication of services and mitigate emerging risks to delivery. Formal reporting on progress of the areas set out in section 1.2 will be to ICB Strategic Commissioning Committee on a quarterly basis. Specific KPIs for monitoring are set out in the service specifications.

1.3. SUMMARY OF AREAS

The table below outlines the areas covered by the MOU.

Role of Herefordshire Place Collaborative	Role of ICB
Better Care Fund	
• Building consensus between partners and setting objectives beyond the nationally determined outcomes as part of the annual planning of the Better Care Fund, including the BCF Plan. • Development and implementation of new and/or revised services or care pathways. • Monitoring, delivery and reporting of performance and outcomes. • Budget management and ensuring spending lives within the resources allocated, identifying remedial actions where spending is off trajectory.	• Approving local objectives and outcomes for the Better Care Fund. • Providing expert advice and support to the Place teams. • Assurance of the Programmes, including delivery of performance and outcomes, as well as achievement of Value for Money • Partner in the Section 75 agreement with Herefordshire Council.
Primary Care LES review and redesign	
• Review of services and identification for areas of improvement. • Building consensus around agreed solutions that deliver more integrated and better value for money services. • Recommendations on continuation or decommissioning. • Supporting the design of new enhanced services. • Ensuring equitable access to enhanced services for all Herefordshire patients, managing any unwarranted variation.	• Contract arrangements with Primary Care. • Providing expert advice and support to the Place teams. • Alignment of resources and outcomes across both counties. • Setting LES investment levels. • Monitoring performance of Primary Care providers against agreed specifications and outcomes. • As services become more integrated, performance oversight will be shared between the ICB and the Herefordshire place collaborative.
Additional Areas: Enhanced care in Care Homes, Urgent Community Response, Proactive Care Planning, Virtual Wards	
• Operational integrated delivery. • Setting local objectives. • Service design, improvement and evaluation of provision.	• Setting outcomes. • Assurance of the Programmes, including delivery of performance and outcomes, as well as achievement of Value for Money

• Monitoring, delivery and reporting of performance and outcomes.	• Providing expert advice and support to the Place teams. • Hold the relationship with NHSE and act as intermediary.

1.2.1	**Better Care Fund**	**ICB Lead:**	Director of Operations & Delivery
		OHP Lead:	TBC

Scope and commitment

The Better Care Fund is part of the NHS mandate 2022-23 issued under section 13A of the NHS Act 2006. This is a pooled funding arrangement (NHS minimum contribution, Improved Better Care Fund grant and Disabled Facilities Grant).

Herefordshire and Worcestershire Integrated Care Board are seeking to engage One Herefordshire Partnership, of which it is a member, in the Better Care Fund, specifically the promotion of integration, the delivery of performance and financial outcomes, the improvement of quality of services and the reduction of health inequalities.

Partners of One Herefordshire Partnership are committing to joint planning and delivery of the Better Care Fund in accordance with the national conditions, metrics and funding arrangements.

The draft BCF plan must be developed by One Herefordshire Partnership, including the proposals to spend / allocate resources within the budget allocation. The final plan will be agreed by Herefordshire Council and the Integrated Care Board. Sign-off of the annual plan is by Herefordshire Health and Wellbeing Board.

Requirements

One Herefordshire Partnership will be required to achieve the performance levels as set out in the Better Fund Plan, which will be approved by the Health and Wellbeing Board and submitted to ICB Strategic Commissioning Committee in June 2023.

One Herefordshire's plans must include:

- Maintaining the NHS contribution to adult social care in line with the uplift to the NHS minimum contribution.
- Implementation of the BCF policy objectives.
- Investment in NHS commissioned out-of-hospital services.
- Managing resource allocation to avoid overspend and demonstrate value for money.
- Demonstrating local added value in addition to the BCF policy objectives by the actions undertaken by One Herefordshire.

Contracting arrangement

The ICB and Herefordshire Council will remain jointly accountable for the BCF spend through the Section 75 agreement. One Herefordshire Partnership will operationally manage the budget and associated contracts commissioned through the BCF. One Herefordshire Partnership is required to manage services within the budget allocated.

If, during the course of the year any overspends are forecast, One Herefordshire Partnership will be required to identify mitigating action to recover the position. If mitigating plans are not agreed by the ICB then the delegation will be revoked.

Annually, a plan to reinvest any underspend will be developed and agreed with the ICB and Council, aligned with the annual BCF planning process, or any underspend will be returned to the ICB and the Council.

There are two allocations covered in this agreement - Better Care Fund allocation of £15,988,428 in 2023/24, of which £9,114,215 is ICB resources; and the Discharge Funding of £1,998,716 in 2023/24, of which £1,040,000 is ICB resources.

1.2.2	**Primary Care Local Enhanced Services**	**ICB Lead:** **OHP Lead:**	Director of Primary Care TBC

Scope and commitment

The Primary Care Commissioning Committee has ten Local Enhanced Services in 2023/24:

- Safe prescribing
- DVT
- Phlebotomy
- Leg ulcers
- Spirometry
- Managing menorrhagia
- ECG (12 lead)
- Safeguarding
- Flu antivirals in care homes
- Diabetes

Performance Requirements

As per each specification approved by the ICB.

Contracting arrangement

- To be undertaken by ICB Primary Care Team, with Herefordshire Primary Care Network Clinical Directors.
- Contract to be between Primary Care Networks and ICB.

1.2.3	**Enhanced Health in Care Homes**	**ICB Lead:** **OHP Lead:**	Director of Operations & Delivery TBC

Scope and commitment

For the purposes of the EHCH implementation framework a ‘care home’ is defined as a CQC-registered care home service, with or without nursing.

The EHCH service applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority: everyone has the right to high quality NHS services. It is equally applicable to homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. Secure mental health units are not in scope.

Partners of One Herefordshire Partnership are committing to joint delivery of the agreed specification as detailed in Schedule 2.3.

Performance Requirements

Key performance indicators are as set out within the service specification in Schedule 2.3.

Contracting arrangement

The ICB will contract with Wye Valley NHS Trust as the lead provider of the One Herefordshire Partnership, for £367,000 in 2023/24.

The DES provision undertaken by Primary Care are excluded and will remain contracted between the ICB and General Practice.

1.2.4	**Urgent Community Response**	**ICB Lead:** **OHP Lead:**	Director of Operations & Delivery TBC

Scope and commitment

Partners of One Herefordshire Partnership are committing to joint delivery of the agreed specification as detailed in Schedule 2.4. This will include meeting national requirements and implementation of specific care pathways.

Performance Requirements

Key performance indicators are as set out within the service specification in Schedule 2.4.

Contracting arrangement

The ICB will contract with Wye Valley NHS Trust as the lead provider of the One Herefordshire Partnership, for £929,000 in 2023/24.

1.2.5	**Proactive Care**	**ICB Lead:** **OHP Lead:**	Director of Operations & Delivery TBC

Scope and commitment

Partners of One Herefordshire Partnership are committing to joint delivery of the agreed specification as detailed in Schedule 2.5. This will include meeting national requirements and implementation of specific care pathways.

Performance Requirements

Key performance indicators are as set out within the service specification in Schedule 2.5.

Contracting arrangement

The ICB will contract with Wye Valley NHS Trust as the lead provider of the One Herefordshire Partnership, for £0 in 2023/24.

1.2.6	**Virtual Wards**	**ICB Lead:** **OHP Lead:**	Director of Operations & Delivery TBC

Scope and commitment

The National Virtual Ward Programme sets out the ambition of having 40-50 Virtual Ward beds per 100,000 population. As a minimum, systems are asked to prioritise Frailty and Acute Respiratory Infection. For Herefordshire this equates to circa 65-80 Virtual Ward beds.

Funding has been agreed to support Herefordshire in delivering three Virtual Wards over a two-year period covering 2022/23 and 2023/24. This covers:

	Virtual Ward	**Number of 'Beds'**
1	Acute Respiratory Infection (ARI)	10
2	Frailty	5
3	Acute Medicine	15

The development of Virtual Wards should be a continuum of care that supports both a proactive and reactive approach to delivering care in a joined-up way. It should build on the existing integrated services and use population health intelligence to transform and enhance capacity within existing pathways, as well as develop additional Virtual Ward models.

Robust benefits realisation will provide evidence and confidence to both the ICS and to partners of One Herefordshire Partnership to scope and develop the Virtual Ward model across other specialisms and boundaries.

For 2023/24 the requirement is a minimum of 20 Virtual Ward Beds. This will be supported by additional funding through the Physical and Virtual Capacity Fund and local transformational initiatives that increase overall capacity within the existing resource envelope.

Performance Requirements

Key performance indicators will be set within each virtual ward. Overarching requirements:

- Delivery of Virtual Ward beds as per the agreed plan for 2023/24.
- 80% utilisation of VW beds by September 2023, with the average length of stay being within agreed parameters outlined in the SOP.
- Monitoring and reporting on the VW LOS
- Reporting of VWs on Foundry to comply with national requirements

- Benefits realisation framework in place for each VW

The Partnership is required to scope additional opportunities to increase the net bed benefit of VWs within the agreed resource envelope. This could include implementing alternative service models that increase overall treatment capacity by adopting innovative workforce solutions.

Contracting arrangement

The ICB will contract with Wye Valley NHS Trust as the lead provider of the One Herefordshire Partnership, for £786,000 in 2023/24.

This is the value agreed for delivery of in excess of 20 beds in Virtual Wards.

SCHEDULE 2

2.1 Better Care Fund Plan

2.2 Primary Care Enhanced Services

2.2 Service Specification – Enhanced Health in Care Homes

2.3. Service Specification - Urgent Community Response

2.4. Service Specification – Proactive Care Planning

2.5 Service Specification – Virtual Wards`

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Patient Safety Incident Response Plan
Status of report:	**☒Approval ☐Position statement ☐Information ☒Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Nursing Officer**
Author:	Lynn Carpenter, Quality and Safety Matron
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The paper presented is the proposed Trust Patient Safety Incident Response Plan. The plan outlines how the Trust intends to respond to incidents under the Patient Safety Incident Response Framework which replaces the Serious Incident Framework nationally. The plan is presented for Board approval.

2. Recommendation(s)

The Board is asked to note:

- The plan has been developed using the national template and adopting good practice from Trusts who have already implemented PSIRF.
- The plan has been sent to Patient Safety Committee and Clinical Effectiveness and Audit Committee members for consultation.
- The plan was sent for review by the ICB Patient Safety Team as a key stakeholder. They provided positive feedback on the plan and their comments with minor changes suggested were incorporated into this draft.
- The plan has been reviewed by our Patient Safety Partners.
- The plan was approved at Quality Committee in September 2023.
- The Trust aims to implement the plan from 1st November 2023 subject to ICB approval.

3. Executive Director Opinion[1]

The proposed plan has been developed through triangulation of various data sources to determine where the trust should prioritise resources to ensure that maximum learning and benefit can be achieved.

This draft is based on the feedback from the draft proposals presented to the Board workshop in July.

The plan is iterative and will be reviewed on a regular basis to ensure it focusses on the right priorities and that it continues to meet the national expectations.

I recommend Board approval based on the feedback the team have received to date.

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

4. Please tick box for the Trust's 2023/24 Objectives the report relates to:	
Quality Improvement ☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes*** ☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)*** ☐ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care*** ***Digital*** ☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy*** ☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways*** ***Productivity*** ☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations*** ☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	***Sustainability*** ☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff*** ☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process*** ***Workforce*** ☐ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☐ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

Wye Valley NHS Trust

November 2023 – March 2025

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FOREWORD

The patient safety incident response framework (PSIRF) is a radical change to the way we respond to and learn from patient safety incidents.

Under the PSIRF, we will no longer be talking about 'serious incident investigations' or 'root causes' which are familiar methods. In their place will be a much more flexible, system-focused approach, with improvement and engagement with patients, families and staff taking centre stage.

Ensuring that patients, their families and clinical staff are directly involved in the incident response process is very much at the heart of the PSIRF, with '*compassionate engagement'* being top of the list of the PSIRF stated aims.

We at Wye Valley NHS Trust are very excited to embark on this journey alongside our patients, relatives and staff because we firmly believe in the importance of working together to improve the system. The Trust is committed to creating a culture of engagement with patients, families and carers particularly when clinical outcomes are not as expected or planned.

Fostering and developing a restorative just culture in which people feel safe to talk about patient safety incidents is key to ongoing improvement. Having conversations with people relating to a patient safety incident can be difficult and we recognise that changing culture is complex. We are passionate about being an organisation that has a positive patient safety culture in which people feel safe to speak up and will continue to explore how we can equip and support our colleagues to best hear the voice of those involved in patient safety incidents.

As we embark on our journey, we will be actively learning throughout the process. We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF, we will seek feedback and adapt as and when our approach is not achieving our aims.

We know that any incident response can't change what happened, but we hope that following the PSIRF principles will help patients, families and staff to learn about what happened and why, and lead to change and improvement for the future.

INTRODUCTION

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is Wye Valley NHS Trusts Patient Safety Incident Response Plan (PSIRP).

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works.

The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. The strategy has three simple underlying approaches; patient safety systems, patient safety cultures and a restorative just culture. We aim to build on these foundations to deliver the strategies strategic aims;

- **Insight**; continuously improve understanding of safety by drawing insight from multiple sources of patient safety information.
- **Involvement**; equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.
- **Improvement**; support programs that deliver effective and sustainable change to patient safety.

The PSIRF advocates a flexible, system-focused approach with improvement and engagement at its core. Organisations decide when a patient safety incident investigation (PSII) should take place based on their patient safety profile, and offer the flexibility to respond in the right way depending on the type of incident and associated factors. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

This document will set out our intended response to patient safety incidents over the next 18 months but is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

PURPOSE, SCOPE, AIMS AND OBJECTIVES

PURPOSE

This PSIRP sets out how Wye Valley NHS Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of its work to continually improve the quality and safety of the care it provides. This PSIRP is a 'living document' that will be appropriately amended and updated as the Trust uses it to respond to patient safety incidents.

SCOPE

There are many ways to respond to an incident. This document covers **responses conducted solely for the purpose of system learning and improvement,** and should be read alongside the PSIRF document which sets out the requirement for this plan to be developed.

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

There is no scope within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- Human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- Legal teams for clinical negligence claims
- Medical examiners and if appropriate local coroners for issues related to the cause of a death
- The police for concerns about criminal activity

The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

AIMS AND OBJECTIVES

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims. The achievement of these aims is underpinned by specific objectives:

1. To improve compassionate engagement and involvement of those affected by patient safety incidents

- Work in partnership with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident.
- Support and involve staff, patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting Duty of Candour.
- Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS.
- Meaningfully involve those affected by a patient safety incident where they wish to be involved when a PSII or other learning response is undertaken.
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.
- Develop a climate that supports a just culture and an effective learning response to patient safety incidents

2. To effectively apply a range of system-based approaches to learning from patient safety incidents

- Use a range of system-based learning response tools to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.
- Consider the safety issues that contribute to similar types of incident and develop systems based improvement plans
- Better measurement of improvement initiatives based on learning from incident response

3. Ensure responses to patient safety incidents are considered and proportionate

- Respond to patient safety incidents purely from a patient safety perspective.
- Improve the use of valuable healthcare resources.
- Use resources for incident response to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.
- Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the

implementation of meaningful actions that lead to demonstrable change and improvement.

- Not to undertake an individual response to an incident – other than to engage with those affected and record that the incident occurred if an organisation and its Integrated Care Board (ICB) are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored.
- Reduce the number of duplicate PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors

4. Demonstrate supportive oversight focused on strengthening response system functioning and improvement

- Develop a local board-led and commissioner-assured architecture around patient safety investigation and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

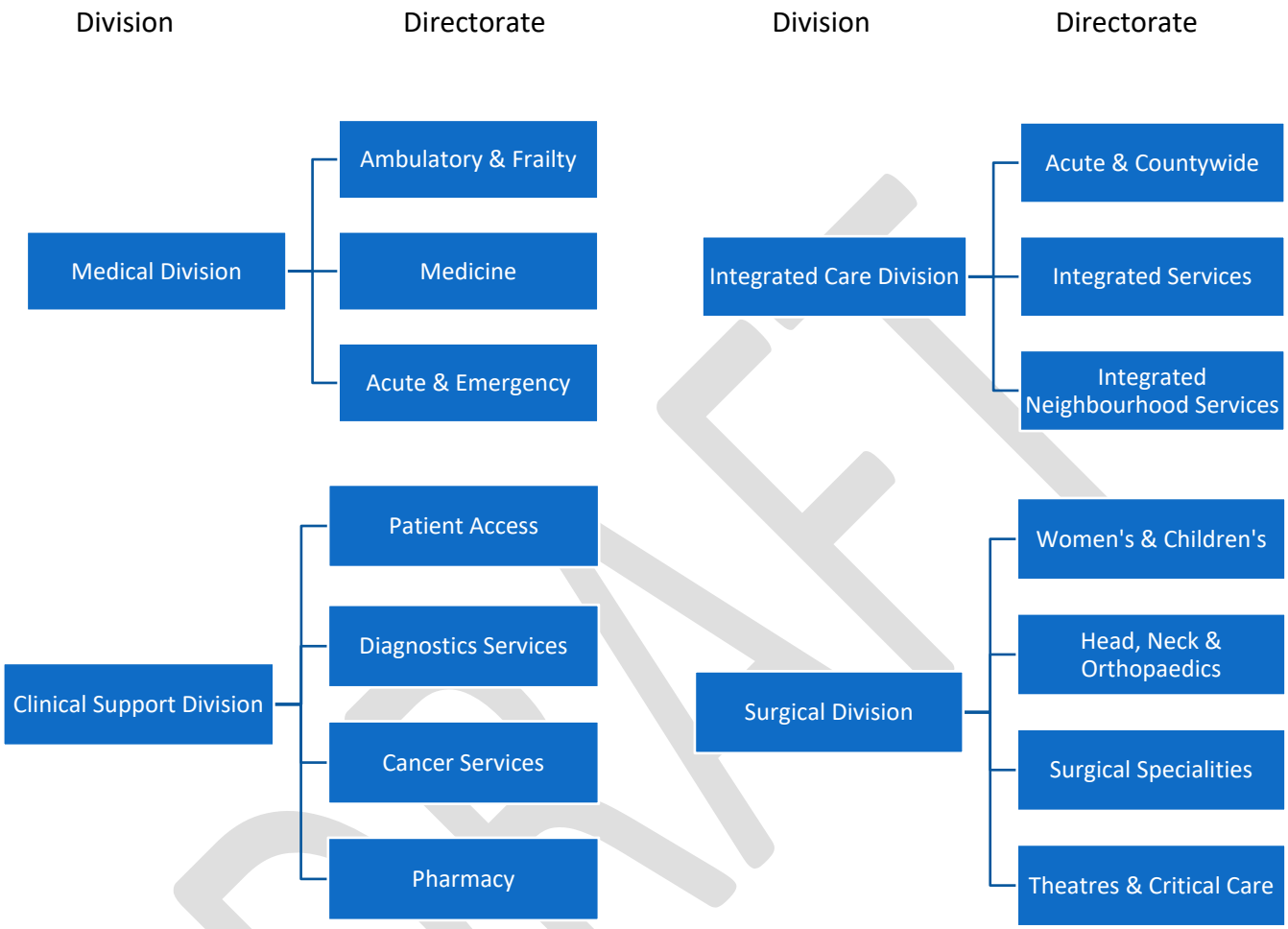
SYSTEM OVERVIEW OF WYE VALLEY NHS TRUST

Wye Valley NHS Trust provides community services and hospital care (acute and community) to a population of just over 180,000 people in Herefordshire. They also provide urgent and elective care to a population of more than 40,000 people in mid Powys, Wales. The Trust's catchment area is characterised by its rural nature and remoteness, with more than 50 per cent of our service users living five miles or more from Hereford city or a market town. The average age of the population is older than the national average.

The Trust's acute hospital, The County Hospital, provides a broad range of acute services including trauma care and hyper acute stroke services. This reflects the rural nature of the county and relatively long travel times to the larger tertiary centres.

The Trust provides a broad range of community services and community inpatient beds across its three community hospitals, which are based in Ross on Wye, Leominster and Bromyard. The Trust's community teams are broadly configured to deliver services across both county-wide and locality geographies. Locality-based teams are configured to develop integrated services in support of the primary care network and population health management, in line with the long-term NHS plan. Broader county wide services are similarly working to offer integrated urgent care functions alongside system partners, to support optimal system patient flow.

The Trust has four clinical divisions, with associated directorates which include a governance structure.



Additionally, the Trust has a corporate division which incorporates the transformation team, freedom to speak up, mortality, infection prevention, safeguarding, health and safety, risk, claims and inquests. These teams provide operational support, working collaboratively with the central quality, safety and experience teams.

Core patient safety activities undertaken at Wye Valley NHS Trust include:

- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Patient Safety Specialists
- National quality improvement programmes

- Audit and compliance programmes (local and national)
- Digital risk management system
- Central Alert System (CAS)
- Non-Executive Director safety visits
- Safety in Sync PLACE based quality, safety and improvement forum

Other activities within the Trust that provide insight into patient safety include Structured Judgement reviews, Learning from Deaths, inquest responses, complaints and feedback.

The operational 'work as done' for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed with expert coordination from their respective Divisional Quality Governance colleagues who are supported through strategic, educational and subject matter expert guidance flowing from the Corporate Directorates.

This emergent system is being built to fit and respond to the size of our Trust and the nuances of the teams, services and structures we work in. This involves key people and teams within Wye Valley Trust, who are integral in facilitating our patient safety system and the continued improvement of our patient safety culture, on our journey to implementing PSIRF.

Our CARE values

Compassion – we will support patients and others, putting individuals at the heart of every decision and ensuring they are cared for with compassion, dignity and respect.

Accountability – we will act with integrity, assuming responsibility for our actions and decisions.

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

Excellence – we will challenge ourselves to do better and strive for excellence

SITUATIONAL ANALYSIS – NATIONAL

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs

through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was clear that:

- Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident. As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.
- There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.

An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.

In addition, the remit for an investigation has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (e.g. professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (e.g. the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (e.g. mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

- Improving the quality of future PSIIs
- Conducting PSIIs purely from a patient safety perspective

- Reducing the number of PSIIs into the same type of incident
- Aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

- Being explored and addressed as a priority in current PSII work, or:
- The subject of current improvement work that can be shown to result in progress, or:
- Listed for PSII work to be scheduled in the future.

In some cases where a PSII for system learning is not indicated, another response may be required. This will depend on the intended aim and required outcome and might include; case note review, timeline or chronology, learning review meeting or sharing of an anonymised incident report. All information relating to Patient Safety Incidents and the insight generated from all responses must be recorded within InPhase, our local risk management system and shared with the National Reporting and Learning System (NRLS) or its successor the Learning from Patient Safety Events (LFPSE) service. PSIIs will also be recorded on the Strategic Executive Information System (StEIS) or its successor the LFPSE when implemented, to allow the organisation to monitor progress of PSII's.

ANALYSIS OF LOCAL PATIENT SAFETY ACTIVITY

LOCAL PATIENT SAFETY RISKS

The patient safety incident risks for Wye Valley NHS Trust have been profiled using organisational data from multiple sources of patient safety activity to include incident reports, complaints and Serious Incident reports, with additional data mined from mortality reports, risks, claims and action plans. An in-depth review of formal complaints and friends and family feedback received by the Trust was undertaken to support reflection of patients and their family's views.

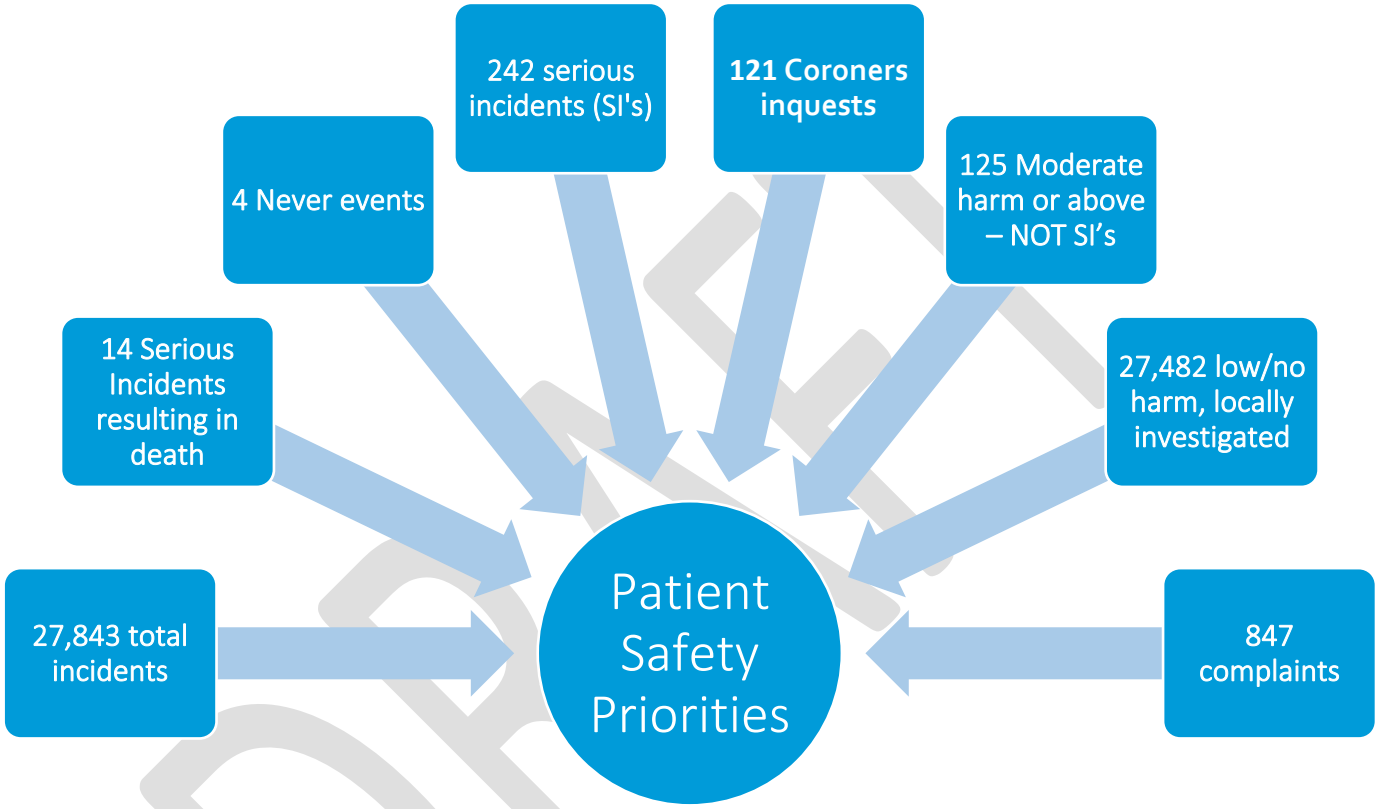
To support the assessment of risk and to agree patient safety incident priorities we undertook an in depth thematic analysis of patient safety incidents and complaints for the period January 2020 – November 2022 for the whole Trust. Incident types, sub-types, categories, recurrence and severity were explored together with incident response activity and resource requirements. Careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place informed our conclusions.

The analysis and themes identified were presented at the Trust's Patient Safety Committee, Quality Committee and at Board workshops and approved as evidence based.

From January 2020 to November 2022 almost 28,000 patient safety incidents were reported at Wye Valley Trust. Less than 1% of these met the threshold for serious incidents and were investigated as per the serious incident framework.

It could be argued that a disproportionate amount of time is spent carrying out serious incident investigations, with the burden of effort from divisional colleagues placed on less

than 1% of all incidents. This significantly limits time to learn thematically from the other 99% of patient safety incidents and implement improvements.



INVESTIGATION RESOURCE

A review of activity associated with patient safety incident investigation has been undertaken by the Trusts Quality & Safety team to determine how many PSIIs can be supported from November 2023- March 2025. This review has been undertaken alongside the Patient Safety Incident Response Standards to ensure that all future PSII's are compliant with these standards.

Engagement with multiple Trusts who were early adopters of PSIRF suggests that the estimated resource allocation for nationally required and locally defined PSII's is likely to be in the region of:

- 60 hours per PSII for 1 lead investigator and 1 support investigator
- 30 hours per PSII for subject matter expertise and family liaison

- 30 hours per PSII for investigation oversight and support, administration support, interview and statement time of staff involved in the incident, governance administration committee approval and board sign off.

Resource requirement for systematic reviews that are not PSII's is anticipated to be:

- Up to 18 hours per response

Resource requirements for locally led Patient Safety Reviews is estimated to be:

- Up to 18 hours per review

The Trusts current resource allocation relies heavily on senior clinicians, employed by the trust, undertaking reviews in their allotted management time. There is acknowledgement of the existing expertise of those at Band 8a and above who currently undertake patient safety investigations or reviews particularly in relation to the following:

- Application of human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarising and presenting complex information in a clear and logical manner and in report form.
- Managing conflicting information from different internal and external sources.
- Communicating highly complex matters and in difficult situations.

Whilst the Trust embeds PSIRF, we will continue with the current model of investigation, acknowledging that further evaluation and iterative process changes over the next 12-18 months will be required to improve our ability to deliver against the Patient Safety Incident Response Standards. To align with PSIRF guidance and strengthen the current investigation model over the next 12-18 months we aim to:

- Assign appropriately trained board member(s) to oversee delivery of the PSII standards and support the sign off of all PSIIs, and provide them with Oversight training.
- Train 20 staff in systems based training to support either leading on or reviewing investigations.
- Provide access to update training for current staff who provide the incident investigation oversight function on use of updated analytical tools, use of improvement science approaches and utilization of the national report template.
- Provide access to update training for existing investigators or investigation teams/staff in specific areas.
- Develop an incident review toolkit to support the review of patient safety incidents where a PSII is not indicated.
- Develop a compassionate engagement toolkit to support the meaningful involvement of staff, patients and families involved in patient safety incidents

- Review the investigation model and make recommendations to the trust Board where resource allocation can be improved

This will:

- Enhance patient safety management and leadership support
- Ensure PSII's are completed by a lead investigator who was not involved in the incident itself, or who directly line manages staff involved in the incident
- Enhance resource and skills to conduct alternative patient safety reviews
- Enhance patient safety investigation with a lead and supporting investigator, subject matter experts, administrative support, patient and family liaison, and executive level oversight and support
- Enable each investigator to:
    - receive systems-based patient safety incident investigation training if required.
    - be dedicated to one PSII at any time

SELECTION OF INCIDENTS FOR PSII

PSII's are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent, or continuously and measurably reduce repeat patient safety risks and incidents.

This section sets out the following requirements for PSII's (see appendix 1 for summary chart):

- **National priorities for referral to other bodies or teams for review or independent PSII**
    - These are incidents which are national priorities requiring a mandated independent PSII response and require external reporting or review processes. The Trust will respond to recommendations or actions from the relevant agency/organisation.
- **Nationally-defined incidents for local PSII**
    - These are incidents which are national priorities requiring a mandated PSII response. The Trust will develop local organisational recommendations and safety actions.
- **Locally defined incidents for local PSII**
    - These are a small number of emergent or pre-defined patient safety incidents selected for a PSII response based on the analysis and review of the local safety landscape. For these incidents, a PSII response is selected only where there is significant system learning opportunity.

NATIONALLY-DEFINED PRIORITIES TO BE REFERRED FOR INVESTIGATION OR REVIEW BY ANOTHER TEAM:

Maternity and neonatal incidents:

- Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation.
- All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- All perinatal and maternal deaths must be referred to MBRRACE

Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge:

- Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team

Child deaths (Child death review statutory and operational guidance):

- Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities:

- Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

Incidents in screening programmes:

- Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:

- Incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

NATIONALLY-DEFINED INCIDENTS REQUIRING LOCAL PSII

Incidents that meet the criteria set in the Never Events list (2018)

- Never events list (2018, updated 2021)

Incidents that meet the 'Learning from Deaths' criteria:

- Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local Learning from Deaths plan, or following reported concerns about care or service delivery.

Further, specific examples of deaths where a PSII must take place include:

Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool:

- And, which have been determined by case record review to be more likely than not due to problems in care

Deaths of persons with learning disabilities:

- Where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review

Deaths of patients in custody, in prison or on probation

- Where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

LOCALLY DEFINED INCIDENTS REQUIRING LOCAL PSII

Locally-defined emergent patient safety incidents requiring PSII.

- An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

Locally-predefined patient safety incidents requiring PSII.

Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

Criteria for selection of incidents for PSII:

- **Increased knowledge**: potential to generate new information, novel insights, or bridge a gap in current understanding
- **Likelihood of influencing**: healthcare systems, professional practice, control potential, safety culture.
- **Feasibility**: practicality of conducting an appropriately rigorous PSII
- **Value**: extent of overlap with other improvement work; adequacy of past actions, influence on wider systems improvement
- **Systemic risk**: complexity of interaction between different parts of the healthcare system

Based on our analysis of patient safety risks and investigation resource, we have estimated the Trust can support the following numbers of PSII's:

Type	Number of PSII's per year
Nationally-defined priorities to be referred for investigation or review by another team	Referred for independent PSII response
Nationally-defined incidents requiring local PSII	8
Locally defined incidents requiring local PSII	16

The number of PSII planned in response to each incident type is a deliberately low number. Reducing the number of duplicate PSIIs into the same type of incident reduces waste, enables more rigorous investigations that identify systemic contributory factors and so enables resource to be focused on effective learning and improvement activity to reduce the likelihood of future incidents of the same type.

This approach also allows us to aggregate and confirm the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents. This enables us to consider the safety issues that contribute to similar types of incidents, develop improvement plans across aggregated incident response data to produce systems-based improvements and support better measurement of improvement initiatives based on learning from incident responses.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

OUR PATIENT SAFETY PRIORITIES

Through analysis of our patient safety insights, we have determined 5 patient safety priorities the Trust will focus on for the next two years.
These patient safety priorities form the foundation for how we will decide to conduct PSII's and Patient Safety Reviews in conjunction with the national requirements.

To support the identification of common causal factors, incident types that form the Trusts patient safety priorities are narrowly defined. This means from a large group of incidents, a smaller subset of incidents (which may be specific to an area, process, and/or presentation of a patient or other characteristic) have been identified.

The Trust's patient safety priorities were agreed at the Patient Safety Committee in August 2023.

	Patient Safety Priority	Rationale
1	**Tissue Viability incidents** – Deterioration of moisture associated skin damage to G3/4 or unstageable pressure damage	Tissue viability incidents are the Trusts highest reported incident type overall and also the second highest proportion of more harmful incidents subject to a serious incident investigation. It is a theme in complaints, safeguarding referrals, the outcome of inquests and requires high levels of investigation resource. Significant deterioration of skin damage whilst under our care requires meaningful analysis to understand contributory factors.
2	**Inpatient falls** In patients with dementia, delirium or a known high risk of falls	Inpatient falls are the second highest reported incident type, and the highest proportion of more harmful incidents. It is a theme noted in complaints and the outcome of inquests and requires high levels of investigation resource. Meaningful analysis of patients with a higher risk of falling will lead to greater understanding and improvement of the falls risk assessment and preventative management of these patients.

3	**Delays in assessment, diagnosis or treatment** Responding well to clinically changing conditions	Incident analysis shows us that delays to treatment, treatment not given and lack of clinical or risk assessments are a patient safety theme, with a delay in diagnosis, or lack of recognition of deterioration resulting in higher levels of harm. Complaints and patient feedback analysis shows that delays in clinical assessment, diagnosis or treatment feature highly.
4	**Admissions and discharges** Incidents relating to the movement of patients, particularly delays to follow up	Incident analysis shows increasing numbers of reported issues relating to admissions and discharges over a 3 year period, with discharge concerns showing the highest growth particularly relating to delays to follow up. Discharge is an increasing feature of complaints received for the same period.
5	**Medication incidents** Incidents relating to the failure of administration of critical medications	Medication incidents are the Trusts fourth highest incident category, with around 12% of incidents resulting in harm. Patient safety concerns include diabetes, Parkinson's and analgesic medications. Medication administration is also patient safety theme in complaints and concerns, and there are risks relating to medicines management on the risk register.

HOW WE WILL RESPOND TO PATIENT SAFETY INCIDENTS

There are many ways an organisation can respond to a patient safety incident to learn and improve.

Patient Safety Reviews (PSRs) include several techniques to identify areas for improvement, take immediate safety actions and to respond to any concerns raised by the affected patient, family or carer. Different PSR techniques can be adopted depending on the intended aim and required outcome. All PSRs are conducted locally by our organisation.

Not all PSRs will require a PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Where this is the case, we will adopt relevant techniques. Further information relating to review tools and techniques is available in NHSE's guide to responding proportionately to patient safety incidents.

The type of response will depend on:

- The views of those affected, including patients and their families
- Capacity available to undertake a learning response
- What is known about the factors that lead to the incident(s)
- Whether improvement work is underway to address the identified contributory factors
- Whether there is evidence that improvement work is having the intended effect/benefit

- If an organisation and its ICB are satisfied risks are being appropriately managed

There are four broad categories of PSRs:

- Immediate incident response (e.g. swarm huddles, hot debrief, timeline mapping)
    - Immediate actions taken to address serious discomfort, injury or threat to life
    - Determining the likelihood and severity of an identified risk
    - Responding to concerns raised by patients, families or carers
- Team reviews (e.g. debriefs, safety huddles, MDT reviews, round tables, after action reviews)
    - Post incident review as a team to identify areas for improvement
    - Celebrate successes
    - Understand expectations and perspectives of those involved
    - Enhance teamwork and collaboration
    - Agree actions
- Systematic reviews (e.g. case record reviews, Structured Judgement Reviews, mortality reviews, thematic reviews, cluster reviews or specialist panel reviews such as pressure ulcers, infection prevention or falls)
    - To determine whether there were any problems with the care provided by a service
    - To routinely identify the prevalence of issues
    - If bereaved families, carers or staff raise concerns about care
- Monitoring
    - Audit
    - Survey
    - Horizon scanning
    - Appreciative inquiry

PSII's are distinct from PSRs and can incorporate a range of techniques (such as interviews and observations) to systematically capture everyday work and identify the circumstances surrounding incidents to ensure meaningful learning.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, "we are very sorry that this happened"
- Provide a true account of what happened, explaining whatever you know at that point.
- Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.

- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

Patient safety incidents that have resulted in severe harm:

These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.

RESOURCE PLANNING

Proactive response planning. Overview of estimated resource allocation for patient safety incidents that fall outside of the national priorities:

Understanding our capacity to respond to incidents enables us to be strategic in proactively allocating resources to responding to patient safety incidents that are not included in the list of national priorities.

This section outlines our approach to understanding our available resources, it describes how we are ensuring our resources meet standards required in the National PSII standards and details how much resource we have available to proactively plan how we will respond to key risks that fall outside of national priorities.

National guidance recommends that 3-6 investigations per priority that requires a learning response are conducted per year. When combined with PSII's from the national priorities this will likely result in 20-25 PSII's per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Apart from the "must investigate" points above, the decision to carry out a patient safety incident investigation should be based on either of the following:

- The patient safety incident is linked to one of Wye Valley NHS Trust's Patient Safety Priorities that were agreed as requiring a learning response.
- The patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Patient Safety Priority	Description	Response type	Maximum Number of responses	Anticipated improvement activity
Tissue Viability incidents	Deterioration of MASD to G3/4 or unstageable pressure damage	Statutory Duty of Candour and chronology, plus biannual thematic review.	--	Inform ongoing improvement programmes
Inpatient falls	Inpatient falls in patients with dementia, delirium or a known high risk of falls	Statutory Duty of Candour where applicable and chronology, plus biannual thematic review.	--	Inform ongoing improvement programmes
Delays in assessment, diagnosis or treatment	Responding well to clinically changing conditions	PSII	3	Build case for new improvement plan
Admissions and discharges	Incidents relating to the movement of patients, particularly delays to follow up	PSII	3	Create local safety actions and feed these into the quality improvement strategy
Medication incidents	Incidents relating to the failure of administration of critical medications	(Statutory Duty of Candour if applicable) Cluster review by type of medication or location plus biannual	3	Inform ongoing improvement programmes

		Thematic review.		
Emergent patient safety incidents	Incidents with extreme level of risk, and where there is significant potential for new learning and improvement	PSII	8 or as determined by the incident response panel	Build case for new improvement plan

The tissue viability and inpatient falls incident priorities have been excluded from the requirement to complete a PSII as they have active improvement delivery plans in place, based on learning identified from previous patient safety incident investigations. However, deterioration of MASD to G3/4 or unstageable pressure damage and inpatient falls in patients with dementia, delirium or a known high risk of falls remain a patient safety concern despite the improvement plans in place.

To ensure learning is captured effectively for these sub-sections in order to effectively address within the existing improvement plans, the Trust will monitor any identified gaps in care via a detailed chronology, and thematically review cases for inclusion in improvement activity. Delivery of these improvement plans will be monitored by the central patient safety team and via their respective specialist sub-groups. A combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

COMPLETING A PSII

Each comprehensive PSII will be:

- Conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8a or above and will receive a minimum of two days' training over the next 12-18 months.
- Undertaken as per the PSIRP and will adhere to the national PSII standards and with national good practice for PSII.
- Use the national standard template to report the findings of the PSIIs.
- Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

TIMESCALES FOR COMPLETING A PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSIIs should ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

INVOLVEMENT OF PATIENTS, FAMILIES AND CARERS AFFECTED BY PATIENT SAFETY INCIDENTS

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. Local arrangements for supporting patients families and carers involved in a patient safety incident are detailed within the Trusts being Open and Duty of Candour policy (PR. 176).

For the PSII's identified in this plan, family liaison will be undertaken directly by the investigating team with support from the patient safety team. For all other types of PSR, family liaison is the responsibility of the nominated investigating officer.

Investigating officers or teams with support from the patient safety team will ensure that:

- Meetings are arranged with patients, families and carers involved in a patient safety incident to explain what has happened, the investigation taking place and provision of contact details for the nominated point of contact.
- Those involved in a patient safety incident can bring an advocate if required to any meetings.
- Opportunities are created to hear the patient/family account of the incident from their perspective and gather any questions they would like the investigation to answer.
- The patient and/or family/carer has been provided with appropriate on-going support

- The details of all discussions with the patient (and/or family/carer), and copies of letters relating to the patient safety investigation are uploaded to the relevant incident record on InPhase.
- Communication with the patient, family and/or carer is maintained as per their wishes.
- Contact will take place following the conclusion of the investigation to share the findings, lessons learned and actions being taken.

Trust staff are empowered to resolve concerns immediately and informally, where this is possible. People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the care team.

The trust is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, service users, family members or carers. On these occasions the trust aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

The Patient Advice and Liaison Service (PALS) at Wye Valley NHS Trust is a free and confidential service to support patients and their families

The PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with:

- Advice and Information
- Comments and suggestions
- Compliments and thanks
- Raising a concern
- Advice on how to raise a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

- telephone: 01432 372986
- email: PALS@wvt.nhs.uk

INVOLVEMENT AND SUPPORT FOR STAFF INVOLVED IN PATIENT SAFETY INCIDENTS

Wye Valley NHS Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement

These principles have been embedded into our procedures for the review of incidents. The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

The Trust patient safety team will support, advise and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of locally accessed wellbeing support for all staff. This includes, but is not limited to:

- Health@Work
- VIVUP 24/7 employee assistance programme
- Counselling via NOSS
- Health Psychology
- Team Time
- Schwartz Rounds
- Freedom to Speak Up Guardian
- Mental health first aiders
- Professional Advocates

HOW WE WILL DEVELOP AND SUPPORT IMPROVEMENT

Findings from PSIIs and PSRs provide key insights and learning opportunities, but they are not the end of the learning and improvement process. Findings from PSII's and PSR's will be translated into effective improvement design and implementation.

At the conclusion of a PSII, the final report will be submitted to the Patient Safety Incident Review Group for discussion and agreement of safety actions and the system improvement plan and ongoing monitoring of progress.

To aggregate learning, findings from each individual response linked to a specific risk will be collated to identify common contributory factors and any common interconnections or associations upon which effective improvements can be designed.

Quality Improvement groups and specialist working groups with Divisional and subject matter expert representation will develop and execute system improvement plans, with support from the central Quality and Safety team to enable delivery of actions, monitoring and evaluation of improvement outcomes.

If a single response reveals significant risk(s) that require immediate safety actions to improve patient safety, these actions will be made as soon as possible. All other

recommendation development will consider aggregated findings across all or a subset of responses into a single risk.

Consideration will be given to the timeframe taken to complete a System Improvement Plan and the impact of extended timescales on those involved in the incident. System Improvement Plans can be shared with those involved in the incident including patients, families, carers and staff.

MONITORING AND OUTCOMES OF PSII'S AND PSR'S

The Patient Safety Incident Review Group will have oversight and undertake monitoring of all improvement plans created following a PSII.

The Patient Safety Incident Review Group reports to the Trust Patient Safety Committee which reports to the Trust Quality Committee.

The group promote a positive culture of continuous learning and improvement using Quality, Service, Improvement and Redesign (QSIR) methodology to facilitate Trust-wide learning and improvement.

Regular update reports will be created for the relevant Committees and Board reviews for assurance. Contents may vary, but will likely include aggregated data on:

- Patient safety incident reporting
- Findings from PSII's
- Findings from PSR's
- Progress against the PSIRP
- Progress on System Improvement Plans
- Progress against the Patient Safety Strategy
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

ROLES, RESPONSIBILITIES AND OVERSIGHT

The leadership and management functions of the PSIRF oversight are wider and more multifaceted compared to previous response approaches.

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

The Trust Board:

The Trust board (or those with delegated responsibility, including members of board quality sub-committees) is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The Chief Nursing Officer:

The Board nominated PSIRF executive lead who will provide direct leadership, advice, and support in complex/high profile cases, and liaise with executive colleagues and external bodies as required.

PSIRF executive lead responsibilities:

- Ensure the organisation meets national patient safety incident response standards.
    - The PSIRF executive lead, supported by the rest of the board/leadership team, must oversee the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring they meet the expectations set out in the patient safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements.
    - Ensure patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s)
    - Ensure roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.
- Quality assure learning response outputs.
    - The PSIRF executive lead should be responsible for reviewing PSII reports in line with the patient safety incident response standards and signing it off as finalised. They may be supported in this by relevant colleagues as appropriate.

Patient Safety Specialists:

Patient Safety Specialists within Wye Valley NHS Trust are individuals who have been designated to provide dynamic senior patient safety leadership.

Each Patient Safety Specialist is dedicated to providing expert support to the Trust and has direct access to the executive team, which facilitates the escalation of patient safety issues or concerns. They also play a key role in the development of a patient safety culture, safety systems and improvement activity.

Key responsibilities relevant to this Plan:

- Improving the quality of incident reporting.
- Supporting their organisation's transition from the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) to the new Learn from patient safety events (LFPSE) service for recording patient safety events
- Involvement in local implementation of the PSIRF
- Supporting local implementation of the Framework for Involving Patients in Patient Safety
- Patient safety education and training

The Patient Safety Team:

- Ensures that patient safety investigations are undertaken for all incidents that require this level of response (as directed by the organisation's PSIRP)
- Develops and maintains local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Ensures the organisation has procedures that support the management of patient safety incidents in line with the organisation's PSIRP.
- Establish procedures to monitor/ review investigation progress and the delivery of improvements.
- Works with executive lead to address identified weaknesses/areas for improvement in the organisations response to patient safety incidents including gaps in resource, skills and training.
- Supports and advises staff involved in the patient safety incident response

All staff:

- All staff have a responsibility to highlight any issues which would warrant further investigation.
- Staff should be fully open and co-operative with any patient safety review process.
- All staff are required to understand their responsibilities in relation to this PSIRP.
- All staff should know how to access help and support in relation to patient safety incident response processes.

Investigation Leads:

- Ensure that investigations are undertaken in a timely manner in line with the patient safety investigation standards.
- Ensure the organisation's legal duty of candour is discharged for appropriate incidents.
- Identify those affected by patient safety incidents and their support needs by being or nominating a single point of contact.

- Provide those affected by patient safety incidents with timely and accessible information and advice.
- Facilitate access to relevant support services for patients, families, carers or staff affected by a patient safety incident.
- Help set expectations of the investigation process and content.

Incident Reviewers:

- Incidents must be investigated and reported using the appropriate tools and techniques for the type of PSR required.
- The reviewer(s) should have the appropriate skills and experience or completed the appropriate training for the review technique to be used.
- The review should be proportionate, fair and thorough using systems thinking.

Department Leads/Managers:

- Encourage reporting of all patient safety incidents including near misses and ensure all staff in their area is competent to submit an incident report using the InPhase reporting system and are provided sufficient time to record incidents and share information.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in investigations as required.
- Liaise with the patient safety team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support the development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

Patient Safety Partners

A role that patients, carers and other lay people can play in supporting and contributing to the Trusts governance and management processes for patient safety.

Roles for PSPs can include:

- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- Involvement in patient safety improvement projects
- Working with organisation boards to consider how to improve safety
- Involvement in staff patient safety training
- Participation in investigation oversight groups.

RESOURCES

The NHS Patient Safety Strategy (2019)

Patient Safety Incident Response Framework (2022)

Engaging and involving patients, families and staff following a patient safety incident (2022)

Guide to responding proportionately to patient safety incidents (2022)

Oversight roles and responsibilities specification (2022)

Patient safety incident response standards (2022)

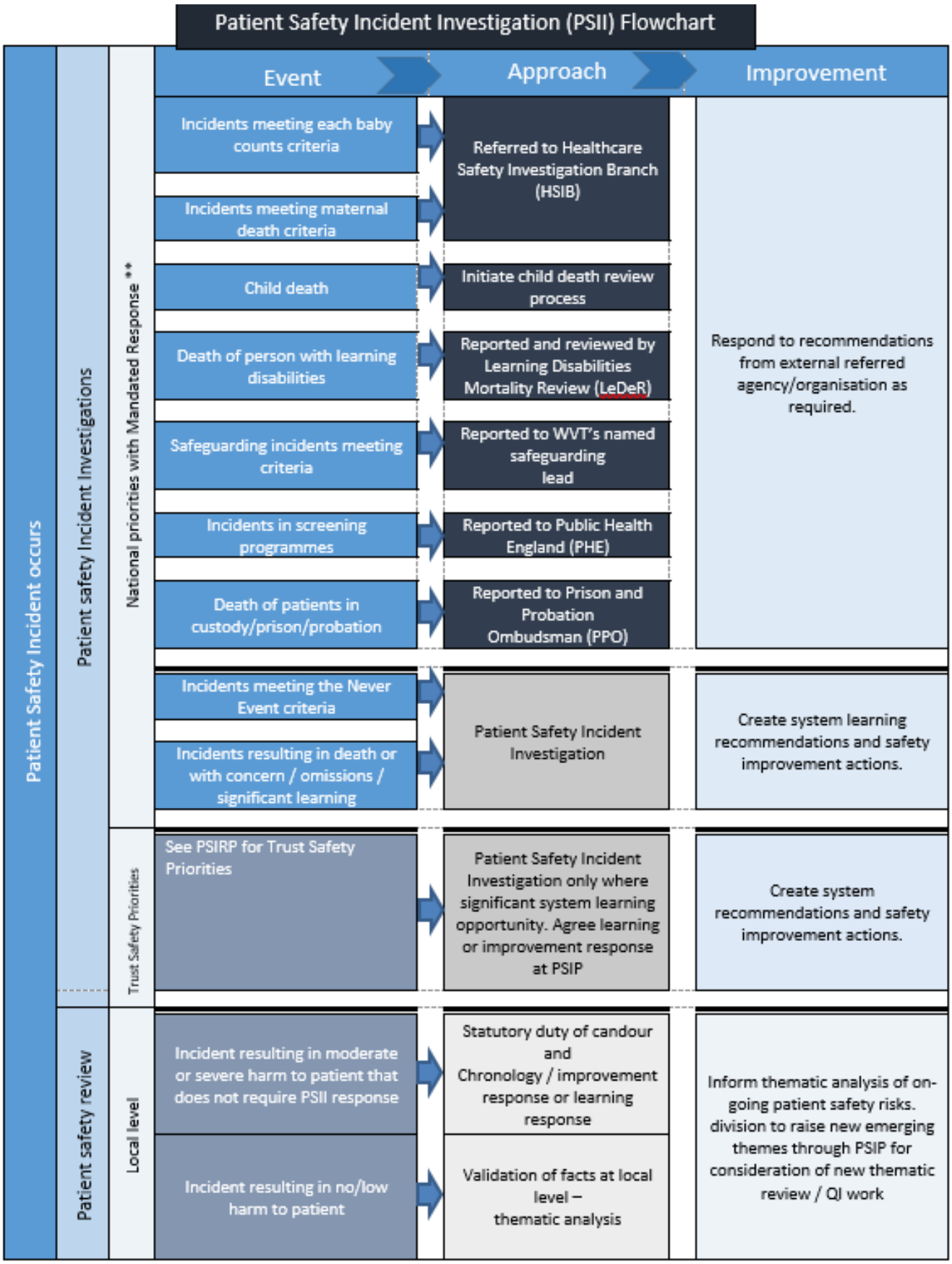
NHS A Just Culture Guide

Regulation 20: Duty of Candour

Learning From Patient Safety Events (LFPSE) Service

APPENDICES

APPENDIX 1



Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Board Assurance Self Certification Protecting and expanding elective capacity
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Operating Officer**
Author:	Andrew Parker
Documents covered by this report:	Protecting and expanding elective capacity Summary Power Point Appendix A - Appendix A - Protecting and expanding elective capacity letter August 2023

1. Purpose of the report

To provide the Trust Board of assurance of the ongoing work to deliver a reduction in our elective waiting lists, through maximising transformational best practice, our ambition to ensure patients waiting 65 weeks are not waiting for a first outpatient appointment by 31st October 2023 and ensure our waiting lists are validated to 12 weeks in line with Referral to Treatment [RTT] rules and use of digital technology to support this processes.

In August 2023 the Trust received Appendix A letter from NHS England asking for:

"Trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives"

The letter details the self-assessment questions required to provide Boards and NHS England of the required assurance.

The twelve key questions and our response is detailed in Protecting and expanding elective capacity Summary Power Point that is submitted with this paper.

Ten of the key questions we have full assurance that operational and clinical plans are in place to address the key lines of enquiry within the letter.

As always, there is risk associated with these plans linked to workforce limitations through key vacancies within teams, the ability to secure additional resource [both internal and externally throughout / in sourcing providers and the independent sector], the pace to deliver Productivity changes, Industrial Action and any pressures faced our Urgent and Emergency Care pathways throughout the remainder of the year.

Notwithstanding any of the above there are various work streams that are aiming to support increase delivery of elective activity and validation of Waiting Lists [WLs]:

- Theatre Productivity Programme lead by the Associate Chief Operating Officer for Performance Improvement supported by our Transformation team
- Getting In Right First Time [GIRFT] Faster, Further Programme. The Trusts involvement with 25 other Trusts, include Foundation Group colleagues, through Clinical Transformation Groups with aims to share and develop coalesce pockets of innovation into a standardised approach and Generated Outpatient Speciality Guides for 'Rapid Adoption and Stretched Ambition'

Though the utilisation of benchmarking information through Model Hospital focusing of key areas of opportunities, such as:
Patient Initiated Follow-ups [PIFU]
Reducing and managing patients who “Did Not Attend” [DNAs]
Increase in Remote appointments
Delivering a reduction in follow-up outpatients
Increasing outpatient activity and capacity
Use of digital technology

- Increased validation of Waiting Lists through the use of digital technology, clinical reviews and

All this work is overseen by the Trusts monthly Productivity Programme Board, the Trusts Management Board [TMB] and Finance and Performance Executive.

There are two areas of concern that both require further work to deliver full assurance:

1. Reduction on Follow-up outpatients compared with 2019/20 activity.

   Due to the Trusts starting position pre Covid with the volume of patients passed their see by date, in February 2020, 24%, this was there is a significant volume of patients. The trajectory to reduce our follow-up outpatient activity by 25% compared with 2019/20 has not yet delivered.
   The improvement plans for reducing follow up appointments are reviewed monthly at Productivity Board at Speciality level and are central to many of the pathway improvements in the GIRFT Further Faster best practice guidance being adopted by the clinical and operational teams.
   We are also keen on separating out its follow up activity with procedures in future planning as this will have an impact on its trajectory towards the 25% reduction target.

2. That we have Transformational priorities for models such as group outpatient follow-ups appointments, one-stop shops and pathway redesign.

   This is also covered in our GIRFT Faster Further programme. Although there is a number of established and new schemes in place much further work is required to maximise these opportunities across a number of specialities.

2. Recommendation(s)

That the Board approve the self-assessment summary for assurance to Nhs England

3. Executive Director Opinion[1]

As per Section 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 2023/24 Objectives the report relates to:	
Quality Improvement ☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes*** ☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)*** ☐ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care*** ***Digital*** ☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy*** ☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways*** ***Productivity*** ☒ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations*** ☒ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	***Sustainability*** ☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff*** ☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process*** ***Workforce*** ☐ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☐ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

Protecting and expanding elective capacity

Self Certification Trust Board Sign Off by September 30th 2023

1. Validation		
The board:	Comments	Assured
a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	although it is not necessarily a realistic comparison as there are so many more long waiters now. As at the end of August 87% of our patients had been validated down to 36 weeks compared to 14% in March 2020 (see Appendix 1). Given the size of the RTT team 36 weeks is considered to be a sustainable validation position but will need to improve moving forward. A full report will be discussed at the next Productivity Board Data Quality reports are also produced daily by the Trusts Information Team and included in Finance and Performance Executive Information Packs for Divisions.	Fully
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	Trust Management Board recently received a business justification to invest in a waiting list validation exercise in order to achieve the deadline set for October 31st 2023. The Trust has been in discussions with its existing text supplier (Envoy) to undertake this and has received assurances that they have the capacity and capability to do this. Plans are now in place to complete this exercise by the 31st October. There will be an initial focus on the 'super seven' specialties within the Further Faster programme and the exercise will also tie in with the new patient choice requirements (PIDMAS). The Trust has now got the process followed by its Worcester colleagues and will seek to replicate where applicable.	Fully
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	The Patient Access Policy sets out the rules and guidance followed by the RTT Team in applying their decisions in relation to rule 5 and do challenge operational team decisions on a regular basis at the weekly PTL meeting.	Fully
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	The Follow Up Request list (past see by date) is periodically reported to Productivity Board and RAG rated accordingly. This is included in Appendix 2 and includes both RTT and non RTT patients. Additionally the surveillance list for patients 25% past their see by date is reviewed weekly and actions taken accordingly (see Appendix 3). Most recently the chair of the PTL sought assurances from the clinical lead for respiratory that the growth in their surveillance lists was being closely addressed. The surveillance reports are also included in the Finance and Performance Executive data packs for (F&PE) discussion at those monthly meetings.	Fully

2. First appointments		
The board:		
a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	The Board received the Trust's plan to meet its 65 week targets on 7th September which is encompassed in the Further Faster programme the Trust is part of. It has selected its 'super seven' specialties to focus on although all 15 of the clinically led outpatient guidance playbooks will be discussed in detail by clinicians and operational managers with action plans ensuing. Various outsourcing and insourcing measures are also being taken to ensure there are no 52 week waiters on non admitted pathways by March 31st 2024.	Fully
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	The Trust is using the Digital Mutual Aid system to source external provision for supporting its recovery plans and is soon to sign an agreement with a West Midlands gynaecology provider for whole pathway transfers. The Trust has plans going in to the medium term to continue using the independent sector to complement its core in-house capacity especially where there are known recruitment issues nationally and the pressures on waiting lists will continue over this length of time. These include radiology reporting and endoscopy. The Trust has recently signed an extended contract for insourced orthodontics support from Eden. Long standing local providers such as the Nuffield continue to treat the Trust's patients together with Foundation Group colleagues. Long term arrangements will be reviewed in those specialities where there are likely to be ongoing issues with recruitment or it is not cost effective to provide an in-house service	Fully

3. Outpatient follow-ups		
The board:		
a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	The improvement plans for reducing follow up appointments are reviewed monthly at Productivity Board at Speciality level and are central to many of the pathway improvements in the Further Faster best practice guidance being adopted by the clinical and operational teams. The Board received a report on the Further Faster programme on the 7th September. There is a realisation that due to the pressure of follow up waiting lists the Trust still has further to go in meeting the 25% reduction target compared to 2019/20. The Trust is also keen on separating out its follow up activity with procedures in future planning as this will have an impact on its trajectory towards the 25% reduction target.	Partly
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	PIFU is a particular focus with the most up to date 4 weekly activity being reported monthly and targets set in line with the best performance nationally. Operational teams will compare clinician performance in discharging similar patients groups to PIFU pathways to ensure there is consistent practice and discuss with the clinical leads where this is not the case. The Board received a PIFU report in September. The Trust is trialling PIFU for breast; colorectal and prostate with remote monitoring. Appendix 4 includes the latest PIFU performance with target performance.	Fully
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	The Trust is planning to reduce its DNA rate down to 5% (currently around 5.5%) and, like PIFU, has speciality level plans to minimise its DNA rate and and is currently considering to undertake a more robust stance including placing patients on to PIFU pathways if they do not attend appointments. The majority of specialities use the 2 way text reminder service for outpatient services and will also phone patients during clinics if they have DNAd and discharge where appropriate.	Fully
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	The Trust regularly exceeds the planning guidance total for A&G requests and uses the GIRFT checklists to ensure all specialities seek to maximise their A&G targets. Where this is not the case there are plans in place, such as within Neurology, to ensure that this improves moving forward.	Fully
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	One stopshops are already in place in some specialties, most notably within Urology and Diabetes to minimise the number of patient visits to hospital. Plans are in place to roll these out in the super seven Further Faster specialities, such as cardiology. Group sessions take place in many of those specialties with longer term conditions with cardio and pulmonary rehab being good examples together with hip and knee replacement patients on waiting lists	Partly

4. Support required		
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	The Trust has received funding for the Further Faster programme and has utilised this for overall programme management and supporting ongoing waiting list validation. The Trust is also making an application for additional resource for administering the additional validation required to meet the October 31st targets for patients waiting over 12 weeks.	Fully
Sign off		
Trust lead (name, job title and email address):		
Signed off by chair and chief executive (names, job titles and date signed off):		

Protecting and expanding elective capacity

Appendices

Appendix 1 – RTT Validation rates compared to pre-COVID rates

This is a comparison between 29th March 2020 (pre-covid) and 23rd August 2023 (this week) >36 weeks and >52 weeks waiting list positions showing the volume and percentage increasing significantly.

WEEKLY RTT VALIDATION COMPARISON - PRE-PANDEMIC VS AUGUST 2023

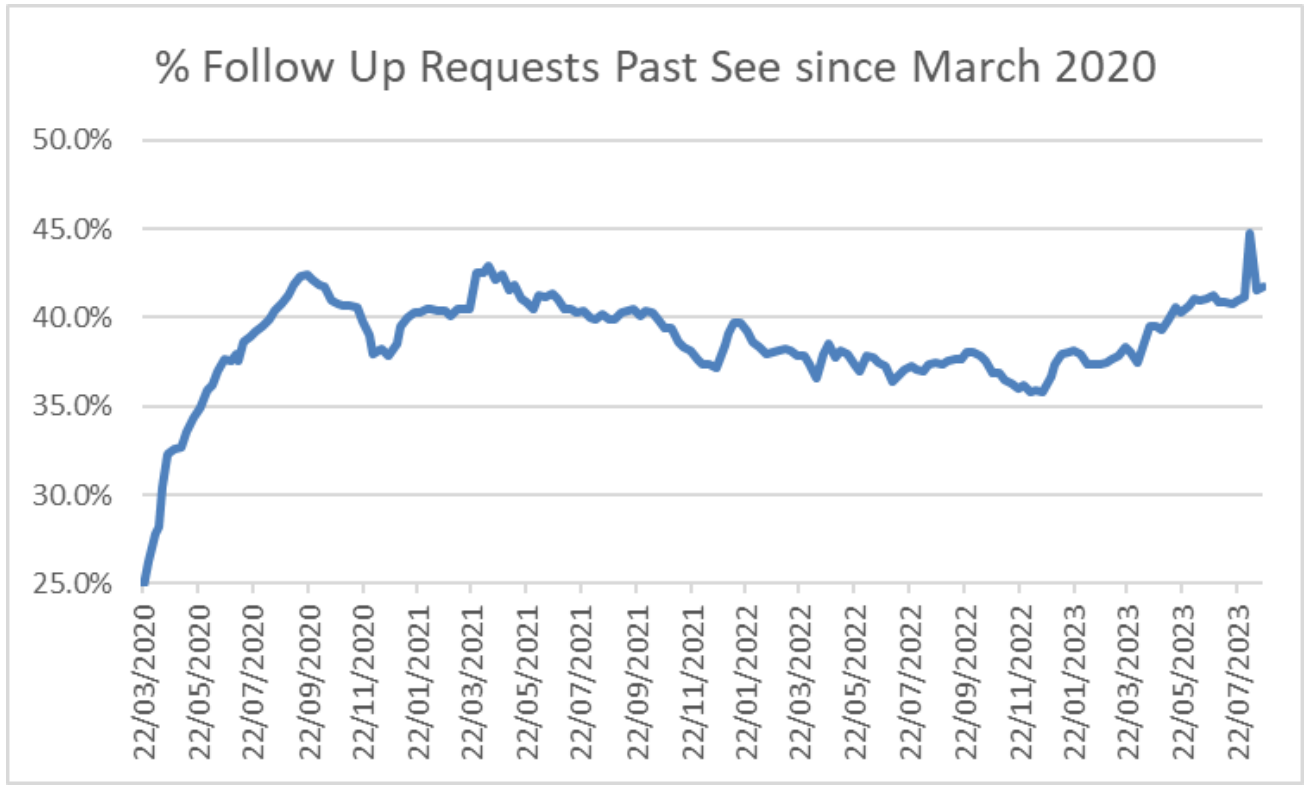
>= 36 weeks wait

Week ending date	29/03/2020	23/08/2023	*Difference*	*Variance*
Total Unvalidated Patients	496	5793	*5297*	*1068%*
Total Genuine Waiters	462	5665	*5203*	*1126%*
Total Validated Genuine Waiters	65	4901	*4836*	*7440%*
% Validated of Genuine Waiters	14%	87%	*72%*	*515%*

>= 52 weeks wait

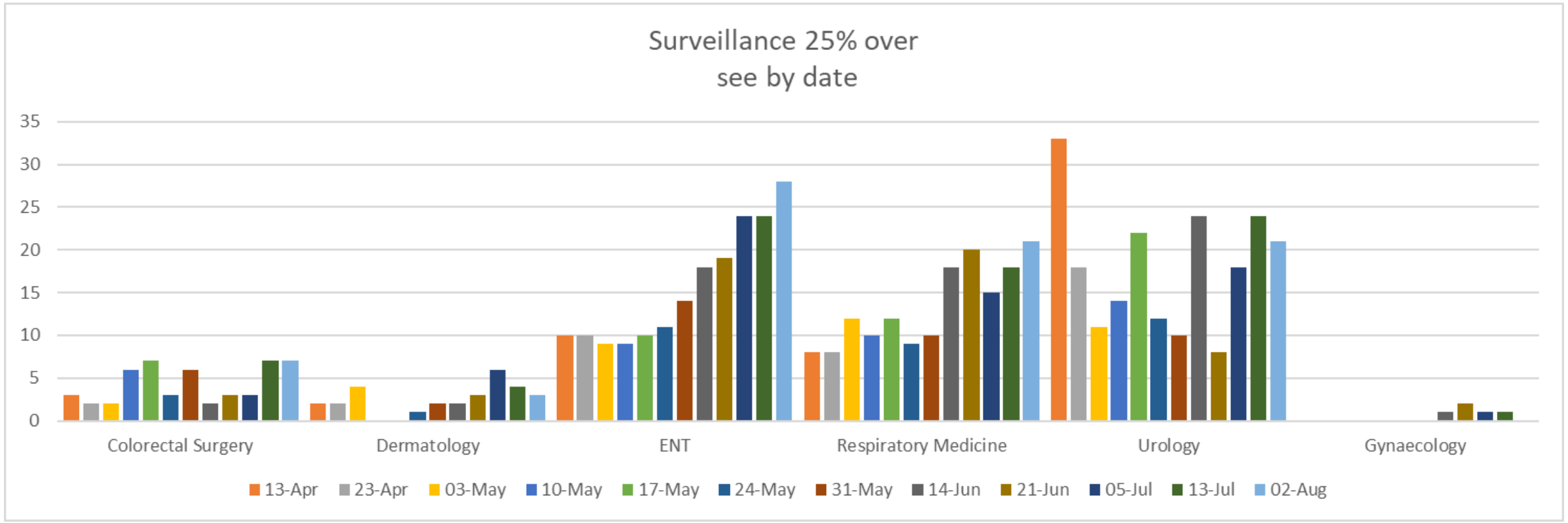
Week ending date	29/03/2020	23/08/2023	*Difference*	*Variance*
Total Unvalidated Patients	19	1999	*1980*	*10421%*
Total Genuine Waiters	5	1929	*1924*	*38480%*
Total Validated Genuine Waiters	5	1929	*1924*	*38480%*
% Validated of Genuine Waiters	100%	100%	*0%*	*0%*

Appendix 2 - Follow Up Requests past see by date

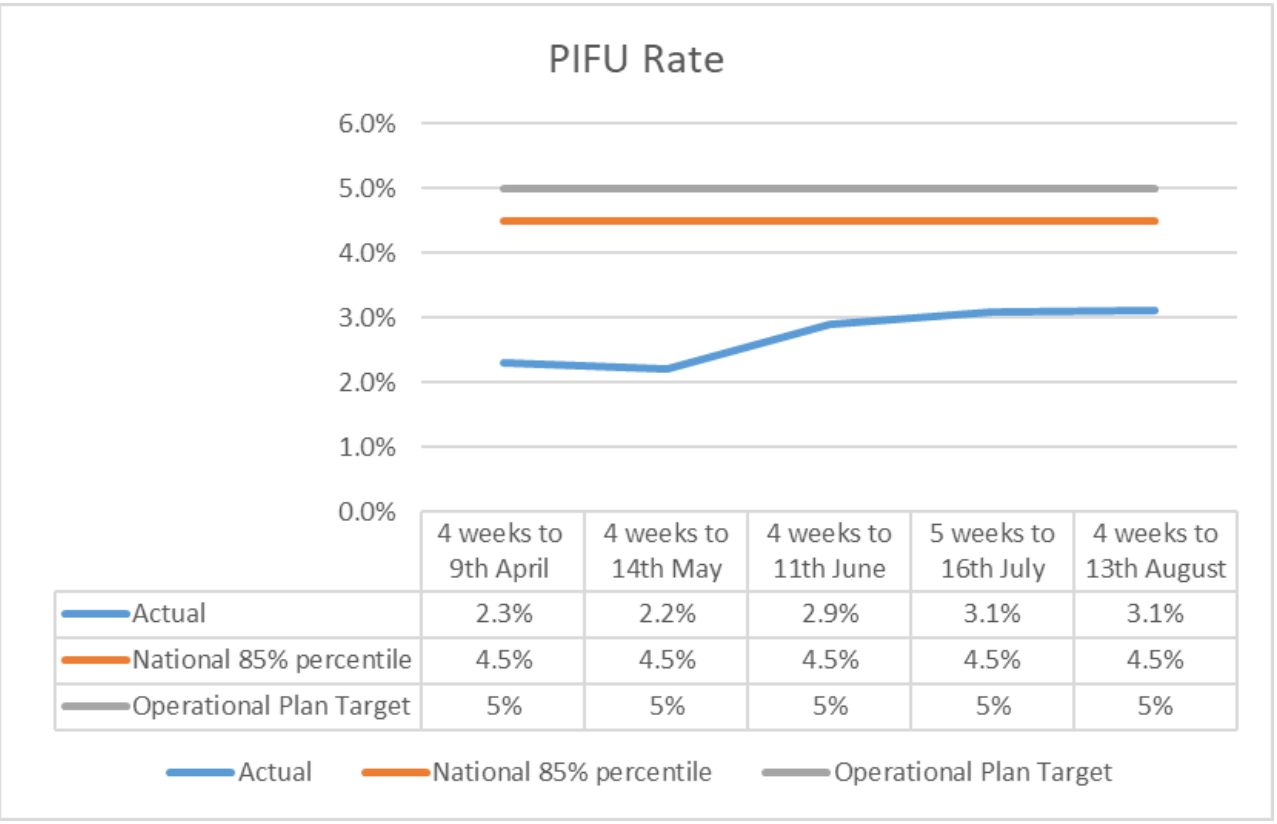


Specialty Name	Y	% Past See by Date
Orthodontics	332	85.6%
Epilepsy Nurse Led	266	84.7%
Audiology	1631	74.8%
Upper Gastrointestinal Surgery	163	70.0%
Parkinsons Disease Nurse Led	116	63.4%
Gastroenterology	1725	58.8%
Occupational Therapy Acute	104	57.8%
Gynaecology	895	53.8%
Cardiology	2543	51.1%
Podiatric Surgery	1616	47.9%
Neurology	413	46.9%
ENT	1124	46.4%
General Surgery	248	45.5%
Urology	1108	44.0%
Community Paediatrics	390	43.8%
Paediatrics	385	43.3%
Rheumatology	1910	42.4%
Grand Total	24572	41.7%
Respiratory Medicine	1927	41.5%
Endocrinology	466	37.1%
Trauma and Orthopaedics	1356	36.5%
Paediatric Allergy	103	36.0%
Diabetic Medicine	416	35.1%
Ophthalmology	2886	34.9%
Obstetrics	127	31.1%
Dietetics Acute	293	28.6%
Dermatology	542	22.7%
Paediatric Audiological Medicine	141	21.7%
Colorectal Surgery	115	19.0%

Appendix 3 Patient Surveillance



Appendix 4 – Outpatients PIFU



	4 weeks to 9th April	4 weeks to 14th May	4 weeks to 11th June	5 weeks to 16th July	4 weeks to 13th August
Actual	2.3%	2.2%	2.9%	3.1%	3.1%
National 85% percentile	4.5%	4.5%	4.5%	4.5%	4.5%
Operational Plan Target	5%	5%	5%	5%	5%

Speciality	Division	4 weeks to 9th April	4 weeks to 14th May	4 weeks to 11th June	5 weeks to 16th July	4 weeks to 13th August	Target (85th percentile) (update
Respiratory	Surgical	23.3%	10.3%	13.3%	19.3%	16.5%	4.1%
Oral Surgery	Surgical	4.5%	2.2%	1.1%	11.1%	6.4%	
Rheumatology	Medical	5.2%	7.0%	5.5%	7.5%	6.8%	6.4%
Paediatrics	Surgical	1.3%	9.7%	7.5%	6.4%	13.0%	5.2%
Dermatology	Medical	2.3%	6.6%	4.1%	5.4%	4.4%	5.6%
T&O	Surgical	6.5%	3.4%	6.5%	5.1%	7.1%	13.8%
Gastroenterology	Medical	1.3%	0.0%	3.1%	5.0%	1.7%	4.6%
Cardiology	Medical	7.0%	5.4%	0.6%	4.8%	3.0%	2.9%
Diabetic Medicine	Medical	0.0%	0.0%	2.6%	4.7%	3.1%	3.8%
Geriatric Medicine	Medical				4.3%	0.0%	
ENT	Surgical	1.0%	2.1%	6.5%	3.6%	3.9%	8.3%
Dietetics Acute	CSS				3.3%	5.4%	
Urology	Surgical	7.0%	1.7%	3.8%	3.0%	1.1%	3.7%
Gynaecology	Surgical	6.0%	4.5%	3.2%	3.0%	3.6%	5.2%
UGI	Surgical				2.4%	2.8%	
Podiatric Surgery	Surgical				2.1%	3.5%	
Breast Surgery	Surgical	3.0%	0.4%	0.7%	1.2%	2.8%	
Endocrinology	Medical				1.1%	2.1%	
Colorectal Surgery	Surgical	3.0%	1.3%	0.0%	0.7%	0.6%	
General Surgery	Surgical	3.0%	1.3%	0.5%	0.5%	0.6%	2.6%
Haematology	CSS	0.0%	0.0%	0.0%		0.2%	1.3%
Endocrinology	Medical	0.0%	0.0%			2.1%	2.1%
Grand Total		2.3%	2.2%	2.9%	3.1%	3.1%	4.5%

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

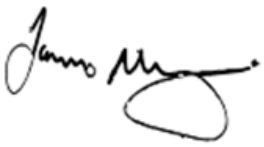
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Audit Committee Terms of Reference
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Finance Officer**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Audit Committee Terms of Reference

1. Purpose of the report

The purpose of the report is for the Trust Board to consider and approve the terms of reference for the Audit Committee.

2. Recommendation(s)

For the Trust Board to approve the terms of reference for the Audit Committee.

3. Executive Director Opinion[1]

In line with the Trust Standing Orders it is good practice for all terms of reference of committees of the Trust Board to be reviewed on an annual basis.

These terms of reference were approved by Audit Committee on 14 September 2023 and incorporate their suggested changes/amendments, highlighted within the document.

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

WYE VALLEY NHS TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE 2023/24

1. Purpose

1.1 The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance.

1.2 The Audit Committee is a Non-Executive Committee of the ~~Board~~ Trust Board~~of Directors~~ and has no executive powers, other than those duties and decisions delegated by the Board through the Scheme of Delegation.

1.3 The Audit Committee shall provide an independent and objective view on internal control, probity and embedded systems of assurance in line with Department of Health Guidance.

1.4 The Audit Committee will provide proactive oversight on the governance arrangements of the Trust and will not infringe on management's responsibility to deliver the arrangements.

2. Membership

2.1 The Committee will comprise three nominated Non-Executive Directors who shall be approved by the Board from amongst the Non-Executive Directors of the Trust and shall include a member with significant, recent and relevant financial experience.

2.2 Neither the Chair of the Trust or the Chief Executive Officer attends this Committee unless invited to do so by the Committee Chair.

2.3 The Chair of the Committee is a Non-Executive Director appointed by the Board of Directors. If the Chair is not present, then members present will agree which of the remaining Non-Executive Directors will chair the meeting.

2.4 The following will be in attendance:

- The Chief Finance Officer (as lead Executive Director);
- The Managing Director and Executive Directors are expected and will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.
- Internal and External Audit representatives.
- Local Counter Fraud Specialist (LCFS).

- Associate Director of Corporate Governance and Company Secretary (as secretary to the committee) whose duties will include:

    - Advising the Committee on pertinent areas relating to governance and risk management arrangements.
    - Supporting the Chief Executive as Accountable Officer on issues in relation to internal controls, governance and risk management particularly providing assurance on such systems through the drafting of the Annual Governance Statement.
    - The development of an annual programme of work for the Committee to approve.

- Executive Assistant, whose duties will include:

    - The development of each Audit Committee agenda based upon the annual programme of work for agreement with the Chief Finance Officer and the Committee Chair
    - Ensuring that the agenda, reports and corresponding minutes reflect confidential items.
    - Ensuring the collation & distribution of the Committee papers at least 5 working days in advance of the meeting.
    - Ensuring the minutes accurately reflect the business of the meeting & keeping an accurate record of matters arising and issues to be carried forward is maintained.
    - Ensuring that minutes and actions are circulated to the Chair for comments within 5 working days of the meeting and circulated to the other members for comments within 10 working days.
    - Keeping a record of matters arising and seeking updates on action points

2.5 In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the Chair's approval.

2.6 The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda.

2.7 Other Non-Executive Directors may attend the meeting at the invite of the Committee Chair or where a nominated Non-Executive Director has arranged for another Non-Executive Director to attend on their behalf.

2.8 The Audit Committee, supported by the Chief People Officer, will ensure that all members are suitably trained and have continuing appropriate training to enable them to be effective.

3. Quorum

3.1 A quorum shall be two Non-Executive members, to include the member with significant, recent and relevant financial experience/ Chair of the Committee. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

3.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. Frequency of Meetings

4.1 Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

4.2 At least once a year, but preferably routinely, the Committee shall meet privately with the External and Internal Auditors.

4.3 It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

5. Notice of Meetings

5.1 Meetings of the Audit Committee, other than those regularly scheduled as above, shall be summoned by the Secretary to the Audit Committee at the request of the Chair of the Audit Committee.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the Committee and any other person invited to attend, no later than 5 working days before the date of the meeting via AdminControl.

6. Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Duties

The duties of the Committee can be categorised as follows:

a. Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities that support the achievement of the organisation's objectives.

In particular, the Committee will: review:

- all risk and control related disclosure statements (i.e. the Annual Governance Statement, Accounting Policies~~, Quality Accounts~~), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

- review the procedures and seek assurance that the quality account presents accurate data and meets the reporting requirements as prescribed nationally;
- the underlying assurance processes that establish the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the Board Assurance Framework and the appropriateness of ~~the above~~ disclosure statements;
- procedures for:
  - ensuring compliance with relevant regulatory, legal and code of conduct requirements;
  - all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service;
  - monitoring compliance with Standing Orders and Standing Financial Instructions; and,
  - ensuring the accuracy of data in responding to disclosure statements.
- Schedules of losses and compensations and making recommendations to the Board;~~.~~
- Schedules of debtor/creditor balances greater than £5,000 and over 6 months; and,
- The annual financial statements prior to submission to the Board.

In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports, policies and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

b. Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive Officer and Board.

This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

- Annual review of the effectiveness of internal audit

c. External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, in line with the requirements of the 2014 Local Audit and Accountability Act and in accordance with any codes, rules and guidance issued by the National Audit Office and NHS Improvement.
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board, together with the appropriateness of management responses.
- review the procedures for the provision of non-audit services, ensuring the effectiveness of the process and the independence of the external auditors.
- Ensuring that the External Audit tenure of appointment conforms with ethical rules regarding rotation of key audit personnel and the provider as a whole.

The Committee shall ensure the cost effectiveness of External Audit.

d. Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health, Arm's Length Bodies or Regulators/Inspectors and professional bodies with responsibility for the performance of staff or functions.

In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and the Executive Risk Management committee.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will receive an assurance report on the process for the Quality Accounts prior to final approval by the Trust Board.

e. Suspension of Standing Orders

The Committee shall review every Board decision to suspend Standing Orders.

f. Management

The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Audit Committee will provide a clear expectation of professional competency and feedback on the Trust's Chief Finance Officer and senior financial management staff to the Chief Executive Officer and Workforce and Development Committee on request.

g. Financial Reporting

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

h. Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

8. Reporting Responsibilities

8.1 Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting.

8.2 The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

9. Review

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Trust Board for approval.

10. Approval

Date of approval: Approving Body: Board of Directors

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	**Proposed Board and Committee dates for 2024**
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Proposed Board and Committee dates for 2024

1. Purpose of the report

To provide the Board with the opportunity to review and agree the proposed Board and Committee dates for 2024.

2. Recommendation(s)

To note and agree the Board and Committee dates for 2024.

3. Executive Director Opinion[1]

These dates have been discussed and agreed with respective Committee chairs, with the exception of Charity Trustee.

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

NHS
Wye Valley
NHS Trust

WVT Board & Committee Dates 2024																		
2023	**NED's Pre-meet with Russell and Glen or Jane**		**Board Workshop**		**Board of Directors**		**Executive Risk Management**		**Charity Trustee**		**Audit**		**RemCo**		**Trust Management Board**		**Quality Committee**	
January		No Meeting		No Meeting		No Meeting	16th	1pm-2.30pm							5th/19th	1pm-3.00pm	25th	1.00pm-4.00pm
February - FG BOARD	***7th***	***8.30 - 9.30am***	***7th***	***9.30am-12pm***	***7th***	***1.30pm- 4.45 pm***	20th	1pm-2.30pm							2nd/16th	1pm-3.00pm	29th	1.00pm-4.00pm
March	7th	9 - 9.30am	7th	9.30am-12pm	7th	1pm- 4.00pm	19th	1pm-2.30pm	14th	1pm-2.00pm	14th	9am-12pm	14th	2pm-3.00pm	1st/15th	1pm-3.00pm	28th	1.00pm-4.00pm
April	4th	9 - 9.30am	4th	9.30am-12pm	4th	1pm- 4.00pm	16th	1pm-2.30pm							5th/19th	1pm-3.00pm	25th	1.00pm-4.00pm
May - FG BOARD	***1st***	***8.30 - 9.30am***	***1st***	***9.30am-12pm***	***1st***	***1.30pm- 4.45pm***	21st	1pm-2.30pm							3rd/17th	1pm-3.00pm	30th	1.00pm-4.00pm
June	6th	9 - 9.30am	6th	9.30 - 12pm	6th	1pm - 4.00pm	18th	1pm-2.30pm	13th	1pm-2.00pm	13th	9am-12pm	13th	2pm-3.00pm	7th/21st	1pm-3.00pm	27th	1.00pm-4.00pm
July EOY Board	4th	9 - 9.30am	4th	9.30am-12pm	4th	1pm- 4.00pm	16th	1pm-2.30pm	EOY MEETING						5th/19th	1pm-3.00pm	25th	1.00pm-4.00pm
August - FG BOARD	***7th***	***8.30 - 9.30am***	***7th***	***9.30am-12pm***	***7th***	***1.30pm- 4.45pm***	20th	1pm-2.30pm							2nd/16th	1pm-3.00pm	29th	1.00pm-4.00pm
September	5th	9 - 9.30am	5th	9.30am-12pm	5th	1pm- 4.00pm	17th	1pm-2.30pm	12th	1pm-2.00pm	12th	9am-12pm	12th	2pm-3.00pm	6th/20th	1pm-3.00pm	26th	1.00pm-4.00pm
October	3rd	9 - 9.30am	3rd	9.30am-12pm	3rd	1pm- 4.00pm	15th	1pm-2.30pm							4th/18th	1pm-3.00pm	31st	1.00pm-4.00pm
November - FG BOARD	***6th***	***8.30 - 9.30am***	***6th***	***9.30am-12pm***	***6th***	***1.30pm- 4.45pm***	19th	1pm-2.30pm							1st/15th	1pm-3.00pm	28th	1.00pm-4.00pm
December	5th	9 - 9.30am	5th	9.30am-12pm	5th	1pm- 4.00pm	17th	1pm-2.30pm	12th	1pm-2.00pm	12th	9am-12pm			6th/20th	1pm-3.00pm	19th	1.00pm-4.00pm

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Maternity Services Quarterly 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 a quarterly update in line with Trust, local and national reporting requirements for maternity services.

2. Recommendation(s)

Trust Board is asked to note the report covers June, July and August 2023. Quality Committee receive the quarterly exception report and further detail through submission of the Perinatal Quality Surveillance Model on a monthly basis.

3. Executive Director Opinion[1]

This report provides an overview of key activities during quarter 2. Board is asked to note:

- Robust management and review of serious incidents and other relevant cases
- Low number of complaints and concerns during the reporting period
- Improved vacancy position for midwifery posts
- Progress with compliance against the CNST 10 standards for year 5
- Requirement to resolve the triage space (work is due to commence shortly)

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

Maternity Services Trust Board Quarterly Report

Executive Summary

This report covers the governance activity of the Maternity Department for the period of June, July and August 2023.

This report addresses four key questions:

- **Are we safe and how do we know?**
- **What is new and different?**
- **What are we especially proud of?**
- **What are we worried about and what are we doing about it?**

The Trust Board is asked to receive this report for information and assurance. This also enables compliance with reporting standards set out in the Clinical Negligence Scheme for Trusts, Year 5 and the Ockenden Report 2022.

Are we safe and how do we know?

This section of the report will focus on the Maternity Quality Indicators that enable us to monitor quality and safety effectively.

Serious Incidents (SI's)
There were 2 cases graded as moderate during the reporting period.

The first case involved a baby that was unexpectedly admitted to SCBU following birth. The baby was subsequently discharged home with no ongoing care needs. Learning was identified relating to expediting birth when concerns with the fetal heart rate are identified during labour. Learning has been shared across the unit and further actions are tracked through the associated action plan.

The second case met the criteria to be reported to the Healthcare Safety Investigation Branch (HSIB) and was subsequently reported as a moderate incident on this basis. The incident involved a baby which required neonatal care in SCBU. An MDT identified no significant concerns with the care provided to the mother and baby.

Healthcare Safety Investigation Branch (HSIB)
There was 1 case referred to HSIB during the reporting period, which is listed under the Serious Incidents section above.

Mothers and babies: reducing risk through audits and confidential enquiries (MBRRACE)
Deaths are reported to MBRRACE using the identified criteria:

- Late fetal loss; that is a baby delivered between 22 and 23 weeks gestation
- Stillbirths; a baby delivered after 24 weeks gestation with no sign of life
- Neonatal deaths
- A live born baby at 20 weeks gestation or later or with a birthweight of 400g or more who died before 28 completed days after birth.
- Maternal deaths

During the report period there have been no cases reportable to MBRRACE.

Complaints and Concerns
We previously celebrated success in a reduction in the number of complaints received, and whilst the number per year is on a positive trajectory, there have been 4 complaints received over the reporting period. We are always disappointed to receive a complaint, but we are very grateful to the women and their families for coming forward to share their experiences to allow us to learn and improve. Through application of learning and a series of service improvements, we hope to reduce further over the remained of the year.

The first complaint was received due to a delay in the mother receiving debrief following her birth. This was due to staff sickness and the complaint was promptly addressed, and debrief provided by an obstetric consultant and the senior midwifery management team.

The second was a comeback in response to an initial complaint letter that had been sent. The complainant required more clarity around 1 aspect of the concerns she had raised. This related to her gynaecology care post birth.

The third complaint was made due to staff attitude during a mother's experience of induction of labour and related to an individual midwife. This has been addressed with the midwife involved.

The fourth complaint related to a case where a mother had complications with her pregnancy.

There were no concerns received during the reporting period.

The ratio of Concerns:Complaints continues to show that we are top heavy on complaints with many women possibly seeking a debrief opportunity through the complaints process. We continue to try and address concerns early, prior to women returning home and are working towards a relaunch of a 'Birth Afterthoughts' service.

Compliments
There were a total of 57 compliments captured across the reporting period. The Friends and Family Test via text messaging has now launched. Launched at the end of July, the data for August demonstrates a response rate of 26% which is above Trust average. We will continue to promote the test and encourage service user engagement. The results also showed 94% of respondents would recommend the maternity service at WVT to family and friends. We are extremely proud of this and will provide more detailed and contextual data in subsequent reports.

What is new and what is different?

Insight Visit
The next insight visit is taking place on the 18th October where the Trust will welcome visitors from the Regional Perinatal Team and the LMNS. We will report on the findings in the next quarterly report.

Perinatal Mortality Review Tool (PMRT)
The Perinatal Mortality Review Tool (PMRT) was introduced to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. CNST requires reporting of cases to Trust Board on a quarterly basis. All case reviews are carried out as a joint MDT with our colleagues at Worcester Acute Hospital Trust in accordance with national requirements.

There have been no cases within Wye Valley Trust within the reporting period, however information is now available for a case reported in Q1 23/24. The case related to an intrauterine death at 25 weeks. Learning identified closer adherence to the Trust Fetal Movements Guideline needs to be maintained. The care provided through pregnancy and up to the time of birth was graded as a B, this means that issues were identified, however they did not impact on the outcome for the mother and baby. Care following birth was graded as an A, this means no care issues were identified.

Service User involvement
Quarterly Maternity Voices Partnership (MVP) meetings continue. Staff and service user representation is generally good, but awareness needs to be raised within our BAME and vulnerable service users groups. Work is underway to raise the profile of these meetings within those groups. The service has worked closely with the MVP to develop a 'Roadshow' where the MVP meetings now take place across the County, including in more difficult to reach areas. The MVP has received a funding boost for the coming year which will be part used to improve the groups represented at MVP. Obstetric consultants now attend the meetings at the request of the MVP service users.

The team completed the co-production training and reported positively on the experience of those in attendance.

Workforce Review – Maternity Continuity of Carer

The workforce review has been delayed due to a number of competing priorities in the service. There is a commitment to complete the review by November. This will be presented to Trust Board.

What are we especially proud?

Bereavement
Our Bereavement Midwife developed a relationship with Petals, a bespoke counselling and psychological support service for bereaved families. This was funded from charitable funds for the maternity bereavement service for one year and so far has supported 5 families. The support has been well received by the families and the service is keen to fund this again next year. The bereavement midwife have led on a raffle to top up the fund in the born sleeping appeal. This has been registered appropriately with the local authority and is expected to provide great benefit to the charitable fund.

The bereavement midwife has also developed a National Bereavement Midwives Network. This will provide great support to those in this challenging role and we are certain it will promote growth of new ideas and shared learning to bring benefit to the local service. She recently presented on this at a national event and we are very proud of her achievement.

Team Work
The maternity, obstetric, paediatric and theatre teams have continued to work extremely hard during the reporting period. The team continue to pull together and support each other, however we are pleased to report that the midwifery rosters are improving with a much improved vacancy rate, and a much improved agency and bank requirement.

Workforce/Staffing
Board are invited to note the prominence of this section within the 'What are we especially proud of section', where it will remain unless the situation changes. During the months of September and October we are welcoming 12 newly qualified midwives to our Academy. This will see our vacancy rate reduce to 4wte which includes pending retirements and expected maternity leave. We are currently out to advert and are expecting to fill all 4 vacancies with midwives due to qualify in February. We will of course be delighted if we are able to recruit experienced midwives as part of the recruitment process.

Caring for you

We are very proud to share that we signed up to the RCM Caring for You Charter on 5th May 2023 – International Day of the Midwife. This is our commitment to care for midwives and support staff to facilitate them to care for women and their families. We have a half day study day that is being launched in line with this and the first day commences in November. The agenda includes:

- Team building
- Insights work
- Culture influence
- Professional Midwifery Advocate sessions
- Building resilience

We are grateful to our team and the HR service who are supporting this work and look forward to reporting the feedback from staff who have participated.

What are we worried about what are we doing about it?

CNST

The MDT have now completed an initial benchmarking exercise to review our current position against the newly published CNST year 5 requirements. The team are confident that safety actions 1, 2, 4, 5, 7 and 10 are achievable will little challenge. Safety actions 3 (Transitional Care), 6 (Saving Babies Lives version 3 implementation), 8 (MDT training) and 9 (safety champions) will require close oversight, further work and review due to an increased expectation on Trusts for year 5.

Of those that remain a challenge, safety action 6 'Saving Babies Lives V3' has many changes and requires many hours of work to undertake and review the evidence. The LMNS are visiting the unit on 4th October to support the team with the gap analysis and to observe compliance with evidence to date. A new element has been added to V3 relating to diabetes and the service is required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% in each individual element. Compliance with this safety action is due by 1st February 2024 and we will report progress in the next quarterly report.

To achieve compliance, there are a number of items that need to be received by Trust Board, either for information or for approval by the 1st December. These include:

Table 1:

Safety Action	Item to be presented	Purpose
3	An action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.	Approval
4	Action plans relating to staffing mitigation to meet compliance across all staffing groups	Progress oversight
5	Midwifery staffing report	Approval
6	Progress report relating to Saving Babies Lives	Progress Oversight
8	Local training plan to meet the Core Competency Framework	Approval

Training

Multi-Disciplinary training continues and compliance for the reporting period is noted to remain below the 90% standard expected by CNST. There is a clear recovery plan to improve the training compliance, where 90% compliance is required by 1st December to achieve CNST.

Table 2:

Staff Group	PROMPT Compliance	CTG Compliance	NLS Compliance
Obstetric Consultants	July 89% August 89%	70%	90%
Obstetric Registrars	July 89% August 89%	100%	83.3%
Midwives	July 94% August 89%	88.4%	85.3%
Anaesthetics	87.5%	N/A	N/A

We are required to have our 3 year Training Needs Analysis signed off at Trust Board as per table 1 in the CNST section of this report.

CQC Report

Publication of the CQC report is due 4th October and we hope to be able to share the report with Board on the 5th. An action plan will be presented to Trust Board at a future meeting.

Maternity Triage / Clinical Space

We continue to experience issues with the significant lack of clinical space within maternity. The lack of clinical space is currently impacting maternity triage, and this remains on the risk register – it is our highest scoring risk at a 20 (despite mitigation actions). It is currently affecting patient experience and staff satisfaction/morale. The work has been placed on the capital list and we continue to work with our colleagues across estates. We will update further as this work progresses.

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Patient Experience Report
Status of report:	**☐Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on the progress in key areas for improving patient experience, supporting the delivering of the Trust quality priority for 2023-24.

2. Recommendation(s)

The Board is asked to note;

- The Trust saw an increase in complaints during June and July. A thematic analysis and recommendations are detailed in the report.
- The Trust continues to receive above national average FFT response rates through the text messaging service.
- Improvements to the Envoy (FFT) reporting system identified by the Integrated Care Division.
- Rapid actions developed to improve the management of patient property in inpatient areas.
- Key improvements demonstrated in previous areas of concern on the National Inpatient survey

3. Executive Director Opinion[1]

The Trust is seeing increased positive feedback from patients and service users, however the negative feedback requires focus and attention to improve patient experience. The Patient Experience Committee continues to have good representation from all divisions and the appetite to improve patient experience is evident at meetings.

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

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.

Headlines

- The Trust saw an increase in complaints during June and July. A thematic analysis and recommendations are detailed in the report.
- The Trust continues to receive above national average FFT response rates through the text messaging service.
- Improvements to the Envoy (FFT) reporting system identified by the Integrated Care Division.
- Rapid actions developed to improve the management of patient property in inpatient areas.
- Key improvements demonstrated in previous areas of concern on the National Inpatient survey

Friends and Family Test (FFT)

The Trust are now using a text messaging services to receive feedback in line with the national Friends and Family test programme.

FFT text message service rollout

The text messaging service is now live in the following services;

- All inpatient areas (inc. community beds)
- All outpatient departments (last report only Oxford Suite rolled out)
- Maternity (last report not live)

Outstanding are the following services below;

- Community Services beyond community beds (next area to roll out)
- Paediatrics (initial meeting held)

In addition, some services have expressed an interest to continue to use QR codes to collate feedback. The FFT lead is looking at how this can be done by linking the QR codes to FORMIC (audit data collection system) to streamline data collection for local and national reporting.

The team are also exploring how InPhase (incident reporting system) can be used to track 'you said we did' actions based on FFT feedback.

FFT Results

Below is the FFT results data from June 2023- August 2023

Headlines

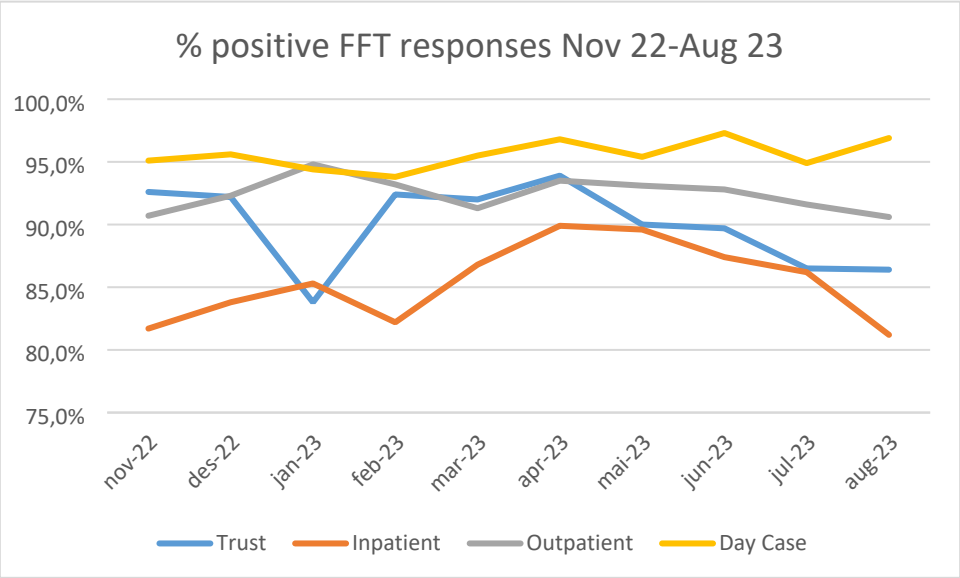
Between 1st June 2023- 31st August 2023;

- The Trust has sent 31,125 messages for feedback.
- 7597 responses were received (21% response rate overall)
- 87.6% of our patients have given positive feedback.
- 17.9% patients gave further comments in regards to how they scored their experience.

Quantitative Data

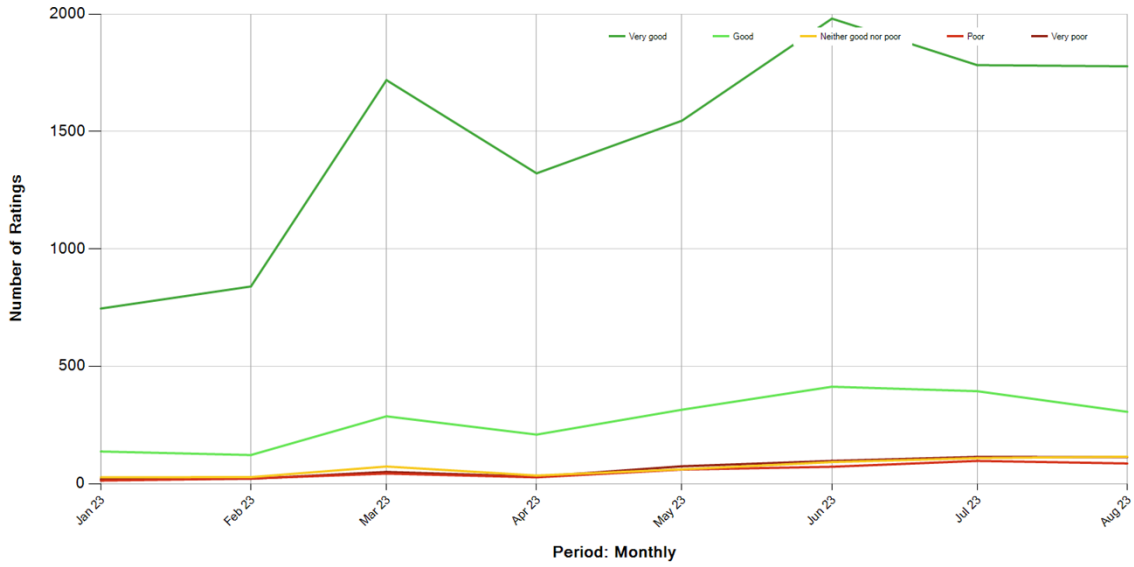
Our latest results in the table and chart below, are the percentage of responses that scored their experience positively (recommendation rate).

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Trust	92.6%	92.2%	83.8%	92.4%	92.0%	93.9%	90.0%	89.7%	86.5%	86.4%
Inpt	81.7%	83.8%	85.3%	82.2%	86.8%	89.9%	89.6%	87.4%	86.2%	81.2%
OP	90.7%	92.3%	94.8%	93.2%	91.3%	93.5%	93.1%	92.8%	91.6%	90.6%
Day case	95.1%	95.6%	94.4%	93.8%	95.5%	96.8%	95.4%	97.3%	94.9%	96.9%



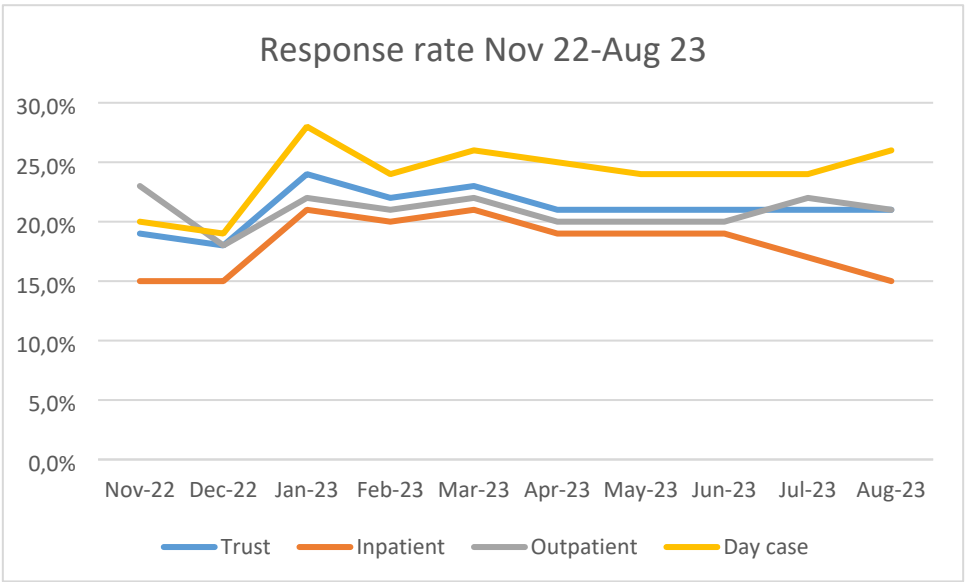
Overall, we continue to see the highest satisfaction ratings in Day Case, followed by outpatients with the lowest ratings we receive overall seen in inpatient areas.

The chart below shows the actual response received by patients and overwhelmingly the most popular response is ‘very good’ month on month.



Since moving to text messages, the Trust overall response rate is 21% with a breakdown by service type shown in the table and chart below.

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Trust	19%	18%	24%	22%	23%	21%	21%	21%	21%	21%
Inpatient	15%	15%	21%	20%	21%	19%	19%	19%	17%	15%
Outpatient	23%	18%	22%	21%	22%	20%	20%	20%	22%	21%
Day case	20%	19%	28%	24%	26%	25%	24%	24%	24%	26%



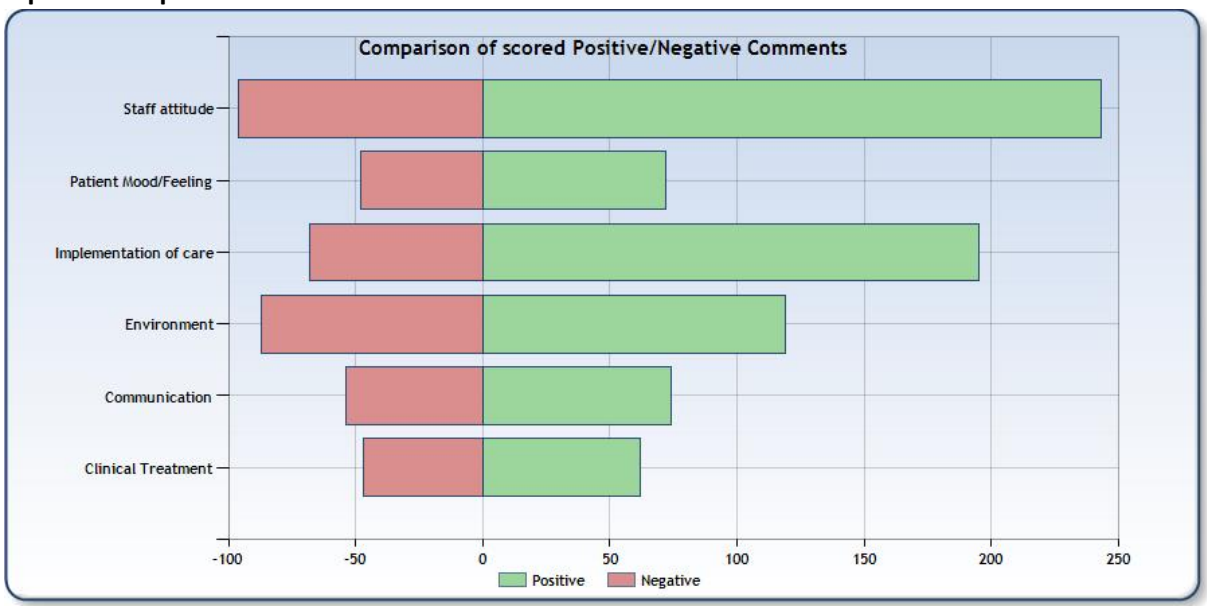
The national average response rate is 20%. We are now receiving responses comparable to this figure overall and in some areas exceeding this.

Qualitative Feedback

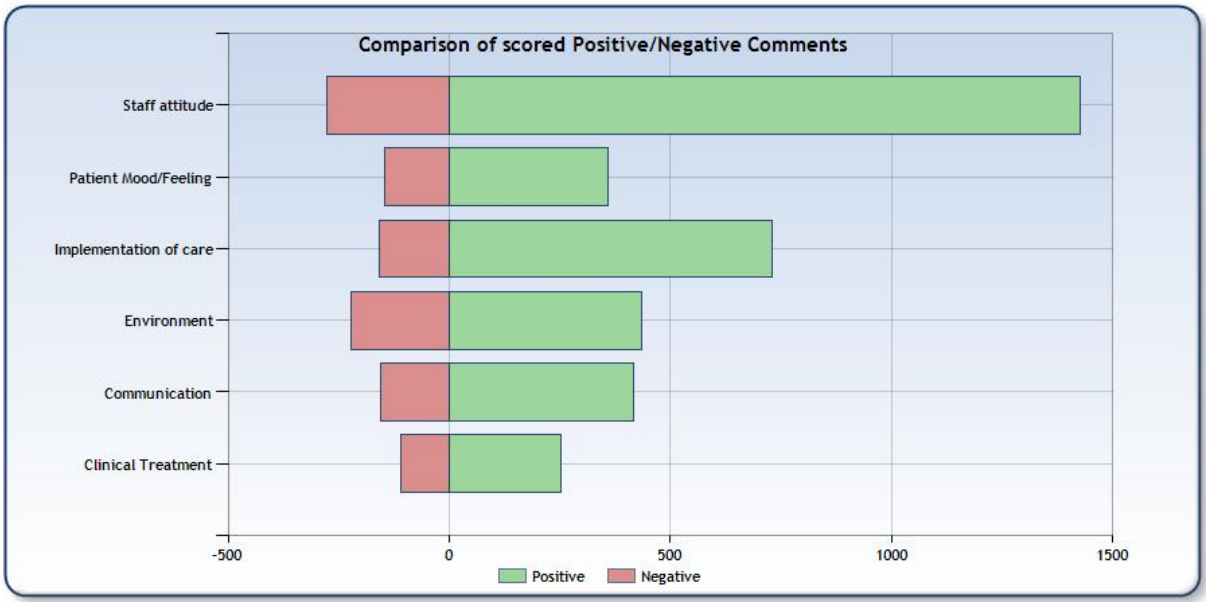
After patients have answered the initial question they are asked for comments. The free text comments message provides a wealth of qualitative data. The Envoy systems allows themes to be identified and categorises the qualitative feedback thematically and by the negative or positive nature of the comment.

The charts below show the top 6 themes broken down by inpatient and outpatient responses.

Inpatient responses



Outpatient responses



Overall outpatient areas have the most positive feedback. However in both inpatient and outpatient areas, for each theme, the positive feedback outweighs the negative.

This quarter when the comments were reviewed for the Trust, staff attitude scored highest for positive feedback with the words ‘friendly’ and ‘helpful’ continuing to be the most used.

The most frequently mentioned negative feedback for this quarter was appointment, with patients reporting 'the appointment was late', or 'there was a long wait'.

Divisions are in the process of undertaking the same analysis of this data and identify areas of good practice and areas for improvement. Divisions are presenting at Patient Experience Committee (PEC) throughout Q3, with a view to regular reporting throughout the year being implemented.

In September, the Integrated Care Division presented their data for community hospitals. Despite an overall response rate of 21% for the Trust, the response rate is 5%. This was discussed at PEC and it was established, 49% of text messages failed to send as the patient did not have a mobile phone number recorded on MAXIMS. It is not currently known whether this is because the patient does not have a mobile phone or that the number is not documented.

The division are working with the FFT lead to establish how the response rate can be improved. A secondary FFT methodology is being looked into whereby QR codes are used during the inpatient stay, supported by staff or volunteers to complete the survey. The QR codes will be linked to FORMIC so the data can be managed centrally and still contribute to the national reporting system alongside the text messaging responses. As the division are seeking to improve their response rate they will be offered the option to trial the new methodology.

Community hospital staff have fully engaged with using Envoy to review their FFT responses. With such good engagement it has also provided the opportunity to critique the functionality of the system. Some elements of the automated reporting are not fit fir purpose including;

- Feedback that mentions acute stay in response to FFT question about community stay (patient commenting on whole inpatient stay) and no way of filtering this to exclude acute feedback in community reporting
- The automated 'you said we did' posters only allow for 3 comments to be added. This limits the feedback shared or requires time to make multiple posters.

The FFT lead will work with Envoy to understand if these issues can be rectified.

Surveys

Since last reporting the following annual survey results have been published;

- National Inpatient survey
- National Urgent and Emergency Care survey
- National Cancer Patient Experience survey

A summary of the results is detailed in this report.

National Inpatient survey

Headlines

The Trust had a 47% response rate to the survey, above the national average response rate (40%). Overall the Trust scored 'about the same' as other Trusts and was not an outlier in any area of the survey.

Of the comparative questions the Trust received;

- improved scores in 50% of questions
- 26% scored the same as the previous year
- 24% received a worse score than the previous year.

The Trust has seen improvement in areas where in recent years we have not made progress;

- **Discharge**- supporting patients to know what happens when they are discharged, understanding what to do if their conditions changes, ensuring they have additional equipment or adjustments to their home to support them on discharge and support from other services if needed. This demonstrates an improvement in regards to communication and information on discharge.
- **Doctors**- the survey notes improved scores in doctor to patient communication and patients having trust and confidence in the doctor treating them.
- **Nurses**- the survey notes improved scores in nurse to patient communication and patients having trust and confidence in the nurse caring for theming them.
- **Feedback**- there was a significant improvement in the score received for patients feeling they were able to give feedback about the quality of their care. Whilst still a low score (0.9 improved from 0.5), it is promising to see that the efforts made in the last 12 months might have made a difference to patients.
- **Disturbance at night**- overall the survey shows improvement in all aspects of disturbing patients at night (staff, other patients and lighting).

The survey revealed some concerns, which need to be considered for improvement;

- **Communication**- before/ after an operation or procedure.
- **Hydration-** patients getting enough to drink during their stay
- **Discharge-** getting medicines on discharge and being given enough notice when leaving hospital.

The Trust scored 'much worse' in one questions; Rate the quality of the hospital food. This is an area where the Trust has scored poorly year on year. However, the other questions in relation to nutrition in the survey have improved; meeting dietary requirements, providing support at meal times and getting food outside of meal times. In addition, the local surveys conducted by the Estates team rate the hospital food positively. The Trust also received positive feedback in the PLACE audit results earlier this year.

Next steps

The results were discussed at PEC in September, which generated a positive and engaged discussion. The divisions alongside the patient experience team will now analyse the qualitative feedback to understand the reasons behind the scores and formulate meaningful improvement by triangulating this with FFT feedback.

The volunteer supported survey will be rolled out in October to capture views of the cohort of patients who might receive the 2023 survey. A plan to roll out this out year round is being developed and will be overseen by PEC.

National Urgent and Emergency Care survey

The results of the survey were presented at Quality Committee in September. The following context was provided in relation to the operational changes in the department over time.

As can be seen in the table below the department attendances, length of stay and time to admission have increased year on year and will undoubtedly impact on survey feedback.

	09/2018	09/2019	09/2020	09/2021	09/2022*
Average No. attendance	5275	5906	5259	5676	5685
Average Length of Stay	3.59	3.48	4.07	5.47	7.18
Average time to be seen	1.39	1.41	1.24	1.58	1.46
Average time to admission decision	4.02	3.55	3.29	4.46	6.05
Complaints 2018 -2022	2	8	7	14	15

*Month to date (as of 21st September 2023)

In all areas of this report, the Trust scored about the same as other Trusts. A detailed breakdown of the results was presented at Quality Committee and the overarching themes identified for improvement were; leadership, communication and capacity vs. demand.

An action plan has been developed to address the specific issues identified for the five areas where the Trust scored poorly.

ACTION POINT:	Recommendation	Action to be completed	Person responsible for action	Proposed Completion date	Evidence of Monitoring
Section 3. Drs and Nurses Q.10 Was there enough opportunity for staff to speak to family members, friend or carer?	Ensure that patients and family members are aware to ask for further information	Review current departmental signage Consistent completion of senior nurse care review	Band 7 Sisters/Acute Floor Matron	Completed October 2023	Complaints/ Concerns FFT results Audit of completion of senior nurse care R/V
Q.13 Did you have enough time to discuss your condition with the doctor or nurse?	Review nursing and medical models to ensure staffing capacity meets demand	Staffing workforce review undertaken Review current nursing roles	ACNO/Matron ACOO/GM Matron	Completed	Complaints/ Concerns FFT results
Section 4. care & Treatment Q. 23 Were you given enough privacy when being examined or treated ?	Quiet space identified in majors ED. Protect assessment cubicles in majors	Mini lab to become fully equipped triage space/quiet room. CN completed to remove sink and work surface	Acute Floor general manager	December 2023	Complaints/ Concerns FFT results
Section 7. Leaving ED q.38 did staff tell you about medication side effects to watch out for	All staff to be aware of their responsibilities when discharging patients	Review SOP in the department regarding discharge process and reissue to all staff Pharmacy to deliver bite size sessions to staff & clinical induction Action on departmental service improvement plan	Band 7 Sisters/Acute Floor Matron Pharmacist Beth Morris	November 2023	Complaints/ Concerns FFT results
q.39 Did a member of staff tell you about symptoms to	All staff to be aware of their responsibilities when discharging patients	Review SOP in the department regarding discharge and circulate	Band 7 Sisters	November 2023	Complaints/ Concerns FFT results

13 140

National Cancer Patient Experience survey

The survey encompasses all aspects of patient care and treatment from diagnosis to discharge. The survey identified two areas of above expected scores and an upward trend over a three year period; patient was told about their diagnosis in an appropriate place and patient has had a review of cancer care by their GP.

There were five areas where scores were below the expected and show a downward trend over a three year period. These areas have action plans developed for improvement.

Q17	Patient had a main point of contact within the care team.	• Urology to review practice of 'named nurse'. • Haematology to review.
Q26	Care team reviewed the patient's care plan with them to ensure it was up to date.	• Haematology alerted and team to review.
Q41(3)	Beforehand patient completely had enough understandable information about radiotherapy.	• Radiotherapy – continue to audit, i.e. switch to online info, link to teams. • RT to build stronger links with MRU Information Centre. • Urology – holding a review with Radiotherapy; EBRT info and timeliness of information.
Q45	Patient was always offered practical advice on dealing with any immediate side effects from treatment.	• Haematology recognise discussion re: side effects needs to be repeated throughout care pathway by MDT. Amore settled team and recruitment to ACP posts should assist. • Urology to review. • Info Centre to consider any barriers related to age re: how support offered.
Q58	Cancer research opportunities were discussed with patient.	• Research – ongoing monitoring re: capacity to take on research.

Complaints

This section of the report provides;

- Performance data update
- Thematic analysis of complaints received in June and July 2023.

Complaints data

KPI	Standard	April 23	May 23	June 23	July 23	August 23
Number of complaints	2022/23 (253)	21	23	50	41	24
Complaints resolved in timeframe	90%	54%	50%	34%	43%	33%

During June and July the Trust saw a significant increase in complaints, with total complaints in the first 5 months equating to 46% of total complaints in the previous year. A thematic analysis of complaints from June and July was undertaken to establish any trends in complaints.

Complaint response times

The Trust saw an improvement in response times in March 23, ending the financial year with a 73% response rate for the month. However, since March there has been a downward trend in response times. There continues to be variation in how complaints are managed within divisions and this impacts the response times.

A focus on response times and best practice will be prioritised at PEC in Q3.

Thematic analysis- complaints June and July 2023

Please note figures below include total contacts received therefore includes comebacks and complaints that may have subsequently been downgraded. However all contacts have been considered for the thematic analysis as the feedback is important.

Total complaints for each division during June and July are shown in the table below.

Division	June	July	Total
Corporate	2		2
Clinical Support	2	3	5
Integrated Care	0	1	1
Medicine	25	17	42
Surgery	21	20	41
TOTAL	**50**	**41**	**91**

The table below shows the hotspot areas by directorate.

Division	Directorate	June	July	Total
Corporate	Corporate	2	0	2
Clinical Support	Diagnostics Services	1	0	1
	Patient Access	1	0	1
	Cancer Services	0	3	3
Integrated Care	Acute & Countywide	0	1	1
Medicine	Acute and Emergency Medicine	18	4	22
	Ambulatory & Frailty	4	6	10
	Medicine	3	7	10
Surgery	Head, Neck & Orthopaedics	6	7	13
	Surgical Specialties	5	1	6
	Theatres and Critical Care	3	3	6
	Women's and Children's	7	9	16
TOTAL	**50**	**41**	**91**	

The table below details the themes emerging from these complaints. The themes relates to specific services; Emergency Department, Obs/ Gynae and Orthodontics.

Directorate	**Total Jun + Jul**	**Themes**
Overarching themes		A large number of these complaints have been escalated as we have not responded or not responded quickly enough to concerns.
Acute and Emergency Medicine	22	All ED complaints except 3 (1 AMU, 1 ED and AMU, 1 ED and CCU) • Pain management- delayed/ lack of (during time in dept and discharge without pain relief). • Lack of information on discharge for ongoing care or treatment • Staff attitudes- lack of compassion and kindness, overhearing staff talking about patients/ other staff members in a derogatory way • Time spent in the department, not getting a bed • Loss of property • Treatment and care of patients at end of life or known palliative patients presenting to ED.
Women's and Children's	16	Complaints span Paediatrics, School Nursing, Gynaecology and Obstetrics Themes emerging from Obstetrics/ Gynaecology • Poor experience of care when having/ had a miscarriage • Environment- shared waiting room with pregnant women and TV showing baby related adverts. Women with fertility issues/ having miscarriages sharing that space • Staff attitude (consultants and midwives)
Head, Neck and Orthopaedics	13	Majority relate to the Orthodontic service; access to the service/ delay in treatment.

The issues in the Orthodontics service are known and active management of the issues is in place. Whilst the complaints predominantly relate to delays, cancelled appointments and overall waiting times, there is a theme regarding psychological impact the lack of treatment/ no plan is having on patients. The patient cohort predominantly being children and young adults.

The themes were detailed at PEC in August with a request that divisions consider these in more detail and develop remedial action plans to address. This will be monitored at PEC and consideration given to review at F&PE meetings. The complaints team will maintain tracking on complaints for ED and Obstetrics/ Gynaecology to identify if these issues are isolated to June and July or a continuing issue.

An update on actions taken and continue monitoring of the thematic issues will be provided in the next quarterly report.

Improvements

The PEC identified an emerging issue of increasing frequency of the loss of patient property. It was recognised the Patient Property Policy was out of date and did not reflect the current practice of documenting and securing property since the introduction of the digital nurse noting system. Updating the policy is a medium term action and a priority for the Patient Experience Manager. However discussion at PEC established that all areas are managing patient property differently. A working group has been convened to identify any immediate actions that can be taken to mitigate the risk of loss of patient property. The group met for the first time on 19th September. There was excellent engagement for all areas and a shared commitment to improving current processes. The immediate actions were agreed and included;

- Re-introduction of the patient property disclaimer (paper) form in all inpatient areas. Some areas still use a paper form, others document in the notes and the tick box on the nurse noting system is not consistently used.
- Re-introduction of a disclaimer poster above the patient bed. This was previously attached to the bedside table/ cabinet but this made them problematic to clean and did not meet IPC standards for cleanliness.
- Production of a patient leaflet outlining how property can be secured in hospital and encouraging valuables to be sent home if not needed in hospital.

Conclusion

The Trust is seeing increased positive feedback from patients and service users, however the negative feedback requires focus and attention to improve patient experience. The Patient Experience Committee continues to have good representation from all divisions and the appetite to improve patient experience is evident at meetings.

In order to maintain this focus, there will be increased scrutiny and oversight of improvement action plans.

In the next quarter, there will be a focus on management of concerns and identifying barriers to timely responses and resolution of concerns with a review of how concerns are being managed across the Trust.

Report to:	**Public Board**
Date of Meeting:	**05/07/2023**
Title of Report:	Infection Prevention Annual Report 2022/23
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Direct
Lead Executive Director:	**Chief Nursing Officer**
Author:	Laura Weston, Lead Infection Prevention Nurse
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

This report summarises the key infection prevention and control (IPC) initiatives and activities of Wye Valley NHS Trust (WVT) from the 1st April 2022 to 31st March 2023. In addition, this report reports on progress against the IPC annual programme for 2022/23

2. Recommendation(s)

Board is asked to receive the report and pursue any key lines of enquiry.

3. Executive Director Opinion[1]

This annual report covers the period 1st April 2022 to 31st March 2023 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022). Reporting against these criteria is deemed best practice. Board is asked to note the following highlights from the annual report:

- Reported below the standard contract level of cases for E.coli bactaermias and Clostridioide difficile infections. Zero Trust attributed Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia reported
- The Trust did not achieve the externally set objectives of reductions in Gram negative bacteraemia infections Klebsiella species (Klebsiella spp.) & Pseudomonas aeruginosa. All bactaermias have been reviewed to identify areas for learning and improvement
- National Standards of Healthcare Cleanliness 2021 (NHS 2021) implemented across the organisation. An additional 1.0 wte Senior Infection Prevention Nurse was recruited into the team to support the implementation and embedding of the standards
- The trust has been receiving intensive support from NHSI for Infection Prevention and Control following an inspection during October 2022, a follow up inspection is planned for November 2023
- Improvements noted across all domains in the annual PLACE inspections
- Emerging infections Monkeypox and measles required a review of current practices and pathways. Wye Valley Trust and the Infection Prevention Service worked collaboratively with the ICS and local providers to ensure all required measures were in place.
- There were 73 infection outbreaks reported during the year. These all meet the national criteria set for declaring outbreaks. This included 60 outbreaks due to COVID-19, 5 due to confirmed or suspected norovirus infection and 8 outbreaks of Influenza.

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

4. Please tick box for the Trust's 2023/24 Objectives the report relates to:	
Quality Improvement ☒ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes*** ☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)*** ☐ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care*** ***Digital*** ☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy*** ☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways*** ***Productivity*** ☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations*** ☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	***Sustainability*** ☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff*** ☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process*** ***Workforce*** ☒ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☐ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

NHS
Wye Valley
NHS Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2022/23

Contents

Executive Summary

This report summarises the key infection prevention and control (IPC) initiatives and activities of Wye Valley NHS Trust (WVT) from the 1st April 2022 to 31st March 2023. In addition this report reports on progress against the IPC annual programme for 2022-23.

The year has continued to be dominated by the COVID-19 pandemic, and our annual report reflects this. Our focus on hand hygiene, cleanliness and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care from us. Some of our programmes of work had to be paused in order to ensure we focused all the resources needed to respond to the demands of the pandemic, especially between October 2022 and March 2023.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas. The Quality Committee continued to scrutinise our infection prevention progress at quarterly intervals on behalf of the Board throughout 2022-23.

Section 1: Key Outcomes of 2022-23

- The Trust experienced zero Trust attributed Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias during the year 2022-23.
- Thirty patients were identified with an Escherichia coli (E. coli) Gram negative blood stream infection (GNBSI). Four cases were deemed as having lapses in care which may have contributed to infection acquisition.
- Fifteen patients were identified with a Klebsiella species (Klebsiella spp.) GNBSI. Three cases were deemed as having lapses in care which may have contributed to infection acquisition.
- Six patients were identified with a Pseudomonas *aeruginosa* GNBSI. One case was deemed as having a lapse in care which may have contributed to infection acquisition. The patient had an indwelling urinary catheter.
- The Trust reported 42 cases of hospital attributable *Clostridioides difficile* infection (CDI) against an NHS England set trajectory of no more than 44. Post infection reviews identified that 20 of these cases were linked to lapses in care which may have contributed to the CDI acquisition. No contractual sanctions were applied.
- There were 463 patients who were deemed to have probable or definite hospital onset COVID-19 infection.
- There were 73 infection outbreaks reported during the year. These all meet the national criteria set for declaring outbreaks. This included 60 outbreaks due to COVID-19, 5 due to confirmed or suspected norovirus infection and 8 outbreaks of Influenza.
- Hand hygiene and bare below the elbow (BBE) audits of compliance are completed monthly by the Infection Prevention nurse team and ward/ department based clinical staff. The mean

compliance score for hand hygiene practice was recorded as 98% and 97% for BBE compliance.

Section 2: Introduction

This annual report covers the period 1st April 2022 to 31st March 2023 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider against the cleanliness and IPC requirements detailed in the legislation. It looks at all aspects of IPC, including monitoring and surveillance, environment, cleaning, staff, policies and laboratory provision.

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

NHS England (NHSE) re-issued the COVID-19 Board Assurance Framework in 2022/23. This is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework.

The Trust supports the principles that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection must be in place within the Trust. Many of the control measures required to prevent the spread of COVID-19 build upon existing infection prevention practices. Therefore, the measures we have taken during 2022/23 to prevent spread of COVID-19 have also been improvements which will help us to prevent the spread of other infections as we move forward next year.

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2023-24 as we continue to manage and move beyond the challenge of the COVID-19 pandemic.

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

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

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

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

Section 3: Compliance

Criterion 1

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

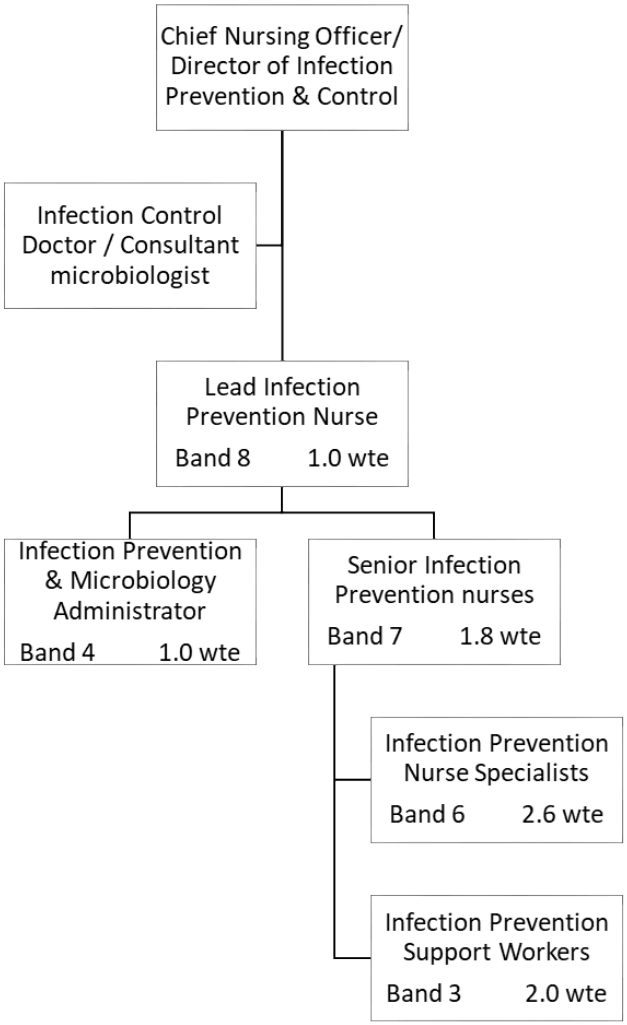
Infection Prevention Service & structure

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

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

A Consultant Microbiologist holds the role of Infection Control Doctor. This post is for 4 programmed activities. The role is supported by the Consultant Microbiologist team in their absence.

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



To enable the Infection Prevention service to support the implementation of the National Standards of Healthcare Cleanliness 2021 (NHS 2021), an additional 1.0 wte Senior Infection Prevention Nurse was recruited into the team

The team continued to support frontline staff and prioritise urgent IPC issues during the waves of the COVID-19 pandemic and during winter pressures. Any priorities that were not completed on this year's schedule have been reviewed and added to the Infection Prevention Improvement Plan 2023-24 schedule as appropriate (Appendix 2).

Committee structures and assurance processes

Trust board

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

Quality committee

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

Infection Prevention committee

The Infection Prevention Committee is chaired by the DIPC and in their absence, by the Infection Control Doctor. The sub-committees of the Infection Prevention Committee are the Decontamination Committee, the Cleanliness Committee and the Water Management Group and more recently the Ventilation Committee. The Infection Prevention Committee then reports directly to the Quality Committee. The Antimicrobial Stewardship Committee reports to the Medicines Safety Committee.

Covid operational meeting/ Tactical Operational Group

At the beginning of the COVID-19 pandemic the Trust introduced a COVID-19 operational meeting which was an engagement and a decision making forum for operational, practice and policy decisions associated with the pandemic. Originally, this meeting met a minimum of weekly and at times two to three times per week. During 2022/23 the format of this meeting has evolved into the Trust Tactical Operational Group (TOG). This bi monthly meeting continues to provide agile decision making and the governance associated with operational, practice and policy changes.

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

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

Members of the Infection Prevention Service were core members of the COVID-19/ TOG meetings.

Antimicrobial Management Group

The Trust has an Antibiotic Stewardship Team consisting of an Antimicrobial Pharmacist and Consultant Microbiologists which meets monthly. The team produces a quarterly report on antibiotic use and audit results which is presented at the Infection Prevention Committee.

Decontamination Committee

The Decontamination Committee is a sub-group of the Infection Prevention Committee. The Trust Decontamination Lead for reusable devices chairs the meetings on a bi-monthly basis. The Decontamination Lead has had appointed an Authorising Engineer (AE) to provide independent expert advice to the Trust on matters of decontamination and has organised for an audit to be undertaken by the AE.

Cleanliness Committee

The Cleanliness Committee is a sub-group of the Infection Prevention Committee. The meeting is chaired by the Trust's Contract Manager and the meetings are held on a monthly basis. The committee provides a strategic focus on the cleanliness and food safety agenda and gains assurance from both Trust & our PFI partners around key cleanliness and food safety standards.

Water Management Group

The Trust has a Water Management Group which is a sub-group of the Infection Prevention Committee. It meets quarterly and is chaired by the Director of Estates and Facilities. The Trust has a programme of water monitoring in accordance with national guidance for all augmented care areas (such as Intensive Care and the Special Care Baby Unit) which is undertaken by our PFI

partner. The monitoring reports are discussed at the IPC as well as at the PFI contract meetings. The Trust has an AE who audits the Trust on our policy and compliance with it to provide additional assurance and technical advice if needed.

External assurance reviews

A multi-agency planned review of infection prevention & control practice at the County Hospital site took place in October 2022. This visit was a follow up from the reviews completed in 2021/22 and was undertaken by specialist advisors from National Health Service for England (NHSE), United Kingdom Health Security Agency (UKHSA) and the H&W ICS. During the review, serious breaches in IPC practices were observed which required immediate attention and Wye Valley Trust has been escalated from AMBER to Intensive Support (previously RED) on the NHSE infection prevention escalation matrix. Immediate action was taken to address the areas highlighted for improvement and an Infection Prevention Improvement Plan (Appendix 2) has been developed collaboratively with the Trust, NHSE and H&W ICS. This adherence and completion with the plan is monitored through the Infection Prevention Committee and the Quality Committee on a quarterly basis.

The H&W ICS Infection Prevention Nurse has undertaken regular assurance reviews throughout 2022/23. Feedback is provided and reported to Department leads as appropriate.

Board assurance Framework

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

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

Infection Surveillance

In April 2022, the NHS Standard Contract for 2022/23 was published. This stipulated that all Community Onset Healthcare Associated (CO-HA) and Hospital Onset Healthcare Associated (HO-HA) infections are to be included in Trust's data reporting.

Healthcare Associated Infections Review Panel

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

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

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

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemias

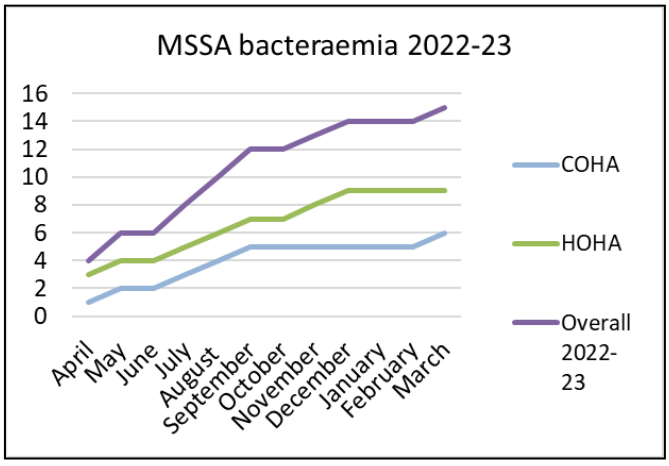
In 2022/23 zero Trust appointed MRSA bacteraemia cases were recorded against a threshold of zero.

Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemias

MSSA is the much commoner antibiotic sensitive version of *Staphylococcus aureus* and less likely to be hospital acquired. We do not have a formal target for reduction of MSSA bacteraemia cases. Fifteen MSSA bacteraemia cases were apportioned to the Trust for the period 2022/23, in comparison to 13 in 2021/22.The 2022/23 cases included 6 CO-HA and 9 HO-HA cases.

All cases were reviewed and root cause analysis carried out to look for preventable causes when the source of infection was unknown or device related. Thirteen cases were identified as being linked to the patients underlying health concerns. Two cases were linked to the presence of an indwelling invasive device, specifically the documentation of ongoing care management.

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



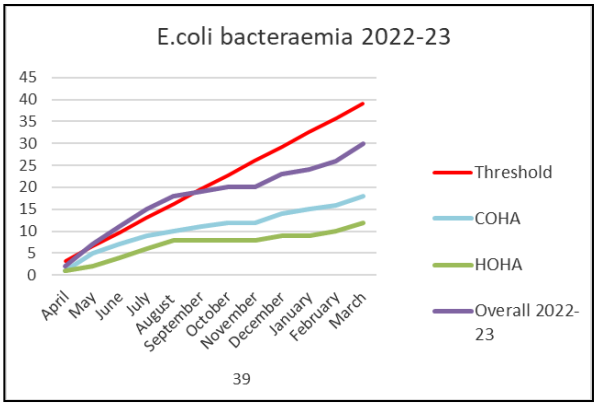
Gram negative blood stream infections

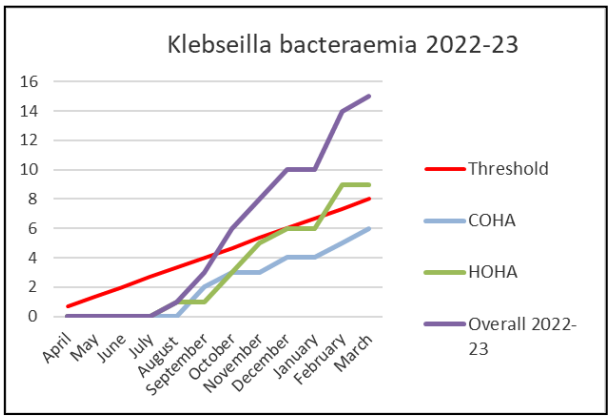
A healthcare associated Gram-negative blood stream infection (GNBSI) is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days. The top three GNBSI causative organisms which account for 72% of all Gram negative bacteraemias are: Escherichia coli (*E. coli)*, *Pseudomonas aeruginosa* (*Pseudomonas*) and *Klebsiella* species (*Klebsiella*). From April 2017, there is

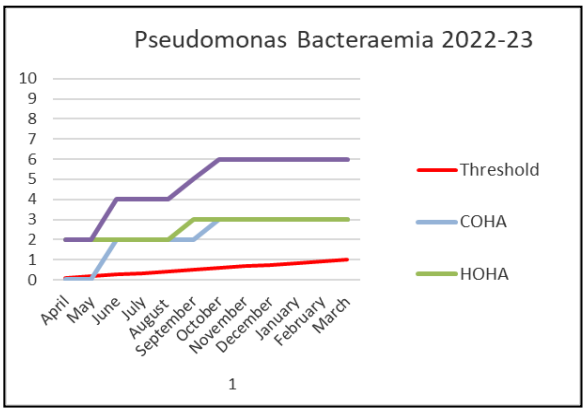
an NHS ambition to halve the numbers of healthcare associated GNBSIs by 2023/24. To support this, NHS Standard Contract 2022/23 (April 2022), included Gram- negative threshold levels for each organisation for this financial year.

The focus is on the reduction of the top three GNBSIs and includes all COHA and HOHA reported cases. In 2022/23 the following cases of GNBSI were reported:

Bacteraemia	Threshold for WVT	End of year tally
E.coli	39	30 ↓
Klebsiella spp.	8	15 ↑
P. aeruginosa	1	6 ↑







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

Seven of the reported GNBSI were linked to the presence of an indwelling device. Lapses in care were linked to the completion of device documentation.

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

Clostridioides difficile infection (CDI)

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

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

The reportable cases of CDI are those that are positive by two tests, polymerase chain reaction (PCR) and enzyme-linked immunosorbent assay (EIA) and which are either hospital onset healthcare associated or community onset health care associated according to the definitions below.

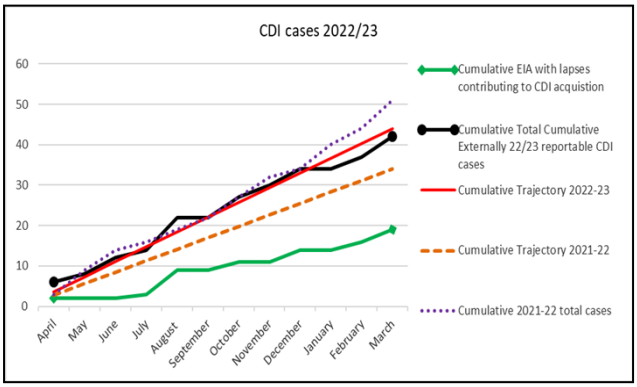
Hospital onset healthcare associated: (>AD+1) - HO-HA	Cases that are detected in the hospital two or more days after admission (where day one is day of admission).
Community onset healthcare associated: (<AD+1) CO-HA	Cases that occur in the community (or within two days of admission) when the patient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

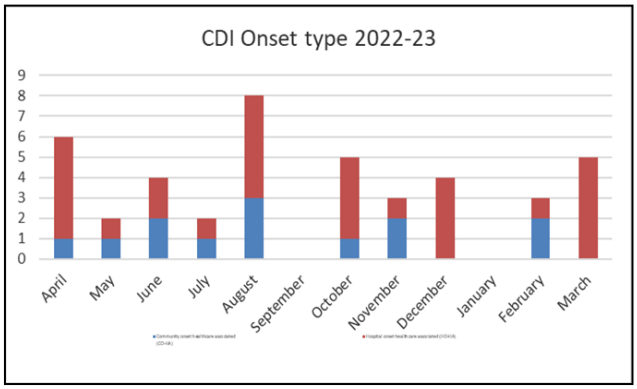
WVT was given an externally set trajectory of 44 cases of CDI this year. This included CO-HA and HO-HA cases. The Trust reported 42 CDI cases by the end of March 2023. This included 13 CO-HA cases and 29 HO-HA cases. All reportable cases of CDI are investigated by the Health Care Associated Infection review panel.

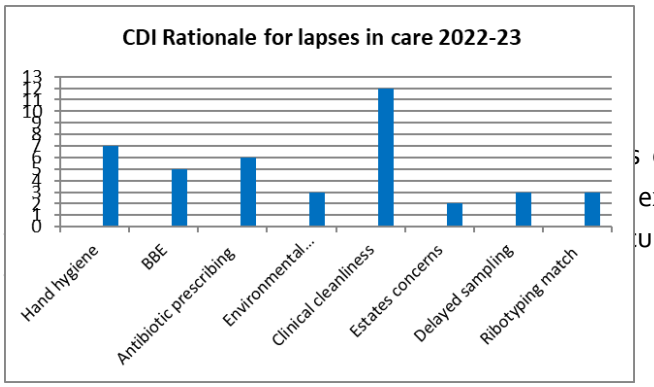
Lapses in care which may have contributed to CDI acquisition were identified in 20 cases. The commonest lapses in care which may have contributed to CDI were below standard compliance with clinical equipment cleaning. Clinical cleaning issues were predominately linked to shared patient equipment: commode and toileting aid cleanliness. Other preventable causes included:

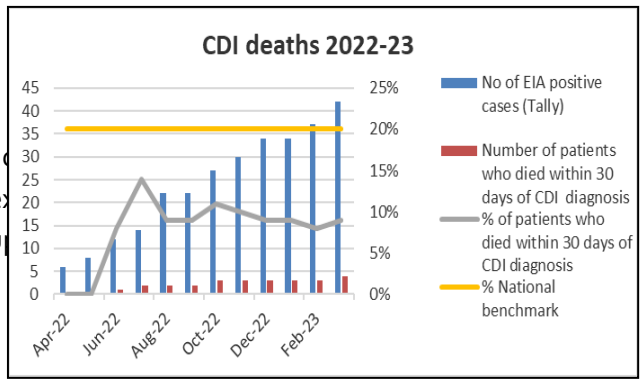
- Poor practices in BBE compliance
- Prescribing and/ or administrating antibiotics outside of guidelines
- Environmental cleanliness
- Delay in sampling
- Evidence of cross contamination

The mortality rate has remained below the national benchmark of 20% throughout the year.









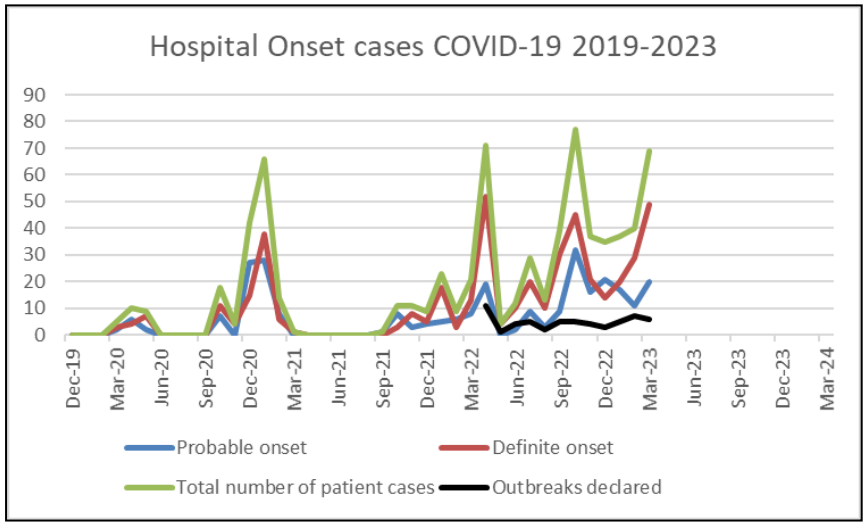
The Quality Improvement initiative #WyeClean was introduced in June 2022. The campaign aim was to improve environmental and clinical cleaning trust wide and to support the implementation of the National Standards of healthcare Cleanliness 2021. The initiative to date has focused on specific equipment cleaning and standardization of practice. #WyeClean will continue into 2023/24 to embed training.

WYECLEAN

COVID-19

The infection prevention year of 2022/23 continued to be dominated by the response to the COVID-19 pandemic.

In total, 463 patients were deemed to have probable or definite hospital onset COVID-19 infection (See Appendix 3 for COVID-19 onset definition); with 60 infection outbreaks declared due to COVID-19 linked transmission. This included three outbreaks that affected staff only areas.



The prevalence of COVID -19 infection both internally and within the Herefordshire community was regularly discussed in the COVID-19 operational meetings chaired by the Director of Operations to ensure a managed yet reactive approach.

National recommendations for COVID-19 management have been implemented by the Trust following approval at the COVID-19 operational meetings.

Outbreak meetings were held regularly and were attended by key stakeholders including NHS England and UKHSA.

The Infection Prevention Service continued to be heavily involved in planning and supporting patient pathways and providing staff education. The communications team issued a daily bulletin with key messages and updates for staff.

Carbapenemase-producing *Enterobacteriaceae* (CPE)

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

There were six healthcare acquired cases of CPE in 2022/23 attributed to WVT. All infection prevention measures were actioned. In 4 of the cases there was evidence of person to person spread.

The annual audit of CPE Assessment of admitted patients was not completed in 2022/23 due to the ongoing demands of the COVID-19 pandemic. This will be completed in 2023/24.

M-POX

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

Prevention Service worked collaboratively with the ICS and local providers to ensure all measures were in place.

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

Tuberculosis (TB)

There were no incidents associated with TB in 2022-23

Seasonal infections

Norovirus

From April 2022, all stool samples submitted to the laboratories are tested for Norovirus as routine. 150 patients were identified as having norovirus whilst inpatients in Wye Valley NHS Trust. A high proportion of these patients were identified on admission to the Trust.

Five norovirus outbreaks were declared in January 2023. No additional outbreak incidents occurred in the following months.

Influenza

184 patients were identified as having influenza during 2022/23. A large increase in prevalence was noted during the months of December 2022 & January 2023. This was reflective of the national picture and also of enhanced testing. Eight outbreaks due to Influenza were declared as per national and regional guidance. All outbreaks occurred during December and January.

Hand Hygiene & Bare below the elbow (BBE) compliance

The Trust expected compliance for hand hygiene and BBE practices for staff working within clinical settings has been set locally as 100%. Compliance with this objective is monitored monthly by clinical areas. The Infection Prevention nursing team undertake validation audits of compliance monthly throughout the Trust. The overall annual score for hand hygiene 2022/23 was 98%. The overall annual score for BBE in 2022/23 was 97%

Criterion 2

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

Decontamination

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

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

A JAG audit on all endoscopy services was completed in 2022 and most actions where completed by end of March 2023. Outstanding items are being completed as part of the actions to the most recent JAG audit April 2023. This audit process provides assurance in the safety and quality of endoscopy decontamination activities and ensures the processes are appropriate. A site wide audit is being scheduled for late 2023 to review decontamination processes further. This will coincided with the potential restructuring of Decontamination Lead and Decontamination authorised person (AP) roles.

All surgical instruments continue to be re-processed in the sterile services department at the Hereford County Hospital which is run by our PFI partner. Protein detection has been implemented and it is effective in assisting Central Sterilising Services Department (CSSD) in managing their decontamination processes.

Local decontamination of dental instruments is undertaken in most of the dental access centres. The washer disinfectors at all sites were on a loan contract. However these assets now belong to the trust. The Trust has extended a 1 year service contract with the current service provider. An updated provision of washer disinfectors and autoclaves is going out to tender in 2023.

A Laundry assurance visit did not occur in 2022/23. This is planned in for quarter 3 of 2023. The visit will be to gain assurance of the laundry providers processes. The laundry providers Elis provide a microbiologist report to the Trust every month, which is reviewed, monitored and discussed at the Decontamination Committee.

Cleanliness Monitoring

With the onset of 2022/3 Wye Valley Trust Board had approved significant investment in the staff required to fulfil its new obligations set out in the National Standards for Healthcare Cleanliness 2021 (NCS21). This included a new independent Monitoring team, dedicated to providing the increased numbers of audits set out in the NCS compliance matrix. Further investment was also required in the Domestic services, both at Hereford County Hospital and Community sites, whereby second (evening) cleaning shifts have been introduced to cover the 'check clean' requirements set out in the new standards.

High Risk areas such as ED, Theatres, SCBU, ITU and Delivery Suite now receive weekly audits as opposed to those carried out monthly before NCS21. The Trust has now adopted a new set of audit terminology (Frequency Ratings FR1, FR2 etc), which are now added to the Star Ratings (1-5), and displayed in view of the public in each department.

This greater scrutiny, increased labour input and overall attention to clinical environments has provided greater assurance due to the independence of the audit team. It is however difficult to

compare 2021/2 with 2022/3 for a number of reasons. Firstly, and mentioned above, the Trust predominantly were self-monitoring by department and the level of scrutiny was often debateable. Secondly, the Trust used a bespoke paper based monitoring tool, and lastly not all staff were trained to the same level in carrying out Cleanliness audits.

In 2022/3, within six months of adopting the new standards, audits are almost entirely carried out by trained independent staff, using the 'Formic' electronic auditing system, thus giving a much more stable platform in which to interrogate and judge audit scores

Year	FR1 Domestic Cleans	FR1 Clinical Cleans	Star Rating
2021/22	95.8%	94.3%	4* & 3*
2022/23	96.3%	94.25%	4* & 3*
Year	**FR2 Domestic Cleans**	**FR2 Clinical Cleans**	**Star Rating**
2021/22	93.7%	95.1%	4* & 5*
2022/23	93.9%	93.75%	4* & 4*

The above scores thus show a very minor improvement in Domestic Cleans and a small reduction in Clinical Cleans from the previous year, across both High and Medium risk areas.

We therefore start 2023/4 aiming to improve on our overall scores, while staffing across the NHS remains challenging, both in Domestic services and Clinical. We do so however with improved assurances of how we have attained these scores, and equal assurance that we are attaining a high level of compliance with the National Standards, something this Trust has not achieved in over 20 years.

Patient Led Assessments of the Care Environment (PLACE)

PLACE inspections commenced in October 2022 following a hiatus of 3 years due to the COVID-19 pandemic. The PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

The aim of PLACE assessments is to provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. Clinical facilities across all four Wye Valley Hospitals were inspected by PLACE assessors between November and December 2022.

The results were published March 2023. An action plan addressing all issues highlighted by the assessment has been developed. This is being reviewed via the Cleanliness Committee.

Individual sites	Cleanliness Score %	Food Score %	Organisational Food Score %	Ward Food %	Privacy, dignity & wellbeing Score %	Condition, apperance & maintenance Score %	Dementia Score %	Disability Score %	Average score %
COUNTY HOSPITAL	97%	91%	94%	90%	84%	96%	87%	87%	91%
BROMYARD HOSPITAL	96%	89%	92%	85%	80%	95%	79%	88%	88%
ROSS HOSPITAL	95%	91%	92%	91%	73%	99%	81%	78%	87%
LEOMINSTER HOSPITAL	99%	95%	92%	98%	80%	96%	82%	83%	91%
Weighted Organisation average	97%	92%	94%	91%	83%	96%	86%	86%	89%
National Average	98%	90%	91%	90%	86%	96%	80%	83%	89%

Key

On or Greater than National Average

Under national Average – within 5%

Under national Average – greater than 6% below national average

Improvements can be noted across all domains.

WVT Weighted Organisation average	2019	94%	85%	91%	79%	73%	88%	71%	71%	82%
	2022	97%	92%	94%	91%	83%	96%	86%	86%	89%
National Average	2019	99%	93%	91%	95%	87%	96%	84%	84%	91%
	2022	98%	90%	91%	90%	86%	96%	80%	83%	89%

PLACE LITE i

Criterion 3

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

Antimicrobial stewardship for 2021/22

This is a programme of activities which aims to ensure that antibiotics are used carefully and in ways which minimise side effects and the development of antibiotic resistance. This is very important as increasing antibiotic resistance threatens the delivery of healthcare now and in the future. The Trust has an antimicrobial stewardship team consisting of consultant microbiologists and a 0.1 Whole Time Equivalent (WTE) antimicrobial pharmacist with support from the whole pharmacy team. There is also an Antimicrobial Stewardship Committee which meets 6 monthly and includes doctors and nurses. The Trust has recognised that there are insufficient resources for antimicrobial

stewardship and have approved the appointment of a third consultant microbiologist. A business case for additional antimicrobial pharmacist resource is in has been approved and the post was advertised.

This year, key achievements of the team were:

- the introduction of antibiotic order sets which mandate the correct choice and duration of an antibiotic and an awareness campaign about antimicrobial resistance in European antibiotic awareness week in November
- the Trust achieved the national targets of reduction in overall antibiotic consumption and also in reducing the higher risk broad spectrum antibiotics

Criterion 4:

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

Patient leaflets

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

Communication Team

With the onset of the COVID-19 pandemic in early 2020, establishing a clear communication programme has been a key requirement in the improvement of patient care, the instigation of IPC initiatives, public information and visitor safety, as the way we all worked had to change, often at short notice.

The Trust's dedicated Communication Team has been instrumental in assisting with this ensuring the correct media information has been developed in a timely and clear manner. The Infection Prevention Service has worked closely with the Communications Team throughout 2022/23.

The Communications Team attend incident and outbreak meetings to ensure that appropriate messages are delivered both to Trust staff and to the public. They have issued frequent Trust bulletins throughout 2022-23 with regular contributions from the Infection Prevention Service team members. Wider dissemination of current issues is also achieved by global emails and through the Trust weekly Team Brief newsletter.

A COVID-19 information page was developed early on in the COVID-19 pandemic and continues to be regularly updated with Trust wide communications, COVID-19 policy changes and advice for staff on working through the pandemic, including information for patients and visitors. This included topics such as volunteering, symptoms of COVID-19, how to keep healthy and avoid infection, how to get tested and visiting.

The page continues to be updated by the Communications Team with advice from the Infection Prevention Service as new information becomes available. The Trust website also promotes the IPC information page for general IPC issues and guidance including link nurse information, information on MRSA, *Clostridioides difficile* and other organisms. This is also the media area to review a range of information leaflets on various organisms and access the regularly updated policies and guidance.

Criterion 5:

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

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

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

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

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

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

Mandatory surgical site infection surveillance (SSI)

During the financial year April 2022 – March 2023 there were a total of 253 hips operations and a total of 264 knee operations in WVT.

From April 2022 the Trust has undertaken continuous SSI surveillance and will participate in each of the 3 month data collection periods going forward.

Since July 2022 the post discharge data collection has been undertaken by a designated clinical member of staff & data collection has been completed in a more robust way than the first data collection period when data collection was undertaken by non-clinical staff (April – June 2022).

The following data only includes externally reported SSI's for both local & national percentage rates.

Type of surgery	April - June 2022	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
Knee replacement	0%	0%	0%	0%
National rate	0.5%	0.5%	0.5%	0.5%
Hip replacement	0.0%	1.4%	1.6%	3.2%
National rate	0.5%	0.5%	0.5%	0.5%

The Trusts rates for Hips replacement SSIs reported between July and March 2023 are noted to be higher than national rates for that period. These have been reviewed by the Infection Prevention service and Orthopaedic Surgeon team and can be apportioned to a cohort of complicated hip revisions and the Trusts small case load (denominator). One reported SSI case by the Trust means a rate of >1%.

During 2022/23 the patient reported cases have highlighted the need for additional analysis of data gathered including accuracy and input from primary care colleagues. This work is ongoing with the Orthopaedic team to gain assurance that the patient reported data is reliable & accurate for 2023/24.

Outbreak and incident management

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

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

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

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

A list of all outbreaks declared in 2022/23 can be found in Appendix 3,

Criterion 6

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

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

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

Infection Prevention Team/Team Development

The Infection Prevention Service found this a challenging year due to the ongoing waves of the COVID-19 pandemic and surges in seasonal infections, staff shortages and clinical demands. However, in July, 3 of the nursing team were able to attend a regional infection prevention conference held by the Infection Prevention Society Midlands regional team.

Additional team training has included: Insights, Leadership and development, Mary Seacole Development programme and QSIR (Silver training).

One Infection Prevention Nurse has completed the Infection Prevention Degree Course at Birmingham City University.

Criterion 7

Provide or secure adequate isolation facilities.

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

A Prioritisation Reference Guide has been developed for the Clinical Site Management team to follow out of hours. The team are also receive regular updates on the priority side rooms for

environmental decontamination using the ultra violet and hydrogen peroxide environmental decontamination equipment.

Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for WVT are located in the purpose built Pathology Laboratory on-site at the County Hospital site. The Microbiology Laboratory has full UKAS accreditation. The Trust has 2.6 WTE Consultant Microbiologists. The Trust is fully staffed although some of this is by the use of locum staff. The department also has a trainee Consultant Clinical Scientist in post.

Despite this, the Microbiology department were heavily involved in both the laboratory side of developing COVID-19 testing and giving IPC advice and assisting with outbreak management throughout the pandemic. A number of technical staff had to be recruited to assist with COVID-19 testing.

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

Criterion 9

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

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

The Infection Prevention Service has a rolling programme of policies which require updating each year. In addition, policies are updated prior to review date if national guidance changes. In 2022/23 the team updated the following IPC polices & Standard operation procedures (SOP)

- IC. 04 Bed Management policy
- IC.05 Isolation Policy
- IC. 07 Hand Hygiene Policy
- IC.16 Multi resistant Gram negative Policy
- IC.29 Standard Infection Control precautions policy
- EFS.02 Portable fan policy
- SOP: Monitoring hand hygiene, BBE and escalation process

The following policies were developed and introduced during 2022/23:

- IC.38 Clinical Cleaning policy
- IC. 39 Influenza management

All information regarding COVID 19 guidelines, protocols, pathways and practices have been available to Trust staff via a dedicated page on the Trust Intranet. This was updated regularly

throughout the year in line with changes to national and regional guidelines. Daily bulletins via email have also been issued to staff and are available on the Trust staff myWVT app.

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

Infection Prevention team audit program

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

This year's programme of audit concentrated on gaining assurance that standard infection control standards were being upheld across the Trust with a strong focus on outbreak management, clinical and environmental cleaning and monitoring the implementation of the National Standards for Healthcare Cleaning 2021. These were mainly practice audits.
This has meant that several audits planned for 2022/23 were postponed.

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

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

The deferred audits have been marked against the 2022/23 Audit plan (Appendix 4).

Saving Lives: High Impact Intervention audits

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

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

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

- Preventing ventilator associated pneumonia

The HII audit results are presented to the Infection Prevention Committee by the Divisional Directors of Nursing.

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

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

Criterion 10

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

Personal Protective Equipment including FFP3 mask fit testing

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

This role and responsibility was undertaken by a dedicated Fit mask testing service up until March 2023. This service was managed by the Education and Development team until October 2022, and from November 2022 the service was managed by the Lead Infection Prevention Nurse (LIPN). From April 2023, the Trust fit testing service will be undertaken by the infection Prevention nurse team.

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

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

Safety Sharps Working Group

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

Due to the demands of the COVID-19 pandemic this group did not meet regularly. Regular meetings resumed in quarter 4 of 2022/23. It is planned that this will return to its usual agenda in 2023/24 following a review of the group's Terms of reference and required attendance.

Trust Staff COVID-19 internal Track & Trace service

The Infection Prevention nurse team have continued to support and participate in the tracking and tracing of COVID-19 positive staff following the disbanding of a dedicated Track & Trace team March 2022. The team have also had responsibility for undertaking the PCR testing of symptomatic staff who have reported a negative lateral flow device (LFD) test.

Staff mandatory infection prevention training

All staff must attend Trust induction before commencing work within WVT. Infection prevention constitutes part of formal teaching on the clinical staff induction and annual refresher sessions. If there are any emerging infection threats or increased incidents of infection, extra targeted training sessions are undertaken. Training has also been provided for specific staff groups as requested. The Trust threshold for mandatory compliance is 85%. In 2022/23 Trust compliance with IPC mandatory refreshing training:

Level 1 (Non clinical staff): 94.46%

Level 2 (Clinical staff): 83.18%

Infection Prevention Champions

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

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

Section 4: IPC Focus for 2023/24

Infection prevention & control is a priority for Wye Valley NHS Trust. Our focus for 2023/24 will be:

- Reducing the incidence of HCAI infections including MSSA, GNBSI and C. difficile in WVT based on a strong health economy partnership approach including surveillance, implementation of best practice, audit and root cause analysis.
- We will be involved in planning for further waves of respiratory and seasonal infections over the winter months
- Ongoing training on transmission based precautions; to include contact, droplet and airborne precautions.
- Advising on decontamination of environment and clinical equipment
- Antimicrobial Resistance and stewardship
- Continue to address and monitor outstanding estates maintenance work across the Trust
- Reviewing provision of mandatory training with EDC colleagues to ensure staff receive annual contemporaneous training on infection prevention & control measures
- Embedding best practices defined in the National Infection Control Manual 2022

Section 5: Conclusion

It's been a challenging year for infection prevention at WVT. There have been staffing shortages in the team, large incidents of infection outbreaks and the Trust did not achieve the externally set objectives of reductions in Gram negative bacteraemia infections.

However there have also been achievements. Highlights include a reduction in CDIs, E.coli GNBSI and zero MRSA bacteramias, the launch of a successful Stool SMART campaign, and delivery against the majority of actions in the action plan

There is much planned for the coming year including staff education resources, quality Improvement initiatives on clinical cleaning, PPE usage, stool sampling, and also continuing with interventions to reduce C. difficile and Gram negative bacteraemias. None of this would be possible without the enthusiasm and commitment of Trust and Sodexo staff and the DIPC; The Infection Prevention Service would like to thank them again for their continuing efforts.

Section 6: References

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
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NHS (2022) Infection prevention and control board assurance framework. Published 01/09/22. Available online 03/04/23: https://www.england.nhs.uk/long-read/infection-prevention-and-control-boardassurance-framework/

NHS (2022) National infection prevention and control manual (NIPCM) for England Version 2.4 published 09/01/2023. Available online 03/04/23: https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/version-history/

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Appendix 1: List of Abbreviations

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

NHS	National Health Service
NHSE	National Health Service for England
PCR	Polymerase chain reaction
PFI	Private Finance Initiative
PPE	Personal protective equipment
Pseudomonas	*Pseudomonas aeruginosa*
QSIR	Quality service improvement and redesign
UKAS	United Kingdom Accreditation Service
UKHSA	United Kingdom Health Security Agency
PLACE	Patient led assessments in the Clinical environment
PFI	Private finance initiative
SSI	Surgical site infection
TB	Tuberculosis
TOG	Tactical Operational Group
WTE	Whole time equivalent
WVT	Wye Valley NHS Trust

Appendix 2: Infection Prevention Improvement plan 2022

Wye Valley NHS Infection Prevention Improvement Plan 2022-24						
Theme	**Link to H&S care Act 2012**	**Programme of work**	**Rationale (Why)**	**Measurement (How)**	**Internal Lead**	**Target date**
CDI	Criterion 5	Audit clinical staff compliance with collecting Type 5-7 stool for sampling in line with Trust and national policy.	Benchmarking against policy. Early identification of infection	IP Committee (IPC)	ICD & LIPN	Jun-23
CDI	Criterion 1	Undertake a GAP analysis against the "how to deal with the problem" guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/340851/Clostridium_difficile_infection_how_to_deal_with_the_problem.pdf	Benchmarking against national standards	IPC	ICD	Jun-23
Cleaning	Criterion 2	Establish Cleanliness Scrutiny Meetings	Address/resolve deficits in cleaning standards/requirements Address issues reported in areas scoring 3 stars and below in line with National Cleaning Standards	Cleanliness Committee	LIPN/ Trust Estates	Mar-23
Cleaning	Criterion 2	Commence Cleanliness efficacy audits in line with National Cleaning Standards requirements	National cleaning standard requirement Benchmarking against national standards	Cleanliness Committee	LIPN/ Trust Estates	Dec-22

Cleaning	Criterion 2	Implement the NHSE Cleaning for confidence e- learning programme to all clinical staff and appropriate estates staff Trust wide.	Improve staff knowledge and awareness around cleaning	Cleanliness Committee	LIPN/ Education team	Mar-23
Cleaning	Criterion 2	By 01/07/23 85% of identified staff will have completed the cleaning for confidence e- learning training	Improve staff knowledge and awareness around cleaning	Cleanliness Committee/ IPC	LIPN/ Education team	Jul-23
Cleaning	Criterion 6	IPT to deliver Commode & toileting aid Train the trainer practical sessions to 100% of wards and department with toileting aids by 28/02/23	Recurring lapse theme in the HCAI Post Infection Review process. Also identified on assurance walk rounds. Improvement required	IPC Via Divisional KPIs	LIPN/ DCNO	Feb-23
Cleaning	Criterion 6	IP Champions to cascade commode and toileting aid cleanliness training in their clinical settings to a minimum of 50% of their clinical staff * by 31/03/23 and 85% of available staff by 30/06/23 * staff who have responsibility for commode & toileting aid	Recurring lapse theme in the HCAI Post Infection Review process. Also identified on assurance walk rounds. Improvement required Cascade training to wider team	IPC Via Divisional KPIs	Ward level ownership	Jun-23
Cleaning	Criterion 6	All wards where commodes & toileting aids are used are audited a minimum of monthly by clinical areas and post HCAI or quarterly assurance by IPT	Benchmarking against National Cleanliness standards	IPC Via Divisional KPIs	LIPN/ DCNO	Nov-22

Cleaning	Criterion 1	Undertake a spot check mattress and cushion review to ensure all items in use or in storage are fit for purpose, are clean and have no fluid ingress. Replace any that are not deemed fit for purpose. Provide assurance report to IPC	To establish baseline of current needs Deficit in standard identified on assurance walk rounds. Improvement required	Cleanliness Committee	LIPN/ DCNO	Mar-23
Cleaning	Criterion 2	All clinical areas with mattresses, trolleys and chair toppers will audit their cleanliness and damage a minimum of monthly by clinical areas and via quarterly assurance by IPT Number of items to be audited based on bed base: 10 or less items - 100% audited 11 or more items - minimum of 10 items	Deficit in standard identified on assurance walk rounds. Improvement required	Cleanliness Committee IPC Via Divisional KPIs	LIPN	Mar-23
Cleaning	Criterion 1	All patient beds frames, couches and trolleys are audited for cleanliness and damage a minimum of monthly by clinical areas and via quarterly assurance by IPT. This will include the removal of any bed rails Number of items to be audited based on bed base: 10 or less items - 100% audited	Deficit in standard identified on assurance walk rounds. Improvement required Benchmarking against National Cleanliness standards	Cleanliness Committee	LIPN/ Trust Estates	Jun-23

		11 or more items - minimum of 10 items				
Cleaning	Criterion 6	Develop screensavers and additional resources to refresh & inform clinical staff knowledge on cleaning type terminology - Red, Violet, Amber & Green	Ensure the correct clean is requested/ undertaken post patient transfer/ discharge Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	Cleanliness Committee	LIPN	Mar-23
Cleaning	Criterion 2	Implement PLACE lite programme of audits for 2023-24	Strengthen governance on clinical cleanliness To support the Trusts prompt identification of cleanliness & estates concerns in the clinical environment	Cleanliness Committee	LIPN/ Trust Estates	Apr-23
Cleaning	Criterion 2	Produce a Clinical Cleaning policy	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC	LIPN	Dec-22
Cleaning	Criterion 2	Gain assurance from Domestic services that cleaning methods and products are used in accordance with National guidance	Variation in standards noted on assurance walk rounds. To gain assurance of standardised practice	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Apr-23
Cleaning	Criterion 9	Develop a cleaning product formulary agreed by all parties for use across the Wye Valley sites	To gain assurance of standardised practice To ensure products effective for task and used correctly	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Sep-23

Cleaning	Criterion 2	Undertake an evidence based review of existing cleaning products/ processes used across the Trust	To ensure products effective for task and used correctly	Cleanliness Committee	ICD/ LIPN/ Trust Estates/ Sodexo Soft FM Estates	Sep-23
Cleaning	Criterion 2	Escalate concerns raised from NHSE inspection October 2022 regarding the Domestic trollies being suitable for task	To ensure equipment effective for task	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Nov-22
Cleaning	Criterion 2	Explore opportunities (? Task & finish group with domestics) for reviewing available Domestic trollies with a long term replacement plan	To ensure equipment effective for task	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Mar-23
Cleaning	Criterion 2	Seek monthly assurance from Domestic service providers that a robust process is in place that ensures the Domestic trollies are clean, intact and used appropriately by their staff	Deficit in standard identified on assurance walk rounds. Improvement required. Improve clinical cleaning standards	Cleanliness committee	Trust Estates/ Sodexo Soft FM Estates	Mar-23
Cleaning	Criterion 2	Develop a process for escalation of ongoing/ long standing Soft FM cleaning concerns (including Domestic trollies) to ensure discussion in appropriate forums for resolution	Deficit in standard identified on assurance walk rounds. Improvement required. Improve cleaning standards	Estates and Facilities committee/ Cleanliness committee	Estates team	Sep-23
SICP	Criterion 6	Analyse results of Hand hygiene audits to allow training to target specific staff groups and / or key moments & tasks	HCAI reduction Compliance with policy	IPC Via Divisional KPIs	LIPN	Nov-22

SICP	Criterion 6	All isolation rooms will have the appropriate PPE available outside for staff use	Deficit in standard identified on assurance walk rounds. Improvement required. HCAI reduction	IPC	LIPN	Nov-22
SICP	Criterion 6	Review department use of lubricant gel. Ensure trust is compliant with recommendations set out in https://www.gov.uk/government/publications/ultrasound-gel-good-infection-prevention-practice	Comply with national guidance.	IPC Via Divisional KPIs	LIPN	Jan-23
SICP	Criterion 10	Roll out of Regional Gloves off campaign planned in line with regional communication campaign.	Direct staff to correct/best practice	IPC Via Divisional KPIs	LIPN	Mar-24
SICP	Criterion 10	Update PPE posters in line with National guidance and disseminate Trust wide	Direct staff and visitors to correct/best practice Compliance with national guidance	IPC	LIPN/ Comms team	Mar-23
SICP	Criterion 7	Review Isolation door signs in line with national IPC manual routes of transmission/ PPE guidance	Streamline current signage and promote best practice and compliance Comply with national guidance. Direct staff and visitors to correct/best practice Reduction in cross contamination	IPC	LIPN/ Comms team	Mar-23

Estates	Criterion 1	Establish an Estates Scrutiny Team	To review backlog maintenance issues to address and prioritise outstanding works Deficit in standards identified on assurance walk rounds.	Estates & facilities Committee	LIPN/ Trust Estates/ Sodexo Hard FM Estates	Mar-23
Estates	Criterion 1	Standardise the use of Dirty Utilities including storage.	Standardisation of practices Improve clinical cleaning standards & reduce cross contamination	IPC	LIPN/ Trust Estates	Mar-23
Estates	Criterion 1	Roll out agreed standardised Dirty Utility layout/ plan trust wide; Share expected standard photographs with all areas as gold standard	Improve clinical cleaning standards & reduce cross contamination	IPC	LIPN/ Trust Estates	Apr-23
Water management	Criterion 1	Undertake a review of all swan neck taps outlets across Trust sites to ensure compliance with HTM 04-01 Safe water in healthcare premises and HTM 07-04 Water management & water efficiency and consider long term future plans/ replacements	Benchmarking against National HTM standards	Water management committee	Sodexo Hard FM Estates	Mar-23
Water management	Criterion 1	Review sinks and waste pipe drainage position across Trust sites to ensure compliance with HTM 04-01 Safe water in healthcare premises and HTM 07-04 Water management & water efficiency and consider long term future plans/ replacements	Benchmarking against National HTM standards	Water management committee	Sodexo Hard FM Estates	Mar-23

Quality	Criterion 1	Develop template action plan for Lapses identified in HCAI panel	Strengthen governance around HCAI reduction/ management	HCAI panel	LIPN	May-23
Quality	Criterion 1	Complete Health Act compliance review to ascertain areas requiring additional action	Benchmarking against National standards	IPC	LIPN/ ICD	Mar-23
Quality	Criterion 1	Develop a proposal to streamline the IPS annual IPC audit plan for 2023-24	Streamline current process to provide timely rectification to issues raised and ensure key themes are recognised and acted upon	IPC	LIPN	Mar-23
Quality	Criterion 1	Review IP committee structure and develop proposal and framework for reporting to Trust Board	Streamline current process for reporting	IPC/ Quality Committee	DIPC/ LIPN	Mar-23
Quality	Criterion 6	Facilitate an IP team away day	To support team development and enhance knowledge and skills	LIPN	LIPN/ NHSE	Feb-23
Quality	Criterion 1	Establish Infection Prevention assurance checks with the ICS	To provide assurance to ICS & external agencies and strengthen Trust governance	IPC	LIPN	Jan-23
Quality	Criterion 6	Facilitate NHSE training to Board on Infection Prevention & control Responsibilities	Strengthen governance and clarify role responsibility for clinical staff.	IPC/ Quality Committee	LIPN/DIPC/ NHSE	Mar-23
Quality	Criterion 6	Facilitate NHSE training to Matrons & Lead nurses on infection prevention & control to include responsibilities & how to complete a IP Quality ward walkabout	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC/ Quality Committee	LIPN/DIPC/ NHSE	Mar-23

Quality	Criterion 1	Plan a peer review with Shrewsbury and Telford NHS Trust or other key Trust to share good practice	To share learning with peers To provide assurance to ICS & external agencies and strengthen Trust governance	IPC	LIPN	Mar-23
Quality	Criterion 6	Establish baseline numbers of IP Champions across Trust	Strengthen governance and clarify role responsibility for clinical staff.	IPC	LIPN/ Matrons	Mar-23
Quality	Criterion 6	Undertake a TNA for IP Champions learning needs	To identify training needs	IPC	LIPN	May-23
Quality	Criterion 6	Plan and deliver an educational conference for IP Champions with a focus on IPC standards based on TNA outcomes * deliver by end of September 23	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	IPC	LIPN	Mar-24
Quality	Criterion 2	IP team to undertake quarterly Quality IP Ward Walkabouts trust wide with Matrons/ Lead nurses across divisions to strengthen IPC governance.	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	Divisional Governance meetings	LIPN	Dec-22

Appendix 3: Hospital declared Infection outbreaks

COVID-19 infection onset definition

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

Norovirus Outbreaks

Location	Date outbreak declared	Date Outbreak incident closed	No. of affected	No. of affected
Lugg ward	03/01/2023	09/01/2023	9	1
Linden ward	05/01/2023	12/01/2023	13	4
Arrow ward	07/01/2023	13/01/2023	9	0
Garway ward	10/01/2023	16/01/2023	11	0
Merlin ward	21/01/2023	25/01/2023	9	0

Influenza outbreaks

Location	Date outbreak declared	Date Outbreak incident closed	No. of affected patients	No. of affected staff
Lugg ward	23/12/2022	05/01/2023	5	0
Redbrook ward	24/12/2022	30/12/2022	7	0
Arrow ward	25/12/2022	01/01/2023	2	0
Teme ward	26/12/2022	02/01/2023	3	0
DCU	27/12/2022	04/01/2023	4	0
Merlin ward, ross	27/12/2022	03/01/2023	3	0
Leominster ward	30/12/2022	05/01/2023	5	0
Peregrin Ward, Ross	02/01/2023	09/01/2023	2	0

COVID-19 Outbreaks

Location	Date outbreak declared	Date Outbreak incident closed * 28 days from last positive case	No. of affected patients	No. of affected staff
Ross wards	01/04/2022	20/05/2022	23	2
Garway ward	08/04/2022	06/05/2022	3	0
Wye ward	13/04/2022	11/05/2022	5	0
Arrow ward	16/04/2022	15/05/2022	3	0
Frome ward	18/04/2022	22/05/2022	8	0
Dinmore ward	19/04/2022	21/05/2022	4	0
Lugg ward	19/04/2022	18/05/2022	14	0
Leominster ward	21/04/2022	25/05/2022	15	0
Wye ward	27/04/2022	27/05/2022	5	0
Bromyard ward	28/04/2022	26/05/2022	2	0
Garway ward	28/04/2022	26/05/2022	3	0
Ross wards	23/05/2022	19/06/2022	2	0
Bromyard ward	02/06/2022	18/07/2022	11	0
Frome ward	07/06/2022	06/07/2022	4	0
Monkmoor court	24/06/2022	25/07/2022	0	10
Theatres	30/06/2022	31/07/2022	0	29
Ashgrove ward	04/07/2022	06/08/2022	4	5
Ross wards	05/07/2022	15/08/2022	17	5
Lugg ward	08/07/2022	13/08/2022	2	0
Frome ward	09/07/2022	28/08/2022	19	2
Bromyard ward	23/07/2022	05/08/2022	3	0
Lugg ward	10/08/2022	11/09/2022	15	9
Arrow ward	12/08/2022	09/09/2022	3	3
Lugg ward	20/09/2022	17/10/2022	6	0
Leominster	21/09/2022	14/11/2022	24	6
Ross	21/09/2022	14/11/2022	22	0
Bromyard	24/09/2022	07/11/2022	12	11
Frome	30/09/2022	01/11/2022	4	0
Ashgrove ward	07/10/2022	09/11/2022	11	0

Dinmore ward	07/10/2022	09/11/2022	7	0
Garway ward	10/10/2022	11/11/2022	8	0
Wye ward	12/10/2022	12/11/2022	11	1
Lugg ward	13/10/2022	09/11/2022	2	0
Ross	10/11/2022	11/12/2022	13	0
Arrow Ward	21/11/2022	19/12/2022	3	1
Ashgrove ward	22/11/2022	20/12/2022	2	0
Frome	25/11/2022	28/12/2022	10	0
Lugg ward	05/12/2022	02/01/2023	6	0
Ross	14/12/2022	15/01/2023	5	1
Leominster	30/12/2022	28/02/2023	8	0
DCU	01/01/2023	24/01/2023	5	0
Frome	02/01/2023	26/01/2023	5	0
Bromyard	06/01/2023	03/02/2023	3	0
Redbook	06/01/2023	09/02/2023	7	0
Wye ward	11/01/2023	12/02/2023	5	0
Dinmore ward	02/02/2023	08/03/2023	5	0
T&O staff	03/02/2023	06/03/2023	0	8
Wye ward	08/02/2023	13/03/2023	8	0
Leominster ward	10/02/2023	16/03/2023	6	0
Merlin ward	19/02/2023	19/04/2023	16	3
Dinmore ward	28/02/2023	27/03/2023	3	0
Ashgrove ward	28/02/2023	29/03/2023	5	0
Gilwern	06/03/2023	17/04/2023	9	0
Bromyard	09/03/2023	09/04/2023	15	10
Redbrook	09/03/2023	31/03/2023	10	0
Leominster	14/03/2023	21/04/2023	19	1
Lugg ward	29/03/2023	21/04/2023	10	1
Dinmore ward	30/03/2023	12/04/2023	2	0

Appendix 4: Infection Prevention team audit plan

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Completion	Progress
Post infection Spot Check Clinical Environment (Including hand hygiene, & BBE compliance)	Not applicable	Completed post HCAI acquistion	Locally developed tool focusing on the cleanliness of the clinical environment and equipment	HCAI Review panel	Completed as required	Completed
Hand hygiene & bare below the elbow (BBE) compliance	Monthly in all inpatient & outpatient clinical areas Bi annual in neighbourhood team	Completed post HCAI acquistion	Based on the Infection Prevention Society's hand hygiene observation tool	Infection Prevention Committee	Completed as required	Completed
Commode & toileting aid cleanliness compliance	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquistion	Locally developed tool focusing on the equipment's cleanliness	Infection Prevention Committee	Completed as required	Completed
MRSA Screening compliance	Not applicable	Monthly in High Risk areas Monthly review of 28 day screening Monthly monitoring of patients with known alert	Surveillance data	Infection Prevention Committee	Monthly KPI data	Completed
Infection Prevention Matrons Checklist	Monthly in all inpatient & outpatient clinical areas by Matrons	Monthly, supporting Matrons as per plan	Locally developed tool focusing on environmental cleanliness and clinical practices	Division Governance meetings	Monthly	In place
Audit of Diarrhoea & C. difficile infection prevalence, isolation and management documentation	Not applicable	Planned annual review	Locally developed tool reviewing the prevalence of patients with diarrhoea and their subsequent management	Infection Prevention Committee	Planned August 2022	Isolation audit completed
Audit use and completion of transfer documentation when patients are discharged to community hospitals and into district nurse care	Not applicable	Planned annual review	Locally developed tool monitoring communication between providers regarding a patients infectious status & management	Infection Prevention Committee	Planned August 2022	Audit not completed - roll overto 23/24
High Impact Interventions - Urinary indwelling catheter - Peripheral venous cannula - Central Venous Access Device - Ventilated patient	Quarterly	Following lapses in care being identified following HCAI - Completed as planned	Based on the Infection Prevention Society's High Impact Intervention care Bundles	Infection Prevention Committee	Various throughout year	completed
Audit of Time to isolation	Not applicable	Planned annual review	Locally developed tool monitoring compliance with the Trust isolation policy	Infection Prevention Committee	Planned September 2022	Audit not completed - roll overto 23/24
Infection Prevention Society Audits Waste management Linen management Dirty Utility Clean utility Equipment Equipment store room PPE Isolation Beverage Area Hand Hygiene environment Local Clean Toilets & Bathrooms	Not applicable	Planned annual review by theme Quarter 1 Quarter 2 Quarter 3 Quarter 4	Locally developed audits adapted from the IPS Process Improvement Tools (2019)	Infection Prevention Committee	Quarterly reports to IPC	75% audits completed. Discussed with NHSE. New plan set for 2023/24
National Standards for healthcare Cleanliness 2021: Efficacy audits:	Not applicable	Planned annual review of all patients facicing FR1,2,3 and 4 areas	National tool	Cleanliness committee	Planned to commence Jan 23	Completed
Mattress cleanliness and intergity audit	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquistion & manage annual review	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Planned to commence Feb 23	Completed

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	CQC report - Maternity inspection June 2023
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

The CQC inspected the Trust maternity services in June 2023 and inspected the safe and well led domains, other domains were not inspected. The final report was published by the CQC on 4th October 2023 and is presented to Board.

2. Recommendation(s)

The Board is asked to note:

- The safety domain is rated as requires improvement
- The well led domain is rated as good
- The overall rating is rated as good
- Actions were put in place after the initial inspection feedback to address any immediate areas requiring attention
- An action plan has been developed based on the findings and in relation to the regulatory requirements
- The draft action plan has been presented to Quality Committee and a final version will be presented to Board at the next meeting. Quality Committee will take overall responsibility for oversight of the action plan and a summary update will be provided to Board on a quarterly basis.

3. Executive Director Opinion[1]

The maternity service should be proud of the improvements that have been made since the last inspection and the ratings for well led and overall are to be celebrated. These improvements are as a result of the hard work and dedication of the maternity services MDT and management team whose focus is to ensure that services users and their families receive the very best care.

Actions are already underway to address the limited number of findings and recommendations contained within the report.

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

4. Please tick box for the Trust's 2023/24 Objectives the report relates to:	
Quality Improvement ☐ ***Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes*** ☐ ***Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)*** ☐ ***Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care*** ***Digital*** ☐ ***Reduce the need to move paper notes to patient locations by 50% through delivering our Digital Strategy*** ☐ ***Optimise our digital patient record to reduce waste and duplication in the management of patient care pathways*** ***Productivity*** ☐ ***Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations*** ☐ ***Reduce waiting times by delivering plans for an elective surgical hub and community diagnostic centre***	***Sustainability*** ☐ ***Reduce carbon emissions by delivering our Green Plan and launching a green champions programme for staff*** ☐ ***Increase the influence of One Herefordshire partners in service contracting by developing an agreement with the Integrated Care Board that recognises the responsibility and accountability of Herefordshire partners in the process*** ***Workforce*** ☐ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☐ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☐ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

Wye Valley NHS Trust

The County Hospital

Inspection report

County Hospital
Union Walk
Hereford
HR1 2ER
Tel: 01432355444
www.wyevalley.nhs.uk

Date of inspection visit: 27 June 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at The County Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at The County Hospital, Hereford.

We inspected the maternity service at The County Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

The County Hospital is a district general hospital located near Hereford town centre. It provides a full range of maternity services including a mixed antenatal and postnatal ward with 17 beds including three single rooms. There are 5 ensuite rooms on the delivery suite and an obstetric operating theatre located within the footprint of the maternity services. The hospital has a special baby care unit with 12 cots, but we did not inspect this as part of this inspection. There are approximately 1600 deliveries each year.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

The rating of this hospital stayed the same. The County Hospital ratings remains as requires improvement.

Our reports are here: https://www.cqc.org.uk/provider/RLQ

How we carried out the inspection

We provided the service with 48 hours' notice of our inspection.

During our inspection of maternity services at Wye Valley NHS Trust we spoke with 4 women and birthing people, 36 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the pregnancy assessment unit, triage bay, the delivery suite and the maternity ward. We reviewed the environment, maternity policies while on site as well as reviewing 6 maternity records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign and asked the service to send text messages to women and birthing people who had used the service to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We did not receive any feedback from women and birthing people in response to this campaign.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good ↑

Our rating of this service improved. We rated it as good because:

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vison and values, and how to apply them in their work. Managers monitored the effectiveness of the service. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it. Staff were committed to improving services continually.
- Staff morale was good. Staff felt respected, supported and valued.
- The service engaged well with women and birthing people and the community to plan and manage services. Women and birthing people we spoke with during the inspection were positive about their experience of maternity services.
- Leaders were focused on improving outcomes for women and birthing people receiving care.

However:

- Not all staff had training in key skills or had been trained in how to protect women and birthing people from abuse. Staff did not always carry out daily safety checks of specialist equipment. Planned and actual staffing numbers did not always match.
- The service could not be assured that cardiotocography (CTG) monitoring was reviewed in line with guidance.
- Leaders could not be assured staff assessed risks to women and birthing people or acted on them because policies were not always up to date, nor were they aligned to current and evidence-based practice.
- The role of the surgical assistant had not been risk assessed to ensure the role was carried out by staff with the right level of qualification and additional training.
- Leaders had not fully assessed the risks associated with the delivery of level 1 care for women and birthing people who were acutely ill and required enhanced care and monitoring.

Is the service safe?

Requires Improvement → ←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

Maternity

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training.

Staff were not up-to-date with their mandatory training. The service had undertaken a training needs analysis for all clinical staff working within the maternity department. The documents defined mandatory training as including both statutory and mandatory training. 'Specialist' training applied to staff working within the maternity department only.

The trust had an 85% training compliance target. Training records showed this target had not been achieved in over half of identified mandatory training for staff. For example: Moving and Handling Training Levels 1 and 2. Ninety-six percent of required staff had completed Level 1 but only 61% of required staff had completed level 2. For Adult Basic Life Support (Level 2) training, the compliance rates at the service for both medical and nursing and midwifery staff compliance was 44%. This meant the service could not be assured staff had the necessary skills and competence to provide lifesaving treatment to women and birthing people in their care. Training compliance for all staff for medicine management was at 79% which was below the trust target. However, further information sent to us following this inspection showed an improving compliance rate with most training compliance meeting trust targets. Adult basic life support and moving and handling remained below trust target at 50.2 and 79.3 % respectively.

The service provided multi-professional simulated obstetric emergency training (PROMPT) and 'clinical drills training' which included pool evacuation training, baby abduction training and clinical emergencies. The service monitored attendance for maternity specific training. Training was allocated by the training team, to individuals and they were allocated via the staff roster. We asked for training compliance data for pool evacuation, however the service was unable to provide this. We were told drill-based pool evacuation training took place monthly and was facilitated by the practice education midwives.

Training data indicated the service had achieved the 90% compliance target for midwifery staff. One hundred percent of active midwives had completed PROMPT training, 83% of midwifery care assistants had completed PROMPT training with skills and drills as a minimum and compliance rate for medical staff ranged from 80% for obstetric consultants through to 87% for other anesthetic doctors contributing to the obstetric rota. One hundred percent of midwives had attended the midwifery update day which included saving babies lives updates and 69% had attended external neonatal life support training within the last 4 years.

The practice education midwives told us more midwives would be trained to be NLS instructors and some would attend this training with a neighbouring trust in order to increase compliance with this mandatory training. Three midwives were already booked on with a December 2023 completion timescale.

Midwifery and obstetric staff were required to attend a cardiotocograph (CTG) fetal wellbeing training day. CTG is used to monitor fetal heart and uterine contractions. Consultant and junior obstetric doctors had achieved the trust target with 91% compliance for junior doctors and 90% for consultants. One hundred percent of midwives had completed the training.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Records showed staff completed level 2 safeguarding adults training. This was not in line with intercollegiate (2019, 2020) guidelines. The overall compliance rate was 92%, although only 73% of medical staff and 82% of maternity leadership and specialist roles had completed this training.

Training records showed that staff had completed safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Overall compliance rate for level 1 was 75%, for level 2 78% and for level 3 90%. However only 55% of medical staff had completed safeguarding children level 3 training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The trust had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the trust’s baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Maternity service areas had suitable furnishings which were mostly clean and well-maintained. Wards had recently been refurbished to the latest national standards.

We found some equipment had dust on them in difficult to reach places and there was visible dirt in one ensuite bathroom on the delivery suite. Cleanliness scores displayed on the delivery suite showed the level of cleaning met 3 stars of 5 possible. The service carried out cleaning audits weekly on the delivery suite, monthly on the maternity ward and bimonthly in antenatal clinic. Cleanliness scores were awarded using a star rating system, 5 being the highest rating. The service told us areas for improvement were actioned and reported to the Divisional Quality Group for monitoring. We saw that the delivery suite had improved their cleanliness rating from 1 star overall for April 2023 to 4 stars overall for June 2023. The maternity ward had decreased to 4 stars overall for June 2023 from 5 stars overall in April and May 2023. The score for antenatal clinic in May 2023 was 2 stars overall. Areas identified for improvement were actioned and reported at monthly divisional quality group meetings.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. We looked at the most recent (April 2023) audit for 5 moment hand hygiene which showed 100% compliance across the maternity unit. The service also audited that staff were bare below the elbow and demonstrated 100% compliance across the maternity unit.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic. Staff signed and dated when equipment was cleaned and ready for use.

Environment and equipment

Daily checks of emergency equipment were not always carried out. The design, maintenance and use of facilities, premises and equipment mostly met national standards and kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. For example, the obstetric airway trolley in the maternity theatre was only checked on one day in the week commencing 12 June 2023 and the major haemorrhage trolley had only been checked on 4 days the week commencing 15 May 2023.

Processes to ensure all consumables were checked and stored in intact packaging within their expiry date were not always effective. Staff did not record when the seal on the tamper-evidence trolley in the maternity theatre had been broken to check stock items were in date. We found 4 items which had passed their expiry date. Staff took action to replace these items immediately.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. However, the design and use of the anaesthetic room as a second operating theatre did not meet national standards and it was not clearly signposted as a second operating theatre. The anaesthetic room contained the minimal requirements such as anaesthetic equipment, resusciatiare and access to medicines but there was not a separate scrub area, and the airflow did not meet national guidance. It was only used in an emergency when it was assessed to be safer for the patient to have surgery urgently rather than being transferred. Records showed the anaesthetic room had been used on 3 occasions in the 12 months prior to our inspection. The service had completed an environmental risk assessment for the use of the intervention room as an emergency theatre and there was a plan for a new theatre suite to be in use by May 2024.

Following our last inspection of maternity services in 2019, the service had installed a curtain in the small recovery area to provide privacy for women and birthing people, their baby and their partners when they were recovering following a caesarean.

Access to the delivery suite was restricted. All people without swipe card access (staff), had to be let in and let out of the unit by staff.

There was one adult resuscitation trolley shared between the delivery suite and the obstetric theatre. This trolley was located in the main corridor of the delivery suite but not all staff in the maternity theatre knew where it was.

Maternity

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. The service had two birthing pools, one was an inflatable birthing pool and the other a static pool built into the ensuite bathroom facility. We were concerned that the location of the static birth pool would not allow for sufficient people and equipment to be used in the event of an emergency evacuation. Following the inspection, the service carried out an evacuation drill with their health and safety team. A decision was made to decommission this birth pool until an alternative option could be found because staff were at risk of hurting themselves in the event of a pool evacuation.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There were small touches in the otherwise clinical delivery rooms that made them cosier and more homely such as battery-operated candles and one room had a large mural on the wall. All delivery rooms had ensuite facilities.

There was a bereavement suite which was sensitively decorated and furnished This provided bereaved women, birthing people and their families with the necessary space and distance from the rest of the department.

The service had identified a lack of space in the triage area as a risk and was in the process of moving triage to a new area with more space to facilitate safer assessment and patient flow.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the delivery there were pool evacuation nets in all rooms with pools and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration. However, staff did not always use handover tools effectively.

Midwifery staff recognised when women and birthing people deteriorated and escalated concerns to medical staff. Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. An audit of 10 sets of patient records carried out in May 2023 highlighted good practice but also areas for improvement. MEOWS had been completed for each woman or birthing person, although it was noted in 1 out of the 5 cases that required escalating to a midwife, doctor or senior midwife had not been recorded. The audit concluded that the documentation needed to be improved when escalating to senior colleagues, including recording the action taken, provide a more detailed overview of the patients' physical state and rationalise when a specific observation had been missed. MEOWS audits were discussed at the maternity governance meetings along with any action required if applicable.

The service recognised the potential risk of worse outcomes for women from a Black heritage and other ethnic minority groups. Staff told us there was a lower threshold for escalating concerns and for transferring women and birthing people to a specialist maternity unit if required.

Maternity

The service had identified that triage posed a potential risk to women and birthing people due to the lack of space and current staffing model, and consequently triage had been included on the risk register. The service had a three-bedded triage bay located on the maternity ward as well as a separate one-bedded day assessment unit. Both areas were accessed via the main doors to the maternity ward. Triage was open 24 hours a day 7 days a week and staffed by two midwives, with support from a midwifery support worker during the day.

Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. The service had developed and implemented guidance which included a colour coded triage trigger list to help midwives and medical staff determine the clinical urgency in which women need to be seen.

The service had audited the use of their triage tool over 7 days during July 2022, although the analysis of the information was incomplete. However, the findings indicated that not all women and birthing people were seen within 15 minutes of arrival by a midwife, or within 30 minutes by a doctor. The audit also identified that 91% of attendees did not have a risk assessment completed. The long-term goal was to introduce a nationally recognised evidence-based triage system. A new triage call log had been introduced as an interim measure until data collection around triage arrivals and assessment times could be improved within electronic records. Following this inspection, the trust sent further audit information which showed women and birthing people were seen within 15 minutes of arrival 97.3% of the time and had a completed risk assessment 100% of the time.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used during pregnancy to monitor fetal heart rate and uterine contractions. Staff were required to attend a CTG Fetal Wellbeing Study Day and complete a competency test before they were recorded as passing the training. The Fetal Wellbeing Lead Midwife supported staff with CTG training and provided additional one to one support for staff as required. All CTG machines were wireless and linked to the electronic patient records. The service had introduced a centralised CTG monitoring system on the labour ward to support reviews imminently. There was an expectation that staff used a 'fresh eyes' or buddy approach for regular review of CTGs during labour. The recent audit in May 2023 highlighted that 'fresh eyes' had been completed hourly in 73% of cases reviewed. Risk assessments had been completed appropriately in 93% of cases, although only 20% had been updated hourly. However, following our inspection the trust sent us the CTG audit for June 2023. This audit showed improved compliance with 'fresh eyes', completion of risk assessment and hourly updates with compliance rates of 85%. Information and updates around CTGs were shared via the weekly newsletter, meetings and training sessions.

Staff completed surgical safety checklists in accordance with national guidance (World Health Organization: Safe Surgery) (WHO). Staff used an electronic patient care platform to record this. However, this platform was separate from women and birthing people's other electronic medical records and there was no paper copy completed and added to individual paper-based records. Leaders audited compliance with WHO checklists completed for all specialities and found that between January and March 2023 99.5% (707 out of 710) of checklists had been completed correctly.

There were arrangements for emergency transfers to specialist maternity units and the service worked well with the ambulance service to transfer patients in emergencies. It was recognised that it was a small service and there was a low threshold for transferring women and birthing people out.

There were processes to highlight anaesthetic risks such as potential difficult airway management during obstetric operations (caesareans) and if women and birthing partners wished to have a spinal anaesthetic for planned caesareans. This information was entered onto the electronic patient record system.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

However, shift changes and handovers did not always include all necessary key information to keep women and birthing people and babies safe. Midwifery staff told us they used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. The service audited 15 randomly selected patient records each month, to check all handovers from admission to discharge. We reviewed audits of handovers which identified there had been a decrease in the SBAR handover tool being used at each handover. The SBAR handover tool had been used in 53% of all handovers in the records audited in May 2023. In addition, the SBAR was most frequently missed when transferring between triage to the maternity ward or from change of staff member. The audit identified that staff amended management plans to reflect changes of care recommended by the medical staff but did not always record the name of the responsible clinician for the care.

During the inspection we attended medical staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The medical handover did not use a format which described the situation, background, assessment, recommendation for each person when sharing information, however, each medical handover was followed by a ward round where each patient's needs were discussed.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

The service provided transitional care for babies who required additional care as part of the overall Special Care Baby Unit (SCBU). Staff told us babies requiring transitional care who could be managed outside of the SCBU environment were cared for on the maternity ward with input from paediatric and SCBU team.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staffing on the delivery suite on the day of inspection, did not meet the planned staffing. There were 3 midwives working with no maternity support worker when there should have been 1 on duty in accordance with planned staffing levels. Staffing on the maternity ward and triage usually met planned staffing of 2 midwives and 2 maternity support workers on the ward, and 2 midwives and 1 maternity support worker in triage. However, there were multiple times the

triage area did not have a midwifery support worker and the second midwife was moved to another area when acuity was low. The day assessment unit was closed due to a lack of staff. One woman attending for a routine appointment had to be seen in triage, they had been waiting for several hours and said they had the same experience at a previous appointment.

The maternity theatre was staffed by staff from the main surgical theatres. There was a designated team on call for emergency caesareans and a separate team on days when women and birthing people were booked in for elective (planned) caesareans.

The role of the surgical assistant to assist consultants during caesareans was carried out by staff who were not suitably qualified in accordance with national guidance. We discussed this with leaders of the service following this inspection. They made the decision to continue this arrangement as it had been in place for a number of years and there had not been any recorded incidents as a result of this practice.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In May 2023 there were 11 red flag incidents, these included delays in induction of labour of more than 2 hours and movement of midwifery staff to cover other areas. All red flag incidents were discussed at safety champion and governance meetings along with causative factors and action plans to reduce further risk.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance. Planned and actual staffing numbers were closely monitored. For the weeks 27 March 2023 to 15 May 2023, the service was up to 1.75 midwives short for 12% of shifts and more than 1.75 midwives short for 2% of shifts. From December 2022 to May 2023, 5841planned hours were not fulfilled. Staffing shortages were identified as a risk and were on the risk register. Staff said told us staffing numbers were improving. The service had recruited 12 new midwifes commencing employment in September 2023. International recruitment was also ongoing.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

There was a clear escalation policy and process with identified priority rated triggers. This included collaboration with the wider local maternity services when required. Community escalation where community midwives were brought in to support inpatient areas had been used 3 times in the last quarter, additional measures to reduce the risk of staff working when they were tired had been introduced so staff did not work any more than 6 hours before having a break.

The service mostly made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Maternity

There were systems and processes for managers to support staff to develop through yearly, constructive appraisals for their role. However, not all staff were up to date with their annual appraisal. The figures ranged from 56% for staff working in antenatal clinic, 70% for staff who worked in leadership and specialist roles through to 95% of staff working on the maternity ward / delivery suite. However, information supplied by the trust following our inspection showed improving compliance rates with staff appraisals. Appraisal rates for leadership and specialist roles had improved to 100% with an overall staff appraisal rate of 82%.

A practice development team supported midwives. The team included 2 practice development lead midwives. There was a team of specialist midwifes to provide additional training and support. For example, the bereavement midwife was working on a new package of training for staff, they used an interactive case study during midwifery update days and medical staff training days. The service had recruited to all nationally recommended roles. This included the successful recruitment of the Trust's first consultant midwife.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

The service had 10.3 whole time equivalent (WTE) consultants in post, which exceeded minimum requirements in line with national guidance (Royal College of Obstetricians and Gynaecologists, 2010). The service had one vacancy for middle grade medical staff, and 8.5 WTE in post. There were 6 WTE junior grade medical staff in post, with 0.4 WTE vacancy.

There was a designated anaesthetic registrar rostered to cover the emergency maternity theatre. They had no other roles and were protected for maternity services 24 hours a day. They had access to a consultant to assist with emergency caesarean sections or for any other advice 24 hours a day. The anaesthetist consultant was either an anaesthetist consultant covering obstetrics, intensive care or general surgery. The elective caesarean sections were covered by a consultant three days a week.

There were twice daily consultant-led ward rounds which followed on from medical handovers. Medical staff also took part in daily multi-disciplinary team meetings where treatment and care for each woman or birthing person was discussed.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Whenever possible, the service used internal bank staff to cover any gaps in the staffing rota. Figures for May 2023 indicated the service used 121.5 hours of bank middle grade doctors and 50 hours of bank consultant on the delivery unit and maternity ward to fulfil the staffing rota. In June 2023 the hours had increased to 229 hours for middle grade doctors and decreased to 24 hours for consultant cover. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

Maternity

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Some medical staff told us there were limited opportunities for training and development and that they did not always have access to formalised supervision. This was reflected in the General Medical Council National Trainee Survey (GMT NTS) (2021) when only 25.6% felt local training met expectations. This had declined from 33.9% in 2019. There were fewer than 3 doctors that had completed this question in the survey in 2022 so this was not reported in the survey. The 2022 GNC NTS showed results had improved in 11 measures, 'overall satisfaction' increased from 51 to 78%.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. Wherever possible paper records were scanned into the electronic system. Staff completed surgical safety checklists in accordance with national guidance (World Health Organization: Surgical Safety Checklist). Staff used an electronic patient care platform to record this. However, this platform was separate from women and birthing people's other electronic medical records and there was no paper copy completed and added to individual paper-based records. We reviewed 6 electronic patient records and found records were clear and generally complete.

A digital midwife was employed to oversee and audit records. The trust was an early adopter of electronic record keeping within maternity services. The digital midwife had identified some required staff training and updates regarding functionality and utilisation and was working towards implementation. A maternity services documentation audit dated May 2023 reported 100% compliance with record keeping on the services electronic systems.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, although these were not always used effectively.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 6 prescription charts and found staff had not always recorded when medicines were administered or recorded the reason when medicines were omitted.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

We found medicines were managed safely. Staff monitored fridge temperatures to ensure medicines were stored under the correct conditions. Pharmacy department check medicines every day Monday to Friday.

Two staff checked controlled drugs twice a day. Two registered staff checked and signed when controlled drugs were administered. Medicine cupboards were locked and there was a separate key for the controlled drugs cupboard. However, the fridge in theatres was not always kept locked.

Oxygen cylinders were not always stored safely. We observed one oxygen cylinder which was stored on the floor and without being secured, in the recovery area of the obstetric theatres.

We found medicines were managed safely on the maternity ward and staff monitored fridge temperatures to ensure medicines were stored under the correct conditions. However, we noted there were gaps in the fridge temperature records, one in June 2023, 2 in May 2023, one in April 2023 and 2 in March 2023.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the10 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 3 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. Where appropriate to do so, managers shared duty of candour and draft reports with the families for comment.

Maternity

Managers did not review incidents potentially related to health inequalities. Although the trust's incident reporting policy required an equality impact assessment to be carried out. There was no record of this taking place in the 3 incident investigations we reviewed.

All incidents were a standing agenda item at safety champion and governance meetings. Incidents were discussed along with required action plans.

Managers shared learning with their staff about never events that happened elsewhere. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. The service used handover sessions to communicate incidents. Incidents were featured in 'theme of the month' learning for staff. Incidents were also discussed at monthly governance meetings along with action taken and action required to improve safety.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident. Case reviews also took place and explored what the team did well along with any learning to be shared with staff.

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons.

Maternity

The service was supported by maternity safety champions and non-executive directors. The board safety champion and non-executive director completed a monthly walk around and produced a written report. Safety champions were encouraged to attend these walk rounds, and time was taken to speak with women, birthing people and partners as well as members of staff.

Not all staff were aware of who the non-executive director supporting maternity services were or any direct route of escalating concerns if this was required.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Following a change in leadership and governance and management review, further specialist roles had been developed with new teams and additional matrons appointed.

A preceptorship programme was in place to support band 5 midwives with basic competencies and specific skills such as suturing.

All midwives completed enhanced care training about the management of arterial lines and had their competency assessed, this meant women and birthing people who required enhanced care could remain on the delivery suite with their baby where possible. However, not all risks associated with women and birthing people requiring level 1 care on the delivery suite were assessed.

Vision and Strategy

The service was developing a vision and strategy for maternity and neonatal services. Leaders told us although the trust had developed a strategy which included the vision and values, this did not include maternity services. They told us work was underway to develop the vision and strategy, including away days to enable consultation with staff.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. An Ockenden assurance visit took place in April 2023. The service was working towards meeting all essential actions and had an action plan in place. For example, changes were being made so that serious incidents were reported to the board monthly rather than every 3 months and work was underway to increase the accessibility of information for women and birthing people.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff told us there was a good atmosphere in the service and staff worked well together. There were arrangements for debriefing all staff involved with stressful or traumatic deliveries. Leaders told us they were proud of their staff and how they supported each other.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

The results of the Maternity Survey 2022 showed similar results when compared to other trusts. A small number of questions showed a decrease in satisfaction and covered all aspects of the service. The survey found that women and birthing people's experience could be improved through better communication throughout their journey. The service had reviewed the results of the survey and developed an action plan. Each action was rated in accordance with priority, had a responsible person and a completion date. All actions were added to, and progress tracked via the Quality Improvement action plan.

The service provided an overview of the main themes from the most recent local staff survey in 2022. The survey focused on staff wellbeing and culture. Staff were asked about how they felt their work week was going and if they accessed any wellbeing support provided by the trust. The survey identified that almost 20% of staff did not feel able to escalate concerns and 22% of staff did not feel the service was a good place to work. In addition, more than half of the respondents felt that they were not able to give the care they wanted to some or all of the time. The main themes were around staffing levels impacting on safety, and not being listened to or action taken when concerns were raised. The service had shared their proposed action plan with staff. Staff we spoke with during the inspection told us they were confident escalating concerns and said The County Hospital was a good place to work.

Staff had an awareness of how health inequalities may affect treatment and outcomes for women and birthing people and babies for ethnic minority and disadvantaged groups in their local population. However, staff were unable to identify specific actions or risk assessments to mitigate risks.

An external midwifery consultant had been commissioned to support demographic profiling. This meant maternity services would have improved information about women and birthing people with complex needs or known vulnerabilities and therefore improve planning to meet these needs.

Staff had access to interpreters if required when caring for women and birthing people for whom English was not their first language.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Staff told us they worked in a fair and inclusive environment.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Safety meeting minutes reported a reduction in complaints since the Matron and Patient Safety Midwife began to spend more time in inpatient areas and offering postnatal debriefs to woman and birthing people.

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. Complaints were a fixed agenda item at maternity safety meetings.

Maternity

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. Complaints risks and incidents were displayed in ward areas for staff updates about themes and feedback received. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Maternity and Neonatal Safety Champions Meetings took place monthly. There was a planned reporting schedule for 2023. Standard agenda items included feedback from the Maternity Voices Partnership, the monthly walk rounds and staff safety concerns. Other agenda items, for example, Avoiding Term Admissions into the Neonatal Unit (ATAIN), Perinatal Quality Surveillance Model update, feedback from assurance visits, Maternity and Neonatal Service Improvement Programme update were reported on in accordance with the reporting schedule. An action plan had been developed in June 2023 to address issues identified in the meeting.

Governance

Leaders operated mostly effective governance processes, throughout the service and with partner organisations. Guidance for staff was not always current and the harm was not always recoded accurately. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Guidance available to staff to plan and deliver high quality care was not always reviewed and referenced to demonstrate they were aligned to current and evidence-based practice. Guidance documents were not always reviewed when they should be and did not always show when the guidance was last reviewed to ensure they were compliant with latest evidence-based practice. For example, the Obstetric Haemorrhage Guidance (version 3) should have been reviewed in February 2022 and this guidance was not referenced to demonstrate it was aligned with current national guidance. Emergency drug boxes and guidance for staff about how to respond to emergency situations such as pre-eclampsia and post-partum haemorrhage were not aligned with best practice and guidance. Some medicines required in such an emergency were not available in the clinical area. The service took immediate action to address this. A rapid review took place, all required medicines were made available, and guidelines and algorithms were reviewed by an expert group along with confirmation they were in line with the National Institute for Clinical Excellence and Practical Obstetric Multi-Professional Training guidelines.

The service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The service reported data quarterly to the Board, ensuring oversight of performance. Quality Committee meetings (a sub board committee) chaired by a non-executive director provided quarterly reports to the board. These reports included safety, risk and successes. Performance measures included how many babies were born (activity), and number of caesarean sections, ante-natal care and ‘midwife to birth ration. However, there was a missed opportunity to report on safety performance measures such as triage within 15 minutes and delayed induction of labour. Other reports shared with the Board included updates on Ockenden assurance progress and compliance with the maternity incentive scheme. The Quality Committee also received the monthly perinatal quality surveillance model report. The Board level safety champion was able to raise anything with the Board at any time.

Maternity

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

All risks were recorded and scored in order of severity on the risk register. This was reviewed monthly at governance and speciality directorate meetings. Top risks across maternity services were staffing and triage. Action was planned and underway to mitigate these risks. The Associate Director of Midwifery was supported to make the necessary changes and told us the funding for improvement work had been agreed.

The maternity dashboard compared outcomes to national averages. Data showed improving outcomes for the months April May and June 2023. In particular, the number of women and birthing people asked about domestic violence had increased. The number of mothers and birthing people with a smoking status at delivery was above the national standard in April and May 2023 but had reduced to below the national average in June 2023. Post-partum haemorrhage of over 1500ml rate was at 5.6% in May and 3.1 in June 2023 against a national average of 3%. Incidents of post-partum haemorrhages were not reported with the correct harm grading in accordance with national guidance.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

They shared perinatal mortality review meetings with a neighbouring NHS trust every month. This meant that learning should be shared, and they could identify if service improvement could be made. These meetings were embedded and had been running for 2 years. Perinatal mortality reviews were holistic reviews of the patient care and pathway and would include specific discussion around those risk factors relating to heritage or social deprivation.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The trust had declared compliance with all ten safety actions required by the maternity incentive scheme.

Information Management

Maternity

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The information systems were integrated and secure.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. There were 2 MVP chairs, both were positive about the relationship they had with leaders and staff. They felt supported and involved. Monthly meetings were held to discuss any issues raised by women and birthing people. Examples of a quick and thorough response to any concerns raised by the MVP's were shared.

The MVP were involved in the Equality and Equity strategy, they were working towards improving engagement with harder to reach communities.

The trust has been using QR codes for the family/friend's test, these were displayed in clinical settings. The response rate had been poor, so a plan was in place to use text messaging to obtain feedback from women and birthing people. Feedback from women and birthing people was discussed and reviewed at governance and safety champion meetings.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. Antenatal education has been made available in multiple languages that had been assessed and based on local population needs.

Leaders were improving systems so the needs of the local population could be better understood.

The bereavement midwife worked with other organisations such as charities to support people after baby loss. Home visits were offered, and information was available in different languages. Staff had an awareness of meeting the needs of people from different cultures and religions.

Staff were engaged through staff meetings and newsletters. Weekly check in handover's took place at ward level to communicate changes or current themes.

A staff consultation period had commenced regarding staff rotation within maternity services. The 2021 NHS staff survey results showed a higher proportion of Black and Minority ethnic staff experienced harassment, bullying and abuse from patients, relatives or the public and staff in the previous 12 months.

Maternity

Results for disabled staff showed results were comparable to the average or showed positive results when compared to the average.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement forum, a multi-disciplinary group responsible for monitoring the progress of action plans and making collective decisions.

Changes were being made to the triage environment and a nationally recognised tool for risk assessments in triage was being introduced. Centralised CTG monitoring was almost ready to go live.

A new theatre suite was planned for May 2024.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The service was involved in the Giant Panda Trial for the evaluation of antihypertensive drugs used in pregnancy.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The service must ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out hourly. (Regulation 12 (2) (a) (b))

- Systems or processes must be established and operated effectively to monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. These must include the checking of emergency equipment, auditing of triage processes, ensuring all guidance meets national standards and reviewing grading of harm reported in incidents in accordance with national guidance. (Regulation 12 (2) (d))

- The service must ensure staff training compliance with mandatory training, including safeguarding training and specific maternity training to meet the local training compliance requirements. All staff must receive annual appraisals. (Regulation 12 (2) (c))

- The service must be assured that the role of the surgical assistant is risk assessed to ensure that the role is carried out by staff with the right level of qualification and additional training. (Regulation 12 (2) (c))

Maternity

- The service must ensure all risks associated with women and birthing people requiring level 1 care are fully assessed. (Regulation 12 (2) (a) (b))

- The service must ensure staff caring for those with an arterial line are trained and competent for the additional observation and care required. (Regulation 12 (2) (c))

Action the trust SHOULD take to improve:

Maternity

- The service should ensure effective communication tools are used when handovers take place at all shift changes and handovers between different areas.

- The service should continue to audit cleanliness in line with national standards and improve compliance.

- The service should ensure all staff are aware of the location of emergency equipment.

- The service should ensure an equality impact assessment is included within incident reviews.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector, a CQC operations manager and 2 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	**InTouch staff engagement**
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Chief People Officer
Lead Executive Director:	**Chief People Officer**
Author:	Chief People Officer – Geoffrey Etule
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To inform the Board of actions being taken to enhance the working culture and environment for staff following the InTouch staff engagement campaign conducted between May and August 2023.

2. Recommendation(s)

To note the actions being taken to address the issues raised by staff during the staff engagement InTouch campaign.

3. Executive Director Opinion[1]

Listening and acting on the issues raised by staff is an important way of strengthening the employee voice. By strengthening employee voice we are encouraging members of staff to be involved in bringing about cultural change to improve the working environment and service offered to our patients.

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

	Workforce ☒ ***Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners*** ☒ ***Develop a 5 year 'grow our own' workforce plan*** ***Research*** ☒ ***Improve patient care by developing an academic programme that will grow our participation in research, increasing both the number of departments that are research active and opportunities for patients to participate***

[1] Executive 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.

Staff engagement *InTouch* campaign – May to August 2023

Overview

The staff engagement *InTouch* 2023 campaign designed with 4 main themes (*patient care, flexible employer, health & wellbeing, compassionate & respectful culture)* was conducted throughout the Trust between May and August 2023. The 4 main themes are aligned to the NHS Staff Survey as we believe in giving everyone a voice in order to make improvements to patient care and the working environment.

Over 400 employees participated in the engagement sessions conducted across all divisions and 353 online survey responses were returned. 217 completed postcards were collected across all sites and HR business partners collated a significant number of verbal feedback from staff in their divisions.

Word cloud on the Intouch campaign

Way forward

Using staff feedback and information obtained during the *InTouch* campaign, the WVT staff engagement working group designed posters on the 4 main themes with actions to address the issues raised by staff during the campaign. These posters provide a high level summary of actions being taken on the issues raised and they are being published across WVT.

In addition to the posters, the Chief People Officer is overseeing a comprehensive staff engagement action plan for WVT and all divisions have local plans with monthly engagement sessions for staff.

The *InTouch* campaign posters are attached for information.

IN TOUCH 2023

NHS Wye Valley NHS Trust

YOU SAID...

How can we create a more compassionate & respectful culture?

- We need more visibility of board members
- We need more education and training
- We must enforce our zero tolerance policy on any bullying, harassment or discrimination
- We should provide more support to our international staff
- We must address all unprofessional behaviours

WE ARE...

- Introducing more walkabouts for board members and expanding the open door process to meet executive directors
- Rolling out civility & respect training sessions for all staff
- Introducing posters & leaflets on zero tolerance approach and taking stronger formal actions
- Developing direct non-executive director links between ward departments and the Trust Board

WE WILL...

- Train colleagues to act as active bystanders in teams so they have the confidence and senior support to call out any bad behaviours
- Introduce a sexual safety charter and policy to eradicate any sexual harassment or abuse at work
- Introduce a charter of support for international staff and enhance our staff support networks
- Recruit more freedom to speak up champions

IN TOUCH 2023

NHS Wye Valley NHS Trust

YOU SAID...

Becoming a more flexible employer?

- We want more flexible working rotas and working patterns
- We want line managers to be more flexible in approving requests for flexible working
- We need more childcare support
- We want to see a more flexible Bank office

WE ARE...

- Piloting flexible self-rostering nursing work rotas in the medical & surgical division from October
- Ensuring senior divisional management review of all requests for flexible working and 95% approved to-date
- Developing WVT partnerships with local childcare providers
- Streamlining Bank office processes
- Providing pensions support to staff and promoting retire & return to work options

WE WILL...

- Be publishing and showcasing different working patterns on the WVT intranet
- Reviewing recruitment adverts to ensure all jobs are advertised as open to flexible working
- Offering bank staff the opportunity to cover any hours they can do when called upon

IN TOUCH 2023

NHS Wye Valley NHS Trust

YOU SAID...

How can we improve health & wellbeing?

- We need more health & wellbeing programmes for staff
- We need more drinking water facilities
- We need hot food out of hours and better prices
- We should educate and train line managers on mental health
- We should enhance security at the Garrick House car park

WE ARE...

- Expanding the Halo wellbeing programme across all sites
- Piloting a staff physiotherapist and a staff mental health nurse in occupational health
- Rolling out mental health awareness training to all line managers
- Engaging with and developing mental health first aiders for staff
- Expanding our health and wellbeing programmes and working with Talk Community and other external partners
- Exploring the feasibility of introducing volunteer escorts to Garrick House car park

WE WILL...

- Install more drinking water facilities for staff in prominent areas of the hospital by December 2023
- Agree a plan with Sodexo by December to promote more reasonably priced food and on hot food options being introduced out of hours
- Provide access to green spaces for staff
- Implement a more comprehensive health & wellbeing strategy for staff by February 2024

IN TOUCH 2023

NHS Wye Valley NHS Trust

YOU SAID...

How can we improve the quality of care?

- We need to employ more staff
- We don't like boarding patients
- We should improve patient flow & discharges
- We need better equipment to enhance care
- We have too many agency staff

WE ARE...

- Improving recruitment & retention and have reduced our vacancies from 400 fte (11.21%) to 197 fte (5.43%) this year
- Implementing boarding to protect patient safety by offloading ambulances quickly
- Setting up a discharge to assess board with the Council to improve discharges
- Providing capital to divisions to purchase essential equipment
- Reducing agency spend from £9.9m (12.3%) to £6.8m (7.8%) this year

WE WILL...

- Introduce agreed ward & professional standards to improve patient flow
- Increase community capacity to reduce admissions, improve discharges and reduce boarding as quickly as possible
- Introduce a system to rapidly replace critical ward and department IT hardware when it goes wrong

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Update from the Integrated Care Executive (ICE)
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	ICE
Lead Executive Director:	
Author:	Erica Hermon on behalf Frances Martin
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the WVT Board on the ICE meetings held in September 2023.

2. Recommendation(s)

The WVT Board is invited to note the continuing development of ICE in providing oversight and assurance in relation to agreed areas of responsibility, including delegated services. There were no issues escalated to the One Herefordshire Partnership (OHP).

3. Executive Director Opinion[1]

NORTH AND WEST PRIMARY CARE NETWORK

The performance report identified five areas which were hoped to be achieved: to stabilise general practice; help solve capacity gaps; prove value from NHS investment in primary care contracts; dissolve the divide between primary and community care; deliver the new services in line with a long term plan. To support the delivery of these areas, data, integration and making effective use of resources was crucial.

In addition, the performance report confirmed that the Safeguarding Care Co-ordinator role has made a big impact in most networks, working closely with the ICB Safeguarding Leaders, to respond effectively to a significant number of cases, the number of which had increased markedly; of particular note are the increases in Weobley and Tenbury of 200+%.

ICE considered the contents of the performance report and discussed what information would be useful/relevant to ICE going forward. Further discussion would take place with the GP Leadership Team.

URGENT COMMUNITY RESPONSE

- Recent implementation of the new EMIS appointment slots for Hospital at Home had improved data collection and validation and is a useful tool for demand and capacity planning.
- Point of care testing is now live, enabling comprehensive blood analysis at patient's side.
- Streamlined referral admin and referral processes within CIRAH are enabling faster response time to service demands. This has received good feedback from General Practice.

DISCHARGE TO ASSESS (D2A)

Two meetings of the D2A Board have now taken place. The recent workshop outputs included how to implement the revised process and how to best source money for one commissioned resource.

[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.

GENERAL

In order to increase partner attendance, ICE will be changing the day/dates for future meetings. Importantly, this will allow PCN clinical directors to be represented at ICE.

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

Report to:	**Public Board**
Date of Meeting:	**05/10/2023**
Title of Report:	Quality Committee 31 August 2023 Summary Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	NA
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and Quality Committee Chair
Documents covered by this report:	NA

1. Purpose of the report

To provide a summary of the Quality Committee proceedings 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 to raise issues and questions as appropriate.

3. Executive Director Opinion[1]

NA

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

Quality Improvement

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

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

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[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.

Colposcopy Report

Committee received the 6-monthly report on Colposcopy services which was presented as a positive picture with acknowledged challenges currently around response times from Histopathology services due to staffing gaps. Committee was concerned that the report as presented makes assurance difficult due to the way data is presented, particularly around 4-week offer-of-treatment times, and some gaps in remedial actions being taken to address issues. We made a number of recommendations to improve future reports and to structure them in a way consistent with our Divisional reports.

Quality Priority – Infection Prevention and Control

Committee received the Annual Report for 22/23 and first quarterly report for 2022/23.

The Annual Report noted the significant efforts and resources invested in this area in 22/23, particularly around ensuring improvements in our cleanliness standards. Both C-Diff and E-Coli infections were below the expected level for the year.

The Quarterly Report noted higher than expected C-Diff rates for Q1, though have come down towards trajectory during Q2 to date. We also have high E-Coli rates and have investigated these further and found that this is related in the majority of cases to the patient's underlying condition.

Committee noted the higher than average rates of cleanliness breaches among agency and bank staff and sought assurance re the processes for recruitment from and reporting back to our agency suppliers.

Quality Priority – Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

Committee was disappointed to note that expected progress regarding auditing of practice following a major initiative to improve training and awareness levels had not happened in the last quarter due to a staffing vacancy. We noted, however, that the new Advanced Practitioner for MCA and DoLs starts on 1 September and audits will be among her priorities.

Quarterly Report – Medical Division

Committee received a comprehensive report from the Medical Division and noted:

- Positive progress with frail patients to reduce both falls and pressure ulcers.
- Working to improve the experience of people with autism and sensory needs when attending ED.
- Operational pressures continue to impact KPI's in ED prompting an increase in complaints and concerns.

We gave particular focus to the development of our virtual wards which have so far supported 204 patients. We heard case examples and patient feedback. Committee agreed that there is now a lot of learning from our virtual wards development and asked for a data-set including quality information to be included in future Divisional reports.

Quality Priority - Mortality

Committee noted the continuation in the reduction in our overall mortality scores with reductions too in areas of fractured neck of femur and heart failure and improvements in the depth of coding.

Maternity – Monthly PQSM Report

Committee received the monthly PQSM report and noted:

- Continuing high rates of caesarean sections for Robson Group 5 births which has prompted introduction of a new approach (iDecide) to support informed decision-making for mums.
- CNST standards for 24/25 have been published and we are reviewing actions need to ensure continued compliance where these have been changed. We are working to be fully compliant as we are with current year standards.

Staffing Report

Committee noted that the additional pressures on staffing due to front-door pressures, need to support patients in corridors and the level of patient acuity. Temporary staff costs have increased, particularly for bank staff. This is being managed tightly but patient need will continue to determine staffing levels.

Patient Safety Committee Summary Report.

The report from the Patient Safety Sub-Committee focused in particular on the new national Patient Safety Incident Framework including the work with the ICB to agree reporting requirements and the need to ensure sufficient resource of staff to continue undertaking investigations.

Patient Experience Committee Summary Report.

Committee was pleased to note the developing work programme for this sub-committee including work to support better stewardship of patient property, end of life care and how to avoid concerns raised becoming formal complaints.

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 15 June 2023 at 9:30 a.m. – 12:00 p.m.
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
Andrew Cottom	AC	Vice Chair, Non-Executive Director (NED)
In attendance:		
Clive Andrews	CA	Associate Chief Finance Officer
Mark Coton	MC	RSM Risk Assurance Services LLP., Assistant Manager, Internal Audit
Alan Dawson	AD	Chief of Strategy & Planning (For agenda item 3.6)
Robbie Dedi	RD	Acting Chief Medical Officer (For agenda item 5)
Mike Gennard	MG	RSM Risk Assurance Services LLP., Partner, Internal Audit
Erica Hermon	EH	Associate Director of Corporate Governance/Company Secretary
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP
Asam Hussain	AH	RSM Risk Assurance Services LLP.
Ian James	IJ	Non-Executive Director
Frank Myers MBE	FM	Associate Non-Executive Director
Katie Osmond	KO	Chief Finance Officer
Lauren Parsons	LP	Senior Manager, Audit & Assurance, Deloittes LLP
Jo Rouse	JR	Associate Non-Executive Director
Manjit Sandhu	MS	RSM Risk Assurance Services LLP., Senior Consultant & Lead Local Counter Fraud Specialist
Bradley Vaughan	BV	RSM Risk Assurance Services LLP., Manager, Local Counter Fraud Service

Minute		**Action**
AC001/06.23	**APOLOGIES FOR ABSENCE**	
	The meeting was recorded for the purpose of producing the minutes. Apologies were noted from Glen Burley, Chief Executive Officer and Jane Ives, Managing Director. Mrs Twigg (NED & Chair) introduced Jo Rouse, Associate Non-Executive Director to the meeting.	
AC002/06.23	**QUORUM & DECLARATION OF INTEREST**	
	The meeting was quorate. No declarations of interest were noted.	
AC003/06.23	**GOVERNANCE**	
AC03.1/06.23	**ANNUAL REPORT AND ANNUAL GOVERNANCE STATEMENT 2022/23**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented the Annual Report and the Annual Governance Statement 2022/23 and the following points were noted:-	

	• The ADoCG confirmed that the Annual Report has not changed significantly from that presented to the Trust Board, although details have been added regarding the PFI Contract Expiry; • Mrs Twigg (Chair & NED) commented that following the last full Board meeting the Audit Committee were delegated to formally sign off the document on behalf of the Board; • The ADoCG reported that before sign off some financial information is awaited, together with the updated remuneration and payroll engagement information, but confirmed that there is no material change expected to the presentation; • The Chie Finance Officer (CFO) reiterated that there were no material items required to change at this point and the Finance Team were working on the financial aspects before submission; • Mr Cottam (NED) questioned if the External Auditors (EA) had undertaken a review to ensure that the Trust is compliant to meet the requirements of the report in its preparation. It was confirmed that the ADoCG was provided with a checklist by the EA's and the NHS guidance format has been utilized to compile the Annual Governance Statement. It was noted that where there is a requirement the Trust is looking to meet the checklist; • The EA commented that the completion of the checklist was a helpful tool and once final numbers have been included the EA can use to cross check.	
	<u>Resolved</u> – that the Annual Report and Annual Governance Statement 2022/23 be received and noted.	
AC03.2/06.23	**<u>ANNUAL ACCOUNTS 2022/23</u>**	
	The Associate Chief Finance Officer (ACFO) presented the Annual Accounts 2022/23 and the following points were noted:- • The Associate Chief Finance Officer (ACFO) provided an apology to the Audit Committee for the delay in submitting the revised draft Annual Accounts 2022/23. A verbal update would be provided to outline any revisions and changes to the notes; • The slow progress on the production of the working papers was due to the volume of work, which has been difficult to maintain. The ACFO expressed that some of the submission dates had not been achieved and confirmed that work over the next few months would continue to ensure that deadlines would be met in future; • With the audits still ongoing, the current accounts position was relayed with some revisions outlined, these included:- o Notes on intangible assets, PPE and right of use assets (notes 13, 14 and 17) relating to asset based information. Following a review the notes are required to restate and reflect changes to asset categorisation and change the values that relate to additions, revaluations and reclassifications. The categorisations do not	

amend the value of the assets within the statement of financial position and therefore do not make any fundamental change to the balance sheet. Some review and amendment is required from the Finance team, which in turn will go through the audit process;

- The second area under PPE under the new assets on the balance sheet under IFRS16, where the Trust is required to re-measure the asset value based upon the market value. If it transpires that the lease value upon which the existing liability is based does not reflect the true market value. The team are looking to mitigate and identify where, if applicable, to any of the assets the Trust holds and to what extent it makes a difference;
- Accounts payable notes - A reclassification is required from accruals to receipts in advance of £403,000 between payables and receivables. The Trust mistakenly coded £35,000 worth of public dividend capital (PDC) debtor to payables instead of receivables, which will be amended accordingly;
- Narrative is required to income notes for agenda for change (note 3). The agenda for change 2023 non-consolidated pay award has to be included in the accounts and this needs to be reflected in the income side of the funding;
- Under note 8, Employee Benefits, the salaries and benefits for the capitalized staff costs have been amended to reflect the bank and agency capitalized costs as well as substantive. The 2022/23 figure has been amended to read £2,151 and the prior year figure has also been amended to reflect the same measurement as it was incorrect last year;
- A review of staffing whole time equivalents, which the Trust is required to report on, is being revised and is with Audit for review;
- The remuneration report is outstanding relating to the information provided around the pay multiples and the impact of the retrospective pay award on the calculation of the pay not supported within the remuneration report;
- The final area for revision is the off payroll engagements, which requires finalizing.

<u>Discussion</u>

- Mr Myers (ANED) requested that the page numbers are identified when presenters are speaking to their agenda items. The ACFO apologized for not stating the page numbers whilst updating, but the references were not available at the point the papers were collated;
- Mr Myers (ANED) commented that on page 75 of 385, Directors salaries and allowances table, Mr Myers is omitted. The ACFO apologised for the omission in this version of the papers but confirmed that Mr Myers will be included in the final version of the document;
- The ACFO confirmed that further amendments had been made, but were not presented in this version of the Annual Accounts 2022/23, therefore a verbal update was provided;
- The ADoCG commented that within the covering report the page numbers relate to the Annual Report and specific reference has been

	made to the page numbers quoted. The remuneration and engagement pieces are still outstanding; • Mr Cottom (NED) commented that there is still work outstanding on the report, but it was reassuring to read that the expected outturn is reported and does not just reflect the numbers presented but reflects a wider governance system that brings the numbers to that conclusion; • The CFO confirmed that the planning round was completed at the end of May 2023. The Trust is now into the audit process, but not as far along as expected at this point due to the Trust's lack of capacity to respond in the time allotted due to competing factors e.g. increased Audit requirements. The Auditors and the CFO are working closely to address the challenges to complete the report and support the team in their effort to finalize the document; • A team within Finance have been identified to focus on providing extra support into the Audit process; • The CFO confirmed that it was unlikely that the Trust would hit the national deadline of the 30th June 2023 for submission and the national team will be briefed to that effect; • Mrs Twigg (Chair and NED) confirmed that the Chair and Non-Executive Directors had been briefed on the current position and thanked the team for the work undertaken to complete the Annual Accounts 2022/23.	
	Resolved – that the Annual Accounts 2022/23 be received and noted.	
AC03.3/06.23	**EXTERNAL AUDIT – AUDIT FINDING REPORT 2022/23 (INCLUDING VALUE FOR MONEY)**	
	Deloittes, External Auditors presented the External Audit – Audit Finding Report 2022/23 (including Value for Money) and the following points were noted:- • Deloittes (EA) agreed that the process and learning from last year was considered and a number of steps had been implemented, including weekly and now almost daily meetings with the CFO to ensure progress is being made; • The EAs confirmed that their requirement is increasing year on year, with Finance teams reducing and with a greater divergence taking place. As a result Finance teams can become overwhelmed by Auditors requests; • The EAs confirmed that the report will not be completed by the 30th June 2023, but teams are pushing for completion. The EA's recognised that the ACFO has put a considerable amount of time and effort into completing the report; • The EAs confirmed that interviews will be scheduled with Executives and Non-Executive Directors following the completion of the Annual Accounts; • The EAs stated that the Trust will be in a similar position to last year, but with no major negative shifts on Value for Money;	

	• It was reported that no major issues have been identified regarding numbers reported in terms of the control total. A couple of issues being raised included the right to use assets and IFRS16, which are required to be completed; • Information relating to Remuneration and the inclusion of agency staff and agenda for change are causing delays; • Mr Myers (NED) received assurance and commented on the support and admiration for the CFO and the Finance team for their work; • Mr James (NED) challenged the EA and asked if the teams had learnt from the late submission from last year and asked if any learning and preparation had been made; • The CFO confirmed that preparation had already began with work commencing earlier, with more interim work with the EA team the restructure of the Finance team and additional capacity being incorporated; • The CFO confirmed that next year's submission is already being addressed with the appointment of new staff in the finance team to work on project work and systems and processes; • The EA commented that the due to the increase in audit regulations and the change in accounting standards, together with the introduction of IFRS16, ISA315 around risk assessments, documentation and the introduction of ISA240 increasing the work being undertaken around PFI, work has increased and there has been no simplification of documentation. The value to the public was brought into question and what can be done to ensure this is made simpler; • The EA commented that documents will be reviewed, which will ensure that the process runs smoothly; • Mrs Twigg (NED and Chair) commented that the proposal from the Audit Committee is that the Audit Finding Report 2022/23 is reviewed and completed via e mail return. There were no objections from the Committee. • The CFO reported that the Trust Board had delegated responsibility to Audit Committee for signing off the Accounts. Confirmation was received that sign off could not take place as an ISA260 had not been received from the EA and a final set of Annual Accounts and report required to review. No material changes are expected and it was suggested that a full set of the Annual Accounts will be circulated with a window for colleagues to confirm agreement or if the Audit Committee is required to reconvene for discussion.	
	<u>Resolved</u> – that the External Audit – Audit Finding Report 2022/23 (including Value for Money) be received and noted. **<u>Resolution</u> – it was AGREED that the Audit Committee circulate the final set of Annual Accounts 2022/23 and report for sign off.**	

AC03.4/06.23	**GOVERNANCE MAPPING**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented an update on governance mapping and the following points were noted:- • Governance meetings have been reintroduced with all Divisions, clinical safety and governance and the ADoCG to review governance mapping and ensure that the Terms of Reference and reporting lines are taking place and that Committees are not operating in isolation; • The completed governance mapping will be presented at the next Audit Committee to receive assurance.	**Agenda item**
	Resolved – that The governance mapping update be received and noted. **(A) Governance mapping to be presented at the September Audit Committee.**	
AC03.5/06.23	**NEW RISK MANAGEMENT FRAMEWORK POLICY AND PROCEDURES - DRAFT**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented the new Risk Management Framework Policy and Procedures in draft and the following points were noted:- • The purpose of the report is for the draft Risk Management Framework, Policy and Procedures to be approved by the Audit Committee. The report will be presented to Executive Risk Management for final approval, but given the recommendations by Internal Audit to review the risk management process the report has been presented to Audit Committee; • Following a review by Internal Audit (IA) of the risk management and Board Assurance Framework (BAF) arrangements and coupled with the implementation of a new risk management system (InPhase), the ADoCG undertook an overhaul of the existing risk strategy and policy documents; • It was noted that the Risk Facilitator had resigned; Discussion • Mrs Twigg (NED & Chair) thanked the ADoCG for the structured format of the report; • The ADoCG commented that the Appendix 1, the process, had been moved into the main document; • The Chief Finance Officer (CFO) requested that before the report is presented to Executive Risk Management (ERM) meeting the scaling on the consequence scores on the Financials be reviewed. **ACTION** • Mr James (NED) queried why there was not a standardized Trust document that ticks the boxes in terms of best practice and have requested that Internal Audit review the document. The ADoCG responded that IA were currently reviewing the document and	**EH**

	confirmed that there is no standard format, but that best practice has been taken into account and although the document has been written by the ADoCG, NHS policies from different Trusts have been utilized to produce the report; • Mr Cottom (NED) commented on the possibility of a GREEN opinion for the Board Assurance Framework (BAF). The IA agreed that once the new BAF has been implemented, the IA may be in a position to award a GREEN opinion. The report was still under review by the IA, but demonstrated that many of the recommendations had been fulfilled.	
	<u>Resolved</u> – that the new draft risk management framework policy and procedures update be received and noted. **(A) The Associate Director of Corporate Governance to review the scaling on the consequences scores within the financials before the report is presented to Executive Risk Management.**	
AC03.6/06.23	**<u>DHSC GATEWAY 5 REVIEW REPORT (HUTTED WARDS)</u>**	
	The Chief of Strategy and Planning (CoSP) presented the update on the Department of Health & Social Care (DHSC) Gateway 5 review report (Hutted wards) and the following points were noted:- • The purpose of the report is to share the outcome of the DHSC Gateway Review – Trust Ward Replacement and Additional Acute Bed Capacity; • Gateway Reviews are a standard approach by HMG for major infrastructure schemes, building in assurance gateways both prior to and after the delivery of the scheme. Gateway 5 is the final review following the completion of a project. The independent assessors interviewed stakeholders, listed in the report, and the investigators concluded that the scheme had been delivered behind an extremely difficult backdrop; • The outcome of the review Delivery Confidence assessment was rated GREEN due to the new wards build to replace the Hutted Wards being successfully delivered and operational for the last 12 months; • Three essential recommendations were made and work is underway to complete the recommendations; • The first is a Lessons learned exercise, which is underway by the Project Team and will be picked up for future capital projects. This will be reported through the new Capital Programme Board, Chaired by the Managing Director; • The second recommendation is a review of the benefits management plan which has been completed and aligns with the new wards; • The third recommendation is to establish a performance dashboard to track revised benefits to provide assurance, critical challenge of future proposed capital projects and assessment of value for money. The Capital Programme Board enables the Project Team to report performance and financial information on the scheme and the team are	

	exploring how benefits can be tracked following delivery of a scheme and future major capital schemes; • This scheme will be reviewed internally and a report outlining the benefits and delivery of benefit, or not, will be submitted to the Trust Management Board (TMB) by the end of September and thereafter the Audit Committee. <u>Discussion</u> • Mr James (NED) congratulated the team on delivering a GREEN rated scheme. One of the recommendations was highlighted around early assurance to test the robustness of decisions that were being made and the implications for current and upcoming projects. The Chief of Strategy & Planning (CoSP) responded that the increase in the governance and reporting mechanism together with a higher level of membership will allow for further scrutiny on decision making. With regard to Board level overview where larger business cases are discussed, outline business cases setting out the decisions made will now be presented to obtain Board support; • Mrs Twigg (NED & Chair) commented with regard to assurance would the three outstanding projects, Same Day Theatre build, Diagnostic Centre and IEC be presented at Audit Committee and would the Lessons learnt be visible in the report. The CoSP responded that the reports will be more explicit regarding the inter dependencies and the points that are being made and will be presented at Trust Board and TMB; • It was noted that with regard to the Lessons learnt exercise the completion date had not been finalized. The CoSP responded that an action plan recommendation to work through an Internal Audit report with a clear action against it will be produced to formalize the deadline dates against the recommendations. It was confirmed that the follow up review will be included once the internal end of project review has been completed as part of the business planning cycle. Confirmation was received that the follow up will be present at TMB followed by a presentation at the September Audit Committee.	**AD**
	<u>Resolved</u> – that the DHS gateway 5 review report (Hutted wards) update be received and noted. **(A) The Lessons learnt report to be presented at the September Audit Committee.**	
AC004/06.23	**<u>MINUTES</u>**	
AC04.1/06.23	**<u>MINUTES OF THE MEETING HELD ON THE 16 MARCH 2023 - DRAFT</u>**	
	The draft minutes were agreed as an accurate record of the meeting.	
	<u>Resolved</u> – that the draft minutes of the meeting held on the 16 March 2023 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	

AC04.2/06.23	**MINUTES OF THE MEETING HELD ON THE 26 MAY 2023 - DRAFT**	
	The draft review of WVT Accounts minutes were agreed as an accurate record of the meeting, with one amendment noted by the CFO in agenda item ACDA002/05.23 – Review of Draft WVT Accounts. "The CFO and Mr James (Chair of the Quality Committee and NED) have held weekly meetings…to be amended to The CFO and Ian Howse, Deloittes have held weekly meeting." The draft Internal Audit reports review minutes were agreed as an accurate record of the meeting.	
	Resolved – that the draft Internal Audit report review minutes of the meeting held on the 26 May 2023 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC004/03.23	**MATTERS ARISING AND ACTIONS**	
	The completed actions on the action log were noted. **Actions from the Audit Committee held on the 16 March 2023** **AC08.2/09.22 – Losses and compensation** – Senior matrons to be contacted regarding their perspective on the initiative to increase awareness to reduce levels of lost items and personal effects by patients. The Chief Finance Officer (CFO) confirmed some e mails had been received and the CFO has agreed to work with the Chief Nursing Officer and the nursing community to reinforce the messages around the wards. **CLOSE ACTION** Mr Myers (NED) questioned the process of loss of personal effects by patients and it was agreed that a proposed next steps is undertaken and brought back to a future Audit Committee. **ACTION** AC06.1.1/12.22 – Effective Recruitment & Retention – As representative of the Recruitment & Retention Steering Group Mr James (Non-Executive Director) to provide weekly updates from the meetings to all NED's. All NED's to be added to the circulation list of the Recruitment & Retention Steering Group. **ACTION COMPLETED** AC05.1/03.23 – Governance Mapping – The meeting structure governance to be share with governance and risk leads at Divisional level to demonstrate the support provided at overall governance level. Governance mapping to be presented to next TMB ahead of wider distribution. Agreed to carry forward. **ACTION** AC05.1/03.23 – Governance Mapping – Governance mapping to include the reporting mechanism and frequency to be distributed with the Minutes. Governance mapping to be presented to next TMB ahead of wider distribution. Agreed to carry forward. **ACTION**	**KO** **EH** **EH**

	AC05.1/03.23 – Governance Mapping – The Associate Director of Corporate Governance to investigate the reporting route of the midwifery and maternity directorate and will feed back after the meeting. Confirmation was received that the reporting route is through the Surgical Division who report through the Finance & Performance Executive. Agreed the ADoCG will take as an agenda item at the next Divisional Governance meeting and update at the next Audit Committee. **ACTION**	**EH**
	AC05.4/03.23 – Progress update to be provided on the InPhase implementation. The ADoCG presented a verbal update to the June Audit Committee. **ACTION CLOSED**	
	InPhase – The key milestones and implementation is delayed with many Trusts moving from Datix to InPhase. The Trust has addressed this with the Company. It was noted that the system was not at full operating capability. A drop in incidents has not been detected, but the transfer of historic data from Datix remains an issue. It was reported that InPhase were the only company that enabled data transfer from Datix. There were some issues highlighted with functionality and the pathway that InPhase used. The ADoCG confirmed that InPhase was on the risk register and the Trust is currently working with the company to work through the issues. A document outlining the change and benefits of using InPhase was presented at the last Audit Committee by Lynne Carpenter, Quality & Safety Matron.	
	AC06.1/03.23 – Internal Audit to share Effective Recruitment & Retention report and Associate Director of Corporate Governance to distribute to Non-Executive Directors and wider committees with interest in workforce**.** It was agreed that the report had not been shared. Action to remain on action log. **ACTION**	**EH**
	AC06.2/03.23 – Recommendation Tracker – Chief Finance Officer to discuss the joint Procurement policy with the Procurement team to progress. The CFO confirmed that the Associate Director of Procurement is now back from maternity leave and is now being prioritized. It was confirmed that a draft Group Procurement policy will be in place by September. **ACTION CLOSED**	
	AC06.2/03.23 – Recommendation Tracker – An extraordinary meeting to be arranged to review outstanding reports. A meeting was held on the 26 May 2023. **ACTION CLOSED**	
	AC06.3/03.23 – Internal Audit Plan 23/24 – Long List – Confirmation received that Internal Audit did update and complete the long list and share with Audit Committee members. **ACTION COMPLETED**	
	AC07.1/03.23 – LCFS Progress Report – Confirmation was received that the link to the Culture Survey from LCFS was circulated by the Chief Finance Officer to Divisional colleagues and budget holders. **ACTION COMPLETED**	

	AC08.3/03.23 – Business Continuity update – The Associate Director of Corporate Governance and CFO to include Business Continuity Plans in the work plans and propose a date to be presented to a future Audit Committee. The ADoCG confirmed that the progress update by area was attached to the Audit Committee papers. The plans are reviewed through the Emergency Planning Committee with deep dives taking place into each business continuity arrangements on a rotational basis. The loss of IT and facilities were highlighted. Mr Myers (ANED) commented on the escalation in Cyber risks and requested that a review of cyber protection. The CFO responded that a Board workshop in July will discuss Cyber risks. **ACTION CLOSED.** AC08.4/03.23 – Accounting Policies changes for 2022/23 – The Accounting Policies paper was circulated and included as part of the Annual Accounts. **ACTION COMPLETED** **<u>Actions from the Audit Committee – Internal Audit Reports Review held on the 15 June 2023</u>** ACIA005/05.23 – Consultant Job Planning – The Chief Finance Officer to review the resource available around job planning and the use of Allocate. The action was forwarded to the Chief People Officer for comment. Discussion at the E Rostering Board regarding the resource and capacity to build on progress already made to embed and obtain the benefits. A resource is in place for one year to support following a due governance and diligence process, which is supported. An update will be provided at the next meeting. **ACTION CLOSED** ACIA005/05.23 – Consultant Job Planning – An update to be provided by the Deputy Chief Medical Officer (DCMO) to provide background around Job Planning Committee and associate work around this area. **ACTION CLOSED.** Consultant Job Planning - Robbie Dedi, Deputy Chief Medical Officer (DCMO) and Chair of the Job Planning Committee presented the update and the following points were noted:- • The purpose of job planning is to identify the work undertaken by the Consultants for the NHS, the Consultants timetable, how it is quantified and the resources available for the work to be completed; • Job planning is linked in part with the appraisal process; • This allows for more accurate business planning and to allow for Consultants capacity; • Appointment of Michael McDonagh is the job planning expert; • Capability and the use of the Allocate system was an issue; • Sign offs of job plan were not being undertaken as two sign offs required; • 38% job plans have now been signed off, with a further 20% awaiting sign off; • Run job planning from April 2024 to August 2024; • Development programme with job planning master classes through 2024/25;	

	Discussion • It was agreed as an action that the presentation is shared with the Audit Committee. **ACTION** • Mr Myers (ANED) expressed concern regarding the amount of resource available to complete the Consultant Job Planning. The DCMO responded that the dedicated resource, Michael McDonagh, together with Band 5 support is helpful but the issue lies with the clinician's time and general management team. There is a risk that traction will be lost and the position would be reversed if the resource was not available. Some resource will always be required to support the general managers and clinicians and permanent back office support; • Mr Myers (ANED) also mentioned cooperative attitude and the possibility of building in a contractual requirement when recruiting new Consultants to ensure this is enforced. The DCMO responded that this is not built into the national Terms and Conditions and cannot be built in. It was noted that almost all the Consultants have engaged in job planning, but capacity is the issue; • The areas within job planning that remain unfinished are Anaesthetics (22), to input on system and sign off and Trauma & Orthopaedics (15), which have raised issues around rotas; • Mr Cottom (NED) suggested that the Audit Committee have sight of Consultant Job Planning as the potential benefits to the Trust are significant. Mrs Twigg (NED & Chair) requested an update on the position at the December Audit Committee and six monthly thereafter. Item to be added to the agenda. **ACTION** ACIA006/05.23 – Cleanliness Standards Audit – Discussion planned by Mr James (NED) with the Chief Nursing Officer regarding cleanliness and infection prevention are captured. **ACTION CLOSED**	**WT**
	Resolved – that the Action Update be received and noted. **(A) Consultant Job Planning presentation to be distributed to Audit Committee members.** **(B) Consultant Job Planning to be added as an agenda item to the December Audit Committee and every six months thereafter.**	
AC006/06.23	**INTERNAL AUDIT**	
AC06.1./06.23	**IA PROGRESS REPORT**	
	RSM, UK Internal Auditors (IA) presented the IA Progress Report and the following points were noted:- • The IA presented the key messages where it was reported that six of the final reports were presented at the Audit Committee meeting held on the 26th May 2023. These included:- o Cost and Productivity Improvement programme (CPIP) which received partial assurance; o Discharge Management , which received reasonable assurance;	

	○ Consultant Job Planning, which received partial assurance; ○ Key Financial Controls – Accounts payable and Accounts Receivable, which received reasonable assurance; ○ Cleanliness Standards, which agreed upon the procedures; ○ Risk Management and Board Assurance Framework, which received partial assurance; • As the final reports had been previously presented at Audit Committee, they were not included with the Progress Report; • The Data Security Protection Toolkit received substantial assurance; • Three outstanding reports remain and include:- ○ Strategic Workforce Planning. This has now been scoped and a start date has been agreed; ○ Business Planning Process; ○ Sickness Absence Management. This review is planned for next quarter; • The IA plan to commence work on reports earlier to avoid delays with future reporting. Two changes were highlighted from last year's Internal Audit plan, the Audit of Audits and the Strategic Workforce Planning, the two plans were deferred from last year's plan. The Audit of Audits requires time for the policy to embed and support to be provided to the different areas and the Strategic Workforce Planning required a large proportion of engagement and therefore a review of the work is planned for next month and will be reported this year; • It was noted that the report times for the KPI's are higher than the 10 day target. The team are working with the CFO and the Finance team to reduce the time back to the 10 day target; • There were 125 actions on the tracker, which is a large increase from the 24 that were previously reported. The reason provided was that eight final reports have been loaded on to the system and 46 actions came out of the Financial Sustainability report. 12 now closed and implemented, 35 closed off as superseded (31 were from the Financial Sustainability review, the actions will be managed by the Finance team), 52 not reached target for implementation date and 26 receiving revised implementation dates; • The CFO commented on the 'In Progress' status within the tracking reports related to the Financial Sustainability audit. All of the actions required completion by the 31 January 2023, when the review had just taken place in quarter 3, this timescale was not realistic; • The ADoCG commented that the Non-Executive Directors were required to undertake their Information Governance (IG) training. It was noted that an e mail, including a power point presentation, was sent to all NED's with the training attached and a six question assessment, which would evidence how to work it.	
	<u>Resolved</u> – that the IA progress report be received and noted.	
AC06.1.1/06.23	**<u>INTERNAL AUDIT PLAN 2023/24</u>**	

	RSM, UK Internal Auditors (IA) presented the Internal Audit Plan 2023/24 and the following points were noted:- • The Long List was shared at the March 2023 Audit Committee. The revised plan within the papers reports that the budgeted number has now been achieved and the plan is within the affordability. The plan includes the risk based assurances and core assurances, together with the reviews that have yet to be carried forward; • Next year the key reviews include Sickness Absence, Health Rostering, Junior Doctors Rota and Management, Business Planning and Agency Spend, Clinical Nurse Specialist Team, DOLS and the application of the Mental Capacity Act, Divisional Governance and a revisit of the Financial Sustainability work from last year; • The IA will work with the ADoCG to review the core assurance around the Board Assurance Framework (BAF) and Risk Management to improve the Opinion and to follow up on the Financial Controls; • Mr James (NED) commented on retention, which is on the plan for next year, but requested that if there was any capacity for this year could the Recruitment and Retention report be prioritized. Mrs Twigg (NED & Chair) responded that a report had come through Audit Committee in January 2023 following a large internal audit which had a number of points to complete this year and to ensure that the actions had time to embed. It was agreed that the Recruitment and Retention report be presented in 2024; • The IA commented that if any slippage or reprioritisation is available, depending on how the Trust has progressed on the actions, the Recruitment and Retention review will be prioritized.	
	<u>Resolved</u> – that the Internal Audit Plan 2023/24 update be received and noted.	
AC07/06.23	**<u>COUNTER FRAUD</u>**	
AC07.1/06.23	**<u>LCFS ANNUAL REPORT 2022/23</u>**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Progress Report and the following points were noted:- • One of the emerging risks highlighted is mandate fraud and scamming frauds. The Trust will be alerted to any new scams over the coming year to ensure that controls are put in place; • The LCFS requested the wet signature of the Chief Finance Officer to confirm the Compliance against Government Functional Standards (page 335) to enable the NHS Counter Fraud Authority to undertake an assessment if required. **ACTION** • The LCFS requested that the Audit Committee consider two questions:- o Is the Audit Committee content there is a strong anti-fraud culture within the Trust and the tone is set from the top?	**KO**

	○ Is the Audit Committee satisfied that there is an effective fraud risk management programme in place to identify and manage the risk of fraud? • Mrs Twigg (NED & Chair) commented that there were no objections and both questions were fully supported by the Audit Committee.	
	<u>Resolved</u> – that the LCFS Annual Report 2022/23 was received and noted. **(A) The Chief Finance Officer to sign page 335 of the LCFS Internal Audit Plan 2023/24 and return.**	
AC07.2/06.23	**<u>LCFS PROGRESS REPORT JUNE 2023</u>**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Work plan and the following points were noted:- • The Trust was fully compliant and received a GREEN rating by the LCFS following the submission of the Counter Fraud Functional Standard Return. An action plan providing individual requirements for further improvements is provided within the report; • 19 high risk matches have been identified, seven have been closed with no further action required. The Trust is reviewing creditor matches; • The ADoCG commented on the response rate from staff on the issue of receiving gifts and hospitality from suppliers and contractors and questioned the best practice for messaging and engaging with staff on these issues; • The LCFS responded that further cyber awareness training is being undertaken for the Trust. The pandemic has had an effect on communication and the LCFS team are keen to visit the Trust to speak to staff to share their experiences.	
	<u>Resolved</u> – that the LCFS Progress Report June 2023 was received and noted.	
AC07.3/06.23	**<u>LCFS 2022/23 WORK PLAN</u>**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Work plan and the following points were noted:- • The Work Plan was approved by the Audit Committee in March 2023 and attached to these papers as a final version of the report.	
	<u>Resolved</u> – that the final version of the LCFS 2022/23 Work Plan was received and noted.	
AC008/06.23	**<u>EXTERNAL AUDIT</u>**	
	• Item discussed in agenda item 3.3 above.	
	<u>Resolved</u> – that the External Audit update was received and noted.	

AC09/06.23	**FINANCIAL FOCUS**	
AC09.1/06.23	**ICS FINANCIAL REPORTING/GOVERNANCE UPDATE**	
	The Chief Finance Officer (CFO) presented the ICS Financial reporting/governance update and the following points were noted:- • The CFO confirmed that at future meetings a report will be presented rather than a verbal update; • Herefordshire and Worcestershire ICS is a deficit plan system and the Trust is awaiting a formal letter to conclude the planning process. There will be a series of enhanced controls applied to the system as a result that we are a system in deficit. Further oversight on pay spend, non-clinical posts and actions and activities around medical and nurse agency, commitment around new spend (business cases) or new items of low value spend. A schedule has been drafted and will be distributed to budget managers and holders to act as a crib sheet in terms of enhanced controls that have been put in place locally e.g. medical agency or vacancy review panel; • From a system perspective a framework for investment and expenditure will identify short term actions coming out the national expectations and provide a framework and forums to review medium term financial plans. A draft document on working together across the system will be presented at a future meeting; • From a system perspective linked to the planning perspective, a review is currently underway on what worked and what did not. A face to face session is taking place with ICS colleagues, workforce and finance teams to feed in some initial thoughts going forward to improve work processes for next year, which will be updated in this section at the next meeting; • Mrs Twigg (NED & Chair) reported that members of the ICS have been invited to join future Audit Committee meetings up to and including the end of the Financial Year. A commitment has been made across the ICB to share the learning and feed into the ICB and bring into line some internal audits going forward; • Mr Cottam (NED) questioned how decisions are being made around investments and the issues involved and how the Trust utilizes the planning process and the allocation of funds held centrally. Could this be improved and whether there is a recurrent decision that all the organisations within the ICB know where they stand; • The CFO responded that there is a lack of transparency around the final steps. Initially there was a plan, but the system has not seen the final output or the clarity of decisions that happen behind it; • Mrs Twigg (NED & Chair) requested that questions are asked at the NED's meeting taking place next week; • The CFO explained about the controls, which will be enforced on the Trust and reported that any new spend over £10k will require ICB and regional support. The national view is that people are committing to spend money that we do not have. In the medium as part of a system	

	we can influence and agree collectively how we work together through the framework to keep decisions moving.	
	<u>Resolved</u> – that the ICS financial reporting/governance update was received and noted.	
AC09.2/06.23	**<u>LOSSES AND SPECIAL PAYMENTS REPORT – QUARTER 4 2022/23</u>**	
	• The Associate Chief Finance Officer (ACFO) will update the Losses and special payments report – quarter 4 2022/23 as a separate item.	
AC10/06.23	**<u>AOB</u>**	
	• No other business was noted.	
AC12/06.23	**<u>DATE OF THE NEXT MEETING</u> –** **14th September 2023 – 9:30 a.m. – 12:00 p.m. via TEAMS**	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 27 July 2023 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
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Associate Non-Executive Director
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director
David Mowbray	DM	Chief Medical Officer – Left during Item 9 and returned during Item 11
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Annette Arnold	AA	Matron for Maternity Inpatients – For Items 10 and 11
Jonathan Boulter	JB	Associate Chief Operating Officer, Surgery
Robbie Dedi	RD	Deputy Chief Medical Officer
Hazel French	HF	Named Nurse Safeguarding Children – For Item 6
Kirstie Gardner	KG	Named Nurse Children In Care – For Item 6
Lucie Grisewood	LG	Infection Prevention and Control Nurse – For Item 5.1
Rachael Hebbert	RH	Associate Chief Nursing Officer – Left after Item 11 and returned during Item 13
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Abbi Maddox	AM	Matron for Community and Antenatal Services – For Items 10 and 11
Sue Moody	SM	General Manager - Acute and Countywide Services
Rachael Skinner	RS	Integrated Care Boards Representative – Left during Item 9 and returned during Item 12
Emma Smith	ES	Divisional Nurse Director, Surgery
Emma Wales	EW	Associate Chief Medical Officer, Medical Division

QC001/07.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Leah Hughes, Operational Clinical Lead Radiographer.	
QC002/07.23	**QUORUM**	
	The meeting was quorate.	
QC003/07.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	

QC004/07.23	**MINUTES OF THE MEETING HELD ON 29 JUNE 2023**	
	Mr James (Chair of Quality Committee and NED) felt that an action should be added in relation to the Clinical Support Division Report around pulling together all the information around 62 day performance for cancer.	**SM**
	Resolved – that the minutes of the meeting held on 29 June 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	
QC005/07.23	**ACTION LOG**	
	(a) QC020/06.23 – Prevention of Future Deaths Report – (B) – The Deputy Chief Medical Officer will review how the Regulation 28 Report to Prevent Future Deaths can be discussed at Safety In Sync. Action carried forward.	**RD**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The Deputy Chief Medical Officer will review how the Regulation 28 Report to Prevent Future Deaths can be discussed at Safety In Sync.**	**RD**
	BUSINESS SECTION	
QC006/07.23	**QUALITY PRIORITY – IPC (CLEANLINESS/C-DIFF)**	
	The Infection Prevention and Control Nurse (IPCN) presented the Quality Priority – IPC (Cleanliness/C-Diff) presentation and the following key points were noted: • **Objectives** - The four objectives are: 1. Monitor infection rates, 2. Develop a joint Cleanliness strategy with Sodexo, 3. Comply with the NHS National Standards of Healthcare Cleanliness 2021, 4. Adhere to actions set in the Infection Prevention Improvement Plan. • **Monitor Clostridioides difficile infections** – This includes: Risk Register, ICS supported analysis of data to identify trends, NHSE West Midlands collaborative working group, Antimicrobial stewardship, Commode cleanliness, #StoolSmart. There have been 17 cases of C-Diff in the Trust so far which will take us above our monthly threshold (the Trust have an annual threshold of 43 cases). Two of these were Community Onset Healthcare Associated and the remaining 15 were Hospital Onset Healthcare Associated (HOHA). Fourteen cases were reviewed at the Healthcare Infection Panel – there were 8 lapses of care identified which may have results in the acquisition of C-Diff. Four lapses were not deemed to be linked to acquisition of C-Diff but linked to lapses in care. • **Joint Cleanliness Strategy** - This has been presented previously. We are working with Estates and Sodexo on this.	

	• There are 5 key strategies: Develop a transparent & integrated cleaning schedule, Implement SOP's in line with national cleaning standards, Develop a robust monitoring system with clear outputs, Deliver exceptional patient service through cleanliness, Continuous improvement patient/visitors touchpoints. The Group meets fortnightly and review any area of concern along with providing support and escalation where required. • **National Standards of Healthcare Cleanliness 2021** – Sodexo FR1 – Generally good performance against the expected standards although a marginal drop for Sodexo for FR1, this is being reviewed and rectified. • Q1 2023 – 3 Stars or below (There are no areas that scored below 3 stars) – Clinical Support - Mortuary (FR3) – Star Rating improved. Integrated Care - Ross public toilet (FR2) – 3 Stars in April and May, revalidated figure in June now 5 star. Medical - ED (FR1) – remains at 3 stars. Surgical – Frome 3 starts in April, 4 starts in May and 5 stars in June. Delivery – 1 star in April, 3 stars in May and 4 stars in June. Ante-natal – 1 star in May. Awaiting revalidation results. In total, 71 areas were reviewed. • **NCS21 – Internal audit** - Audit focused on compliance against the four key areas within the NHS National Standards of Healthcare Cleanliness 2021 (standards 7, 8, 9 and 11). 47 elements checked, 39 compliant, 8 required further work, this is due to report back to the Audit Committee in September • **IP Improvement Plan** – 46 actions agreed. Overall progress against the IPIP to date: 74% (34/46) of the actions have been completed, 24% (11/46) of the actions are on track for completion by the agreed deadline, 2% (1/46) of the actions are on hold, pending review, 0 % (0/46) of the actions have delayed completion One action has been placed on hold pending details from NHSE: Quality; Criterion 1. Seven actions have extensions to enable completion**.** Discussed with key staff who have confirmed that the actions are on track to be completed within the new timeframe. • **Next Steps** – Monitor Infection Rates, Develop a joint Cleanliness strategy with Sodexo, Comply with the NHS National Standards of Healthcare Cleanliness 2021, Adhere to actions set in the Infection Prevention Improvement Plan. We have contacted a Trust who have achieved Exemplar status as we strive to achieve this too. • These standards need to be embedded culture in the Trust – This is not an overnight fix. Our contract with our PFI partners does not reflect the changes made to cleaning standards – we are working to amend this, but the changes are not yet documented. Some issues are long term, eg showers not suitable in Lugg Ward and issues around the toilets in Day Case Unit, which we are working on.	

	• Mr James (Chair and NED) liked the new format. Cleanliness has been an ongoing issues for us which we have been working on now for a number of years. He noted the hard work that has gone into the improvements made. • Mrs Frances (NED) echoed these comments and went on to ask how the Quality Committee, especially the NEDs, can help. The IPCN will be in touch when an opportunity arises. • Mr James (Chair and NED) queried how cleanliness relates to C-Diff, as not all C-Diff cases relate to this. The IPCN advised that all patients are reviewed following a C-Diff diagnosis. This includes a review into any lapses of care which could have contributed to this. It has been noted that some patients have had a HOHA C-Diff with failures to comply with cleanliness, particularly relating to toileting aides and commodes. If this failure is found, it is noted that the C-Diff was linked to a lapse in care. Other elements may also be a factor, eg inappropriate antibiotic prescribing. All patients with C-Diff are typed to see what type they have. • The Chief Nursing Officer (CNO) advised that it is evidence based that good cleanliness will lead to less C-Diff infections. NHSE have linked these two factors together. The Trust used to be an extreme outlier for our number of C-Diff cases, we are now about the middle of the pack. This is not due to an improvement in our performance but due to other Trusts deteriorating post pandemic. We are now part of the West Midlands Collaborative. • The CNO advised that our C-Diff rates are higher than trajectory but it is very rare that stool samples taken are of the same ribotype (ie cross infection). This level of information is included in the quarterly report to the Infection Prevention Committee, which the CNO was happy to share if helpful to the Committee. • The IPCN advised that so far in July, there have been no C-Diff cases reported or being presented to panel. • Mr James (Chair and NED) questioned whether it would be helpful for Sodexo to come to future Quality Committee meetings to discuss these issues as we are now clearly working closely together.	**LF**
	<u>Resolved</u> – that : **(A) The Quality Priority – IPC (Cleanliness/C-Diff) presentation be received and noted.** **(B) To invite Sodexo to attend future Quality Committee meetings when the Infection Prevention Reports are presented.**	**LF**

QC007/07.23	**QUARTER 1 2023/24 SAFEGUARDING REPORTS**	
	The Associate Chief Nursing Officer (ACNO), Named Nurse Safeguarding Children (NNSC) and Named Nurse Children In Care (NNCIC) presented the Quarter 1 2023/24 Safeguarding Reports and the following key points were noted: **Adult** • There were 11 new referrals regarding care at the Trust received in Quarter 1. This is a significant spike as only 4 were received in the previous quarter. There is a lot of work being undertaken to monitor this, with no particular pattern or area of concern. Some of the issues (included in the report) were due to missing medications or unsafe/failed discharge. We are reviewing these in more detail to identify key concerns. • Training Data – Figures are sustained or improved for Safeguarding. The new Lead Nurse Adult Safeguarding is continuing with her bespoke training sessions in MCA and DoLS, which is being well received. • The Advanced Practitioner MCA and DoLS post has been recruited to, commencing in post in September. They will bring a wealth of experience to the team. • A new Domestic Homicide Review (DHR) has been commissioned which we are reviewing. The Children's Safeguarding team are assisting with this due to the staffing challenges in the Adult Safeguarding Team (details within the report). There was one DHR received this month which is being reviewed to see whether this meets the criteria. • Mrs Martin (NED) queried regarding the Safeguarding Referrals from Care Homes, how much are we using our informal relationships to work through issues rather than having the formality of a referral if not necessary. The ACNO advised that our Enhanced Care Home Teams are working with the Care Homes Safeguarding Referrals come from the Local Authority around issues regarding our care. • Mr James (Chair and NED) noted that some of these issues are patient quality issues even if they are not Safeguarding issues and questioned if there are any themes emerging that we need to review. The ACNO advised that we are having conversations around how we review these, with one suggestion that they are discussed at the Vulnerable Patients Group.	

	• The Chief Medical Officer (CMO) noted that on receipt of a Safeguarding Referral, we are presuming that someone is being seriously neglected and then downgrade it if this is not the case. Can we not have a more collaborative review and a different mechanism to declare something that may have gone wrong with someone's care? The Associate Medical Director, Medical Division advised that the two Safeguarding Referrals received for the Medical Division were for patients who had received really good care in the Trust; the issue was not with the Trust, and agreed that this was not necessarily the appropriate mechanism for raising these types of concerns. • The Managing Director questioned if there has been a change in practice or whether the increase in numbers was just due to Nursing Homes also using this system. The ACNO was not aware of any changes, the numbers are just increasing. The Managing Director felt that this is the wrong process and stated that if we are looking to review if this is the right process, we need to replace it with another system. The CNO advised that this is not our process but a multi-agency procedure that is not in our remit to change and it may well be that this is not the most appropriate method of referring quality issues. We need to try to find a way into Care Homes to enable them to directly engage with us if they have any issue with a patient discharge or a patient issue rather than going through the safeguarding process. • The Managing Director queried what the alternative is and if we have one and how we can engage with Care Homes to raise issues directly. Mr James (Chair and NED) suggested a discussion with the Local Authority as none of the referrals proceeded which is a waste of resources. The ACNO will ask the Lead Nurse Adult Safeguarding to review this issue. **Children** • The number of children who have a Child Protection Plan are high but stable. This generates a large number of meetings, including Core Group meetings, conferences and strategic meetings. This is placing pressures on some services. • Training levels are exceeding Trust targets through Level 1 – 4 and for the Board of Directors. • We are monitoring Emergency Department (ED) Level 3 attendance which has increased but is still below the Trust target at 73%. There is good compliance for senior nurses and doctors, with less for staff nurses and more junior members of the team. • There are still some service pressures with MASH with the number of referrals, checks and responses that are required. We are in discussion with the ICB around increasing the capacity within MASH. The job description is predicated as a Band 7. This is currently with our Human Resources team to job match.	**RH**

	• One risk is the delay in us receiving notifications when children have either become subject to a Child Protection Plan or been removed. Our IT system is not up to date with this information. A meeting was held with the Children's Social Care team and a solution identified, which should be completed within a few weeks' time. This is being monitored on an ongoing basis. • Local Child Safeguarding Practice Review – There are new terms for the Serious Case Review with one currently in progress. The Trust report is on target to be completed and signed off within the timeframe. • Mrs Twigg (NED) noted that extra Support Worker for MASH was mentioned in the last report and yet the post is still not filled. Is the holdup due to recruitment or another issue? The NNSC advised that the post was currently with Human Resources for job matching. We were in negotiation regarding the job description and person specification with the ICB. This can then be progressed back through the ICB for agreement of funding. Matching is taking place at the beginning of August. There will be a short turnaround once this is approved. • The CNO queried if the Board level compliance with training was for Executive Directors and NEDs or just Executive Directors. The NNSC advised that this was the overall figure, which is 88%. The NNSC will contact the CNO with the Board members who have not yet received their training. • Mr James (Chair and NED) noted the overall challenges with Children's Services in Herefordshire regarding the number of children in care and the focus on early help, advising that it we get this right, there were will be less issues later on. It will take time to show progress. The Report shows some improvement from the early help aspect with a stabilisation of the number of children coming into care and into Child Projection Plans. He went onto question if there is a sense that things are now going in the right direction. The NNSC advised that there is recognition that investment in early help is needed again. The Local Authority created a new Assistant Director post and revitalisation of the Early Help Strategy. A lot of work is taking place improving the system for children to ensure that they are in the right place. Due to the poor OFSTED report. The last Monitoring Visit, OFSTED report and MASH work were very positive, with concerns in the rest of the system. Another Monitoring Visit by OFSTED took place recently with the report not due until the beginning of August. There is a sense that there are definitely improvements and changes being seen but there is still a long way to go. • The Managing Director noted that the Safeguarding Reports were quite long and complex and suggested that they take on the format of the Divisional Reports to understand where the key priorities are.	**HF** **RH/HF/ KG**

	• The CNO advised that the layout of the reports was discussed in the pre-meet with herself and the Chair. The content is prescribed but we can use the Finance and Performance Executive quadrant. Discussion was held around further developing the Community Paediatric Finance and Performance Executive meetings with a single action plan for areas we are concerned about and how we monitor this in the meeting. **Looked After Children** • There has been a significant dip in Quarter 1 in the number of new children in care which is extremely unusual. Quarter 2 has been much busier. • The majority of new children in care are Herefordshire children rather than asylum seeking children. • Medical Consents – Due to the low numbers, it is difficult to know if there has been an improvement. We are seeing an increase in Medical Consents not being received back. • We are doing well across all our KPI's. All children are registered with a GP. • 76% of our Looked After Children are seeing a dentist on a 6 monthly basis. This is a credit to the work of the Dental Access Centre on behalf of these children. • Mr James (Chair and NED) queried whether there is an improving picture with regards the Review Health Assessments (RHA). The NNCIC advised that this is generally doing well. We have achieved an 80% attainment rate. There are difficulties for under 5s. During Quarter 1, 11 RHA were out of time scale or not returned to us. This does impact on our attainment rate for Health Assessments. The main reason is foster carer cancellations. The initial appointments are offered within timescales.	
	<u>Resolved</u> – that: **(A) The Quarter 1 2023/24 Safeguarding Reports be received and noted.** **(B) The Associate Chief Nursing Officer will ask the Lead Nurse Adult Safeguarding to review the Adult Safeguarding Referral process.** **(C) The Named Nurse Safeguarding Children will contact the Chief Nursing Officer with the Board members who have not yet received their Safeguarding training.** **(D) The Safeguarding Leads will change their reports to reflect the key headlines used in the Divisional Reports to highlight key information.**	**RH** **HF** **RH/HF/ KG**

QC008/07.23	**MORTALITY REPORT**	
	The CMO presented the Mortality Report and the following key points were noted: • This is a positive report with our SHMI now in the acceptable range. • An update provided yesterday shows our SHMI was 102 from April 2022 to March 2023. This is one of the lowest figures since pre-pandemic. • There has been concern raised around our heart failure outlier groups. We have an excellent cardiology team reviewing this. An audit has been completed and analysis of coding to see if this is the real issue. An update will be provided at the next meeting as to whether this is a coding or clinical recording issue. • Stroke – We have the 8th lowest mortality rate in the county. • Palliative Care coding – We are developing a dashboard and have set up a Working Group to review this. The figures are now improving but this is probably because this area is being highlighted. • Mrs Martin (NED) congratulated everyone for taking this issue seriously, along with the CMO's strong leadership. Mr James (Chair and NED) echoed these comments. • Mr James (Chair and NED) noted that Learning From Deaths forms part of this report and queried whether we also learn from good and excellent care as well. The CMO confirmed that this information is delivered to the teams as well as what has gone wrong.	
	Resolved – that the Mortality Report be received and noted.	
QC009/07.23	**CQC ACTION PLAN AND UPDATE**	
	The Associate Director of Quality Governance (ADQG) presented the CQC Action Plan and Update and the following key points were noted: • There are four actions left on the Action Plan that are not closed but are business as usual and subject to a Quality Priority for this year. • There is detail in the report for the amber and red rated actions including a narrative. • It was proposed that progress is now tracked through the Quality Priorities quarterly updates presented to the Quality Committee and that the CQC action plan itself is closed.	**ADQG**
	Resolved – that: **(A) The CQC Action Plan and Update be received and noted.**	

	(B) The CQC Action Plan will no longer be presented to the Quality Committee as the outstanding issues with be tracked through the relevant Quality Priority Reports.	**NO**
QC010/07.23	**<u>DIVISION QUARTERLY REPORT – SURGICAL DIVISION</u>**	
	The Divisional Nurse Director (DND), Surgery presented the Division Quarterly Report – Surgical Division and the following key points were noted: • During the last quarter, there was a decrease in the number of Serious Incidents reported in the Division. • There are currently 20 overdue outstanding Serious Incidents. Of these, 10 are with the ICB for review with work continuing on the remaining 10. • There was 1 Never Event in Ophthalmology. The DND, Surgery provided the background to this. • There were a high number of incidents in Ophthalmology. Following initial learning in relation to the Never Event, we have changed the process for signing forms once the prescription for the injection has been written and the injection administered to ensure a clear and different process is in place. A thematic review and process mapping has been undertaken to review what other learning we can take from this incident. • There had been a decrease in the number of complaints received, but an increase seen in June. It is not clear whether this is due to the changeover from Datix to InPhase. There were 22 complaints received in June, with the average figure usually between 5 and 7. • The robust complaints monitoring process in place continues which has led to an increase in the quality of complaints being written. • There were similar themes with concerns increasing in the last month. Overall, we are seeing both clinical treatment and communication as the main themes. • A high number of compliments are being received through the Envoy system. We had a 22% response rate, of which 92.05% were positive and 5.08% were negative. • There have been a lot of compliment letters received by the Division across all areas. • There were 2 inspections over the last quarter. The Care Quality Commission visit in Maternity received some positive feedback. We are awaiting the formal outcome of this. West Midlands Children's Network – Paediatric Critical Care and Surgery Peer Review – Positive outcomes and good practice was noted. The main actions noted were the need to appoint to a substantive Surgical Lead for Paediatrics in the Trust and the development of a Trust Children's Surgical Board.	

	• The Trust (along with the Foundation Group) are now part of the Getting It Right First Time (GIRFT) – Further Faster Programme. We are looking to go beyond the 65 week challenge for elective surgical patients and have no patients waiting longer than 52 weeks by March 2024. Monthly meetings are held with the Clinical Transformation groups that have been developed to share good practice. • Elective Surgical Hub Update – We continue to progress with this and are still planning on opening next May. • Theatre Improvement Event – This was held from 3 July for 2 weeks. We are looking at improving effectiveness and productivity. There were 103 theatre sessions with reviewers noting how we could do things differently, good practice and any improvements. There are 145 actions to review. • Surgical Robot Update – This continues to be implemented. Urology and Gynaecology are both signed off and General Surgeons are undertaking their training to use this equipment. South Warwickshire NHS Foundation Trust will be joining the next Surgical Governance meeting. We are also having a sterilisation unit at the Trust for the robotic equipment rather than sending this to Gloucester, which is more efficient. • Nurse Agency Spend – Over the last quarter there has been a positive reduction in agency spend across the Trust and in the Division. This is particularly in relation to Health Care Support Workers, for which we are down to 3.8 for the Division. Some wards are now using very little or no agency which is a real achievement. • Jean Blackhurst, Junior Sister in Pre-Op Services has won the University Of Worcester Mentor Award 2023. • The Paediatric Diabetes service have won their bid for national funding for Youth Support Workers to be employed within the Trust. This was the only successful bid in the Region. • Our main concern (as raised at the last Finance and Performance Committee meeting) is our Oral Orthodontic Service. This has been on our Risk Register for some time. There is no substantive Orthodontist in the Trust currently. We have a backlog of work for patients receiving new appointments or having ongoing treatment/review. Outsourcing is in place and a meeting to discuss additional outsourcing held. A review will be undertaken at the end of August to ensure that all patients are on the correct treatment plan or discharged if appropriate. We took some incidents to the Serious Incident Panel recently and are undertaking a thematic review. There is concern that these delays are having a physical effect on patients. A number of young people may suffer from psychological harm due to their delay in treatment.	

	• Community Paediatric Service – There is a workforce concern – we are below our substantive level for Community Paediatricians. This is causing significant waiting times for our children to be seen – over 52 weeks for some (no children are waiting 78 weeks). There is a Locum cover in place and we are trying to source additional cover. Currently the Paediatricians are carrying out extra work to support. We have gone out to advert for a Specialist Nurse and an additional Clinician. We are looking for help from the Region to support with this service. We are supporting staff with this situation. • Elective Pathways – There have been a number of breaches this week for patients over 78 weeks. This is monitored on a daily basis. Patients on a "nil" pathway are on the elective pathway but either have a clock stop not put on correctly or their clock is stopped so we are not aware that they are nearing 78 weeks. Gynaecology and Orthopaedics are the main areas of concern. These patients have been found through our validation process. We are undertaking a lot of work to support and train staff to prevent this occurring in the future. • Mr James (Chair and NED) spent time in Theatre observing, noting that staff were enthused and excellent working practices. • Mr James (Chair and NED) noted that agency cover is a quality issue as well as a cost to the Trust. • Mrs Twigg (NED) also found visiting Theatre very interesting. She went on to question regarding the InPhase concerns, whether anything could have been missed or if everything was recorded on a spreadsheet and then added to the system in bulk, and if this issue is now fixed. The DND, Surgery advised there are always glitches with a new system until fully embedded. The ADQG has taken a presentation to the Trust Management Board to highlight this issue. The ADQG advised that bringing over the legacy data is the main issue – we needed to do this before we could add on the new data. We used a spreadsheet for complaints whilst this occurred. Using this manual system did not delay complaints to Division. There has been a spike in complaints, not just in Surgery but across the Trust. Discussions have been held with staff regarding transferring over to this new system and we are now starting to see the benefits with more positive feedback being received. The ADQG and Mrs Twigg (NED) will meet to discuss InPhase in more detail.	**NO/NT**

	• Ms Quantock (NED) questioned whether anything was being done to reduce the risk of harm for patients whilst waiting for treatment for Orthodontics and Ophthalmology. The DND, Surgery advised that for Oral there is additional support in place from an outsourcing company, which we are hoping to increase further. A Consultant will be undertaking a desktop review of around 400 patients. Regarding psychological harm, the DND, Surgery will feed this back to the ICB as their main point of support is in the Community from their GP. This is an area that we will review to see if there is anything more that we can do. Regarding Ophthalmology, as soon as the Never Event came in we reviewed processes with clear learning to be had to try to prevent any future events. • The Managing Director queried whether the increase in complaints in June was a real increase, a backlog or both. The ADQG advised that this was a real increase with 49 received in June. Head and Neck and Urgent Care were the two main areas. • The Managing Director was expecting VTE and EPMA to be completed by now but in the report the date is October, is this now a confirmed date? The CNO advised that the delay is due to further work needed with Maxims and the Nursing Dashboard. We are hoping that these are just glitches in the testing phase and have October as a confirmed date. • The Managing Director noted that the issues around Orthodontics is a significant failure in our governance systems to not have understood that we had a single handed practitioner. This is also a Commissioning issue as well with no oversight of peer support with a single handed service. We need to understand lessons learnt once patient reviews have taken place. • Mrs Martin (NED) suggested that we liaise with other Trusts regarding standardisation for Ophthalmology procedures and opportunities to learn from other Trusts who do not have issues with wrong site surgery or injections in the incorrect eye. • Mrs Martin (NED) felt that it would be helpful to have an update in the next report on the impact on activity with the introduction of the robot. Obviously the industrial action occurring will also have an effect. The DND, Surgery will review how to provide an update on robotic surgery in a future Surgical Divisional Report.	**ES**
	<u>Resolved</u> – that: **(A) The Division Quarterly Report – Surgical Division - be received and noted.** **(B) The Associate Director of Quality Governance and Mrs Twigg (NED) will meet to discuss InPhase in more detail.** **(C) The Divisional Nurse Director, Surgery will review how to provide an update on robot surgery in a future Surgical Divisional Report.**	**NO/NT** **ES**

QC011/07.23	**DIVISION QUARTERLY REPORT – MATERNITY**	
	The Matron for Maternity Inpatients and the Matron for Community and Antenatal Services presented the Division Quarterly Report – Maternity, which was taken as read, and the following key points were noted: • There was one Serious Incident during Quarter 1 which was reported to HSIB. A review was held but it was not felt that any harm was caused. This was discussed with the parents who did not consent to the HSIB review. • MBRRACE – There were no cases for the Trust. We are however involved in 2 cases reported as our patients were treated by other Trusts. • There was 1 complaint received and no new concerns. • The Care Quality Commission inspection was held on 28th June. We are awaiting the report from that visit. • Workforce Review – This is still ongoing and has so far resulted in revised modelling. This is planned to be completed by the end of August. • Workforce and Staffing – There is some stability around our vacancy rates. Four international midwives have passed their OSCE and are awaiting their NMC Pin number to enable them to join the team. • There is currently a 5.82% vacancy rate (including maternity leave). In September we have 12 newly qualified midwives joining the team. • We are going out to advert for just over 5WTE midwives to work in triage. These posts are expected to be filled by a number of internal applicants – we are also expecting to fill some externally. • Training – Multi-disciplinary training continues – just fallen below 90%, but over 80% across all groups. Sickness is the cause for this reduction. • We have now received the updates for Year 5 CNST guidance and are now able to achieve all training due to this. • Diabetes Service – We have identified learning improvement needs and identified a Task and Finish Group for this. • The team are utilising a new element of the Saving Babies Lives bundle for improvements required. We are currently undertaking a funding review from a recurrent fund we are expecting from the LMNS as we would like to assign this to the recruitment of a Diabetes Specialist Midwife.	

	• LMNS Visit – There are a small number of actions following this visit. We have 15 IEAs from the second Ockenden publication and are progressing work in relation to these – we have asked the LMNS to peer review our progress. • Maternity Triage – The issue of significant lack of space continues. This is impacting on our service and remains a risk on the Risk Register – the highest risk we have scoring 20 despite mitigating actions. Funding is available to enable the maternity footprint to be enlarged – plans were submitted about 12 months ago. Maternity are able to fund some of this. We are awaiting a start date for this work. • Ms Quantock (NED) asked if there is BAME and vulnerable user involvement in Maternity to ensure that we are picking up on current resources with existing literature able to be tweaked at a local level. The Matron for Community and Antenatal Services advised that this is being reviewed with our Maternity Voices Partnership as well as incorporating vulnerable groups. We are trying to get more involvement with charities and the Local Authority. We have a 3 year maternity Plan which will bring all the national drivers together. We are also working with the Real Birth Company which enables women booking pregnancy to get access to additional support in their own language (available in 15 languages). Ms Quantock (NED) will forward relevant literature she has to the Matron for Community and Antenatal Services. • Mr James (Chair and NED) questioned whether women who have given birth at the Trust are being asked to be involved in the Maternity Voices Partnership. The Matron for Community and Antenatal Services confirmed that they are with cards given out and posters on the walls in the Department to further promote this. We need more face to face discussions to ask patients about their experiences, but just post birth is not always the most appropriate time to discuss. We need to tap in with Health Visitors as well and get them involved. The team are also visiting a number of drop in groups to raise awareness.	**GQ**
	<u>Resolved</u> – that: **(A) The Division Quarterly Report – Maternity e received and noted.** **(B) Ms Quantock (NED) will forward relevant literature she has for support for BAME and vulnerable patients to the Matron for Community and Antenatal Services.**	**GQ**

QC012/07.23	**MATERNITY PQSM REPORT**	
	The Matron for Maternity Inpatients and the Matron for Community and Antenatal Services presented the Maternity PQSM Report and the following key points were noted:: • This covers the May data with a significant increase in activity seen. Numbers have increased from around 125 – 130 deliveries a month to 161. There has also been an increase in induction of labour which coincides with this increase. • We continue to work on our Robson Group caesarean rates. The current focus is on Robson 5. Thirty women met this criteria, 5 of which had a vaginal birth and 25 had a caesarean section. We are reviewing what we can in the Outpatient Clinics and introducing Specialist VBAC Clinics by the end of September to discuss with women why they are choosing to have a repeat caesarean section rather than a vaginal birth following a caesarean section. • There is 1 potentially high cost claim from 2015. The case was reviewed against local and national guidance relevant at the time. A multidisciplinary team review was held at the time with no care concerns found. It is not expected that the claim will be successful. • We continue to review claims and requests for notes on a monthly basis to ensure any themes are picked up. • The multidisciplinary team are reviewing the newly published CNST 10 year 5 requirements. We plan to achieve all 10 standards as we have done this year. • We are working hard on our PROMPT compliance as well as Community PROMPT, which we are working with Powys around. • Obstetric Consultant compliance for PROMPT training is at 100%. • The Continuity Of Carer paper continues to progress and will be out for comment soon. • Mr James (Chair and NED) noted that it would be useful to get a head start on reviewing the CNST standards to ensure compliance. The Matron for Community and Antenatal Services advised that there is a lot of Regional discussion around this as they now want data from April this year.	
	Resolved – that the Maternity PQSM Report be received and noted.	

QC013/07.23	**STAFFING REPORT**	
	The DND, Surgery presented the Staffing Report and the following key points noted: • The biannual report was presented to the last Quality Committee with the changes in establishment recommended for frailty and ITU. These will be presented to the Trust Management Board for consideration. • We are collecting data from Wards and the ED for the summer data, which will be presented to a future meeting, ahead of the next biannual review. • There were 23 incidents in June – 22 of which were related to lack of staff and 1 due to lack of skill mix. • Our vacancy factor is improving. We are continuing with our international nurse recruitment and are on track with the 120 recruits for this year. There has also been a slight reduction in sickness. • Agency reduced in the last quarter. The DND, Surgery and Senior Nurses are working to improve this further and looking at how we can work differently to recruit and retain staff and reduce our agency spend. We spend the largest amount of agency on Frailty due to the dependence of these patients, hence a biannual review for Frailty is in place. • Our Thornbury spend is stable and only being utilised in specialist areas. • Mr James (Chair and NED) queried if our agency spend is reducing across the Trust. The DND, Surgery confirmed that we have significantly reduced our agency spend across the Trust and not just for surgery.	
	Resolved – that the Staffing Report be received and noted.	
QC014/07.23	**QUALITY PRIORITY – PRESSURE ULCER REPORT**	
	The General Manager – Acute and Countywide Services (GM) and the ADQG presented the Quality Priority – Pressure Ulcer Report and the following key points were noted: • This is a detailed reported, hence split into Trust data and then further split down into areas. • There has been some very positive work in the Community with Divisions engaged in doing things differently. • We have Tissue Viability Link Nurses now across the board.	

	• The GM has been Chairing the Pressure Ulcer Panel for over a year and has seen a steady improvement in engagement. • We have been reviewing older Serious Incidents and have now adopted a new response to avoidable pressure ulcers incidents that aligns with the Patient Safety Incident Response Framework (PSIRF). It is hoped that each Division will have their own specific Improvement Plan. This will form part of the overarching Trust Improvement Plan. • Tier 1 pressure ulcer training is available for staff via ESR – we are trying to make this mandatory training for front line staff. • There is a new Tissue Viability Nurse Specialist starting in September working with Care Homes as part of the Clinical Care Home Practitioner team. This role will also benefit the District Nursing teams. • The details around the themes emerging from investigations is included within the report. Within the ED this is thought to be due to patients either lying for a long time at home or in the ED. We need to review how to assess and treat these patients at an early point. • The CNO advised that the language has changed in the report to bring this in line with other priorities such as VTE • The CNO queried when we will see the data for inpatient beds for CQUINS and pressure ulcer assessment. The ADQG advised that the CQUIN data is due to be submitted in the next few weeks. This was not included in this report due to timings. This will be included in the next Pressure Ulcer Report. • The CNO questioned the progress on the Improvement Plan for Frailty. The Associate Chief Nurse, Medical Division advised that we are seeing the impact of this with a reduction of Frailty pressure ulcers in June. Staff are really engaged, with the plan to roll this out across the rest of the Trust. There is also new equipment available in the ED for long waiters. • The CNO advised that EPR are developing a dashboard for Sisters and Nurses in Charge to produce a specific dashboard for their area to show whether patients have had a VTE or not. This will help with oversight as to whether an assessment has been undertaken. • Mr James (Chair and NED) asked how progress was going on getting the data for the number of pressure ulcers per bed day. The CNO advised that she had asked the Informatics Team for this and is awaiting a response. This is a better measure than just absolute numbers. • Mrs Twigg (NED) noted the amount of work being carried out around this. She found the new format of the report helpful, including the data around avoidable pressure ulcers.	**NO**

	• Mrs Twigg (NED) did not feel that the "trended graphs" were as positive as the wording in the report suggested. We are still some way from seeing an improvement. The GM noted that if you purely look at the graphs, there are no real improvements. There are "green shoots" at the moment but these are slow. We are only just developing the PSIRF framework and need to clarify the Divisional Frameworks. • Mrs Twigg (NED) suggested having more detail in the report around what the Improvement Plans are working towards, by who and when. Mr James (Chair and NED) agreed that an example of this would be useful as the aim was not to overburden the team with more work. The Associate Chief Nurse, Medical Division will include an update in the next report. The key to this is looking at wider learning, clinical frailty, physiology of aging, nutrition and hydration, which are all important to capture.	**SH**
	<u>Resolved</u> – that: **(A) The Quality Priority – Pressure Ulcer Report be received and noted.** **(B) The data for inpatient beds for CQUINS and pressure ulcer assessment will be included in the next Pressure Ulcer Report.** **(C) More detail around what the Improvement Plans are working towards, by who and when will be included in the next Pressure Ulcer Report.**	**NO** **SH**
	CONFIDENTIAL SECTION	
QC015/07.23	**<u>SECTION 28 – PREVENTION OF FUTURE DEATHS</u>**	
QC016/07.23	**<u>ANY OTHER BUSINESS</u>**	
	There was no further business to discuss.	
QC017/07.23	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 31 August 2023 at 1.00 pm via MS Teams.	

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council
HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HSE	Health & Safety Executive

HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MASD	Moisture Associated Skin Damage
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document
PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review

RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur